groupemutuel

General Terms and Conditions for Collective Daily Allowance Insurance under LCA/VVG

PC-M

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A. General principles

Art. 1 Purpose of insurance

The Insurer indicated on the policy guarantees to cover the economic consequences of an incapacity for work resulting from an illness or accident or, supplementally to maternity benefits under the law on loss of earnings allowances (LAPG/EOG), after childbirth, provided the relevant coverage is included in the insurance policy.

Art. 2 Legal bases

The contract is based on the following legal bases:

1. these General Terms and Conditions of insurance, any additional special terms and conditions of insurance, the policy and any addendums thereto;
2. the statements made in the insurance proposal and any other written statements of the policyholder and the insureds, and the relevant health questionnaires;
3. the Federal Law on Insurance Contracts (LCA/VVG) of 2 April 1908;
4. the Law on Data Protection, which the Insurer duly observes when processing data.

Art. 3 Definitions

1. Illness means any medically and objectively detectable, involuntary impairment of the insured's physical or mental health which is not the result of an accident and which requires medical examination or medical treatment, or which causes incapacity for work. Pregnancy complications are equated with an illness.
2. Accident means any damaging, sudden and involuntary injury to the human body which is prejudicial to physical or mental health, is objectively detectible and was occasioned by an extraordinary external cause.
   Are also equated with accidents, sequels and relapses from accidents, bodily injuries equated with accidents and occupational illnesses within the meaning of the LAA/UVG.
3. Maternity leave means an uninterrupted period of 14 weeks from the date of childbirth.
4. Impairment means any case of illness or accident.
5. Incapacity for work means any full or partial loss by the insured of the capacity to perform work which could reasonably be expected of him within the limits of his profession or area of activity, provided such incapacity is the result of a physical or mental impairment. In case of long-term incapacity for work, the work which could rea-

sonably be expected of the insured may also be work in another profession or area of activity.

6. Case means the occurrence of incapacity for work which qualifies the insured for benefits and was caused by one or more impairments.
7. Relapse / new case
   Incapacity for work which is medically linked to a prior case is equated with a relapse. A relapse will only be regarded as a new case after 365 days have lapsed.
8. Border area
   Border area means the area within a fifty kilometre radius on the other side of the Swiss border.

B. Scope of insurance

Art. 4 Insured risks

1. Unless otherwise provided in the contract, the Insurer covers illness risks by default.
2. Accidents are covered only if the policy expressly provides for such coverage.
   Accident benefits have the same scope as illness benefits.
3. Occupational illnesses and bodily injuries equated with accidents under the LAA/UVG, and their sequels, are only covered by the accident insurance.
4. The supplemental daily allowance is only payable in addition to LAPG/EOG loss of earnings maternity benefits if such benefits are expressly foreseen in the policy in association with a collective insurance covering daily allowance benefits in case of illness.
5. The Insurer grants daily allowances up to the coverage stipulated in the contract, based on a maximum annual salary of CHF 250,000 per person. The corresponding daily allowances are paid within the scope of the loss insurance except for those specified in Article 5(2) which are conceived in the form of a fixed-sum insurance.

Art. 5 Insured persons

1. The circle of insureds is specified in the contract.
2. On request, the employer or the company executives may be insured for a fixed salary amount provided they are specifically designated in the insurance policy. The agreed salary shall then be covered as a fixed-sum insurance.
3. Persons who have exhausted their entitlement to daily allowance benefits, subject to the terms and conditions of the extended loss of earnings coverage (see Articles 17 to 21 of the General Terms and Conditions of Insurance), and staff hired out to the policyholder by third parties cannot join a daily allowance insurance contract.
4. Persons who are fully or partially unable to work on health grounds when the collective insurance contract comes into effect or, subsidiarily, at the start of their employment, are not insured. They will be covered as soon as they have recovered their full ability to work for at least one month. Agreements regulating the free transfer of coverage are reserved.

Art. 6 Insurance coverage

The term of entitlement to benefits is stipulated in the contract.

a. Coverage in LPP/BVG coordination

1. Benefits are granted on a case-by-case basis until the insured is entitled to an LPP/BVG pension, or until his contractual entitlement to benefits is exhausted. Unless otherwise specified in the contract, the maximum entitlement to benefits is limited to 730 days per case. The first limit reached shall be decisive.
2. If, during an insured's incapacity for work, he is affected by an impairment which is related to a prior case, the daily allowances paid in connection with that impairment will be imputed exclusively to the prior case.
   Impairments related to a case in respect of which benefits have been exhausted are no longer covered and there is no entitlement to benefits.

b. Extended coverage:

Unless otherwise provided, the term of entitlement to benefits is 730 calendar days in a period of 900 consecutive days for one or more cases of incapacity for work.

Art. 7 Affiliation with risk assessment

A health examination is mandatory where the insurance proposal or contract so requires or where the annual salary exceeds the maximum limit.

Art. 8 Start and end of insurance contract

1. The policy indicates the effective date as well as the expiry date of the contract which is on 31 December of a calendar year.
2. Unless the contract is terminated by registered letter no later than 30 September of the current calendar year, it will be automatically extended from year to year.
3. If the company ceases its business activities, termination will be accepted for the end of the relevant month. The Insurer must be informed within 30 days if the company closes down or goes into bankruptcy.
4. After each claim for which the Insurer is liable for benefits, the policyholder may withdraw from the contract within 14 days of hearing that the benefit was paid. If the policyholder withdraws from the contract, coverage ceases as soon as the Insurer receives the notice of termination.
5. The contract may be terminated if the policyholder makes or attempts to make illegal profits causing the Insurer prejudice.
6. Individual members may terminate their insurance coverage for the end of the month subject to one month's notice.

Art. 9 Waiver of termination following a loss

The Insurer expressly waives his legal right to cancel the contract following loss or damage save in case of abuse, misrepresentation, fraud or non-disclosure, or attempted abuse, misrepresentation, fraud or non-disclosure.

Art. 10 Beginning and end of coverage

1. For each insured, coverage starts on the first day of employment with the company, but not before the policy comes into effect.
2. Unpaid leave of absence
   a. During unpaid leave of absence, coverage shall be maintained for a period not exceeding 12 months. The entitlement to a daily allowance will first resume on the day the employee is scheduled to return to work.
   b. The employer shall notify the Insurer of the duration of its employee's unpaid leave 30 days before the start of the relevant leave.
   c. If coverage is maintained, the entitlement to a daily allowance will first resume on the day the employee is scheduled to return to work. In case of his incapacity for work on that date, the waiting period shall run from the start of the entitlement to benefits. The daily allowance is calculated based on the employee's AVS/AHV salary for the period before the start of the unpaid leave. During his unpaid leave, the insured shall be released from the obligation to pay the premiums.
3. For each insured, insurance coverage and entitlement to benefits cease:
   a. when the insured leaves the circle of persons qualifying for insurance;
   b. on termination or suspension of the insurance contract;
   c. on expiry of a fixed-term employment contract;
   d. as soon as an LPP/BVG pension is paid in the framework of LPP/BVG coordination coverage.
   e. when the entitlement to benefits under extended coverage is exhausted;
   f. at the end of the month when the insured goes into retirement. If the insured remains gainfully employed beyond the AVS/AHV retirement age and wishes coverage to be maintained, the policyholder shall apply to the Insurer beforehand. Coverage shall be granted, subject to Articles 12(20) and 14(3), until the end of the month coinciding with the insured's 70th birthday and no later.
   Once the entitlement to the daily allowance for 180 days has been exhausted, or upon termination of the collective contract, insurance coverage and the entitlement to benefits shall cease;
   g. subject to Article 13 of these General Terms and Conditions, when the insured transfers his place of residence abroad;
   h. in the case of individually insured cross-border workers, at the end of their incapacity for work, subject to exhaustion of their entitlement to benefits;
   i. when an insured definitively stops work;
   j. if premiums are not paid in accordance with Article 22 of these General Terms and Conditions;
   k. when the framework time limit or the entitlement to unemployment benefits expires. The first limit reached shall be decisive.

Art. 11 Transfer to individual coverage

1. An insured who ceases to be part of the circle of insureds has the right to maintain his coverage on an individual basis if:
   – he is unemployed within the meaning of the Federal Law on Unemployment (LACI/AVIG)
   – he has an incapacity for work or, subject to paragraph 6, if he earns an income in Switzerland after exiting the collective contract.
2. The insured must claim his transfer right within 90 days of exiting the collective contract, in accordance with Article 26(1), otherwise, his right lapses.
3. Exclusions specified under the collective insurance shall be maintained for insureds who transfer to individual insurance.
4. By contracting individual loss of earnings coverage in accordance with Article 11 of these General Terms and Conditions, the transferring person is entitled to the same benefits as those guaranteed under the collective insurance. Premium waivers are not included in such benefits.
5. Daily allowance benefits paid in the framework of the collective contract are deducted from the insured's coverage as an individual member.
6. There is no right to transfer to individual coverage (subject to Article 100 LCA/VVG on the rights of the unemployed) in the following cases:
   a. if the collective insurance contract is terminated by the policyholder;
   b. for self-employed persons, employers and members of their families who are not subject to the AVS/AHV;
   c. for persons employed on a fixed-term employment contract, and persons employed illegally;
   d. if the person to be insured was not employed in good faith;
   e. if the insured leaves his job and is covered under the daily allowance insurance of his new employer;
   f. for persons who have reached the AVS/AHV retirement age or who are retired;
   g. if the collective contract was terminated pursuant to Article 10(3)(j) of these General Terms and Conditions.

C. Insured benefits

Art. 12 Benefits

Terms and conditions:

1. Daily allowance benefits are granted for a degree of incapacity for work of at least 25%.
2. The daily allowance is calculated based on the salary in effect at the time of the claim, as specified by the employer on the declaration form provided by the Insurer.
3. In the case of partially disabled or handicapped employees, the degree of incapacity for work is calculated based on the degree of incapacity to continue their current activity.
4. In the event of an insured employee's total or partial incapacity for work, the employer shall inform the Insurer no later than 7 days after the start of his sick leave by means of a medical certificate issued by a recognised practitioner. However, for waiting periods of 30 days or longer, the time limit for informing the Insurer is 15 days from the date the employee goes off work. If the medical certificate declaring the insured event (initial certificate) reaches the Insurer after the time limit, the day of receipt shall be deemed the first day of incapacity for work and the relevant waiting period shall start running from that date. The entitlement to the insured daily allowance starts at the earliest after that period.
5. If the first medical visit took place more than 3 days after the start of the incapacity for work, the Insurer reserves the right to consider the date of that visit as the first day of the incapacity for work.
6. If the initial certificate was issued more than 3 days after the start of the incapacity for work, the Insurer reserves the right to consider the date of issuance of the certificate as the first day of the incapacity for work.
7. The obligation to pay benefits is suspended during maternity leave.
8. Should a worker die from the cause of the incapacity for work entitling him to benefits, the Insurer shall pay the employer a daily allowance within the limits of the entitlement to benefits and the provisions of Article 338 of the Swiss Code of Obligations.

Calculation of daily allowance:

9. If the allowance is expressed as a fixed CHF amount, the insurer will pay the contractual allowance subject to the rules on excess benefits and overinsurance.
10. If the allowance is expressed as a percentage of the insured's hourly wage or monthly salary, as the case may be, it shall be calculated as follows, up to the maximum ceiling fixed in the collective agreement:

    For hourly wages:

    – gross base hourly wage (plus 13th month if applicable)
      times
      average number of hours worked per week or per year
      times
      52 weeks (for hours on a weekly basis)
      divided by
      365 days (including leap year)
      times
      contractual coverage rate.

    In this method, additional amounts for paid holidays and public holidays are included in the daily allowance calculation. The gross base hourly wage does not include holidays and public holidays which are not added to the basic hourly wage.

    Monthly salary:

    – Monthly salary:
      times
      12 months (or 13 months, if a 13th salary is paid)
      divided by
      365 days (including leap year)
      times
      contractual coverage rate.
11. If the insured's income is subject to significant variation (e.g. work on commission, or irregular part-time work), the daily allowance is set by dividing by 365 the salary earned in the 12 months immediately preceding the incapacity for work.

Payment:

12. A daily allowance is due for each day of incapacity for work (Sundays and public holidays included).
13. In cases of partial incapacity for work, the Insurer will pay a daily allowance pro rata the degree of incapacity for work.
14. Incapacity for work cannot be indemnified until the insured has received an interim certificate or a final back-to-work certificate. Interim certificates must be remitted to the Insurer once a month. Upon receipt of an interim medical certificate, the Insurer will indemnify the insured until the date stated on the practitioner's certificate, but not beyond the end of the current month.

Waiting periods:

15. The insured daily allowance is payable on expiry of the agreed waiting period. In calculating the waiting period, each day of partial incapacity for work counts as a full day.
16. The waiting period applies to each case of incapacity for work, except in the case of a relapse, subject to any residual waiting period.
17. The waiting period also applies if there is a change in risk (illness, accident) during the incapacity for work.
18. The waiting period will be deducted from the term of entitlement to benefits.

Duration of benefits:

19. In cases where the insured can be reasonably expected to exploit his earning capacity in a suitable professional activity, the Insurer shall continue to pay benefits for a transitional period of between 3 and 5 months provided that the insured undertakes appropriate steps such as job hunting, registration with the unemployment insurance, filing an application with the Federal Disability Insurance, etc.

20. After the AVS/AHV retirement age and up to age 70, a person who continues to belong to the company's circle of insureds shall be entitled to 180 daily allowances for one or more cases of incapacity for work. However, if a case of incapacity for work started before the insured reached the AVS/AHV retirement age and the balance of benefits after the AVS/AHV retirement age is less than 180 days, the maximum entitlement after the AVS/AHV retirement age shall be limited to that balance.
21. Each day of partial incapacity for work paid counts as a full day.

Renunciation:

22. The insured must not try to prevent the exhaustion of his entitlement to daily allowance benefits by renouncing his right to a daily allowance before the medical advisor certifies his complete recovery.

Change in individual daily allowance:

23. In case of incapacity for work, the daily allowance cannot be increased before the insured has recovered his full working capacity for at least thirty days.
24. If the insured was paid daily allowances by the preceding insurer, the relevant number of days will also be deducted from the term of entitlement to benefits.

Art 13 Benefits covered abroad

1. During a stay abroad, i.e. outside Switzerland and Liechtenstein, or outside the border area for cross-border workers, no benefits are paid. Benefits shall be granted once the insured is duly certified to have returned to Switzerland or, in the case of cross-border workers, to the border area.
   However, benefits shall only be granted for the period in which he is hospitalised if repatriation is not possible.
2. Persons working abroad for a Swiss company, or who are abroad on paid leave for training purposes, are entitled to daily allowance benefits. The insurance contract and the entitlement to benefits cease after 24 months.
3. An insured who wishes to travel abroad during his incapacity for work must inform the Insurer who reserves the right to continue benefits payments during a limited stay, depending on the circumstances.
4. An insured who has an incapacity for work and who temporarily leaves Switzerland, or the border area in the case of cross-border workers, without the Insurer's consent is no longer entitled to benefits until his return.

Art. 14 Limitation of insurance coverage

1. Benefits may be reduced or, in serious cases, refused altogether, if the insured does not respect his obligations under Article 27.
2. Benefits will be reduced if the insured does not follow the doctor's orders.
3. If the insured has an incapacity for work when he reaches the AVS/AHV retirement age, his entitlement to benefits shall lapse unless the policyholder has filed an application beforehand in accordance with Article 10(3)(f).
4. Benefits will be refused:
   a. if there is an exclusion or in case of non-disclosure;
   b. if a deliberately false health claim is filed;
   c. if the incapacity for work is the result of voluntary plastic surgery;
   d. in case of participation in a brawl or a fight involving two or more persons, or in acts of war or terrorism, or in deliberately attempted or committed crimes and offences;
   e. if the incapacity for work is the result of a condition provoked by the insured (suicide or attempted suicide, voluntary self-mutilation);
   f. for health damages caused by ionising rays and for health damages caused by nuclear radiation;
   g. during earthquakes;
   h. during military service abroad;
   i. in case of participation in hazardous activities within the meaning of the LAA/UVG;
   j. if the person to be insured was not employed in good faith (in particular to avoid a risk assessment or to obtain new entitlement to benefits);
   k. the insured refuses to comply with the Insurer's instructions, in particular if he refuses to be examined by the medical expert designated by the Insurer or refuses to follow rehabilitation measures for the recovery of his working capacity (for example, regrading measures);
   l. if, without the Insurer's consent, the insured changes his attending practitioner when the latter certifies that he is able to resume work full-time or part-time;
   m. if the insured does not respect his obligation to reduce damages;
   n. for claims resulting from events of war:
      – in Switzerland and in the Principality of Liechtenstein;
      – abroad, unless the events caught the insured by surprise in the country where he was staying and provided the incapacity for work arises no later than three months after the start of the events.

D. LAPG/EOG Supplemental maternity allowance

Art. 15 Insurance coverage

1. Payment of a supplemental daily maternity allowance is subject to the benefits entitlement provisions of the Federal Law on loss of earnings allowances during military service and maternity (LAPG/EOG).
2. The insured daily allowances are paid if, at childbirth, the insured had insurance coverage exceeding LAPG/EOG benefits coverage contracted by her employer, and provided she had had such coverage at childbirth for at least 270 days without interruption.

Art. 16 Insured benefits

1. The Insurer grants daily allowances up to the coverage provided in the policy, based on a maximum annual salary of CHF 250,000 per person.
2. The coverage indicated on the policy applies for an agreed term of coverage, coverage level and excess salary.
3. The entitlement to benefits starts on the day of childbirth subject to the maternity leave deferral situations contemplated in the LAPG/EOG. The Insurer shall pay the allowances, without interruption and retroactively for the end of each calendar month for which the insured is entitled to a supplemental allowance, upon receipt of the salary statement.

E. Extended loss of earnings coverage

Art. 17 Scope of coverage

1. If it is included in the policy, extended coverage shall be agreed individually for each employee concerned. The purpose of such coverage is to continue to provide health insurance in cases where the entitlement to daily allowance benefits has been exhausted.
2. The employee must have a residual working capacity. The policyholder and the Insurer shall determine the terms and conditions for such coverage, including a one month waiting period between the actual beginning of the employee's regraded activity and the effective start of coverage.
3. Extended coverage is offered exclusively in conjunction with the collective insurance for a daily allowance offered by Groupe Mutuel insurers.
4. The Insurer pays a daily allowance in accordance with the specified contractual coverage.
5. The daily allowance is calculated following the same criteria as the coverage specified in the policy (percentage of salary, waiting period, risk covered, notion of loss coverage).
6. Deviating from Article 12(18) of these regulations, the waiting period foreseen under the collective policy is not deducted from the maximum term of coverage.
7. If, at the end of the 5-year period running from the start of extended coverage, the insured has not exhausted the term of entitlement to benefits under that coverage, he will once again be entitled to the original coverage stipulated in the policy provided he is still employed with the same company.

Art. 18 Insurance coverage

1. At the policyholder's request, the insured may be granted extended coverage if:
   a. he has fully exhausted his entitlement to daily allowance benefits for illness;
   b. if he has capacity for work which is useful to the company; and
   c. if a job adapted to his capacity has been offered to him.
2. In any event, an employee cannot be entitled to extended coverage more than once.
3. If an employee already belongs to the company's circle of insured persons, the extended coverage and the entitlement to benefits will be valid at the earliest after the time limit indicated in Article 17(2).

Art. 19 Transfer to individual coverage

Coverage is valid exclusively in conjunction with the company's collective policy and is designed to encourage occupational reinsertion.
Employees who no longer belong to the circle of insureds are not entitled to free transfer to individual coverage.

Art. 20 Premium

The collective premium fixed in the policy includes the conventional collective insurance product and the extended loss of earnings coverage.

Art. 21 Additional provisions

1. To obtain extended coverage, the employer has to apply to the Insurer.
2. To qualify for extended coverage, the employee must be the beneficiary of specific measures (reduced working hours, regrading, adapted work place, etc.) decided by the employer in order to allow him to maintain a professional activity within the company.

F. Premiums

Art. 22 Payment of premiums

1. The policyholder is liable as debtor for the premiums.
2. Premiums are contractually fixed for each insurance year. Premiums are payable within the time limit specified in the policy. Provisional premiums may be adjusted at any time to allow for circumstances.
3. Premium instalments maturing in the course of a calendar year shall be considered as amounts payable for the relevant time limits. They may be adjusted at any time to allow for payroll changes in the course of the year. Unpaid portions of the annual premium remain due.
4. If the premium or premium instalments are not paid when due, a formal notice shall be sent to the debtor, at his cost, requesting payment within 14 days of the notice and

pointing out the consequences of late payment. If premium arrears and costs are not paid within the additional time limit, the Insurer's obligations shall be suspended thereafter. A suspension of the Insurer's obligations means:
   - in the case of new claims, that new claims arising during the suspension period will not be considered;
   - in the case of claims in payment, that the payment of the corresponding benefits will be suspended for the duration of the suspension.
5. If the Insurer does not institute debt collection proceedings for the premium arrears and costs within two months following the expiry of the 14-day time-limit, the contract shall be deemed terminated. .
6. During suspension periods, the days of incapacity for work for claims in payment will be deducted from the duration of the entitlement to benefits. Insurance coverage and payment of benefits for claims in payment will only resume – non-retroactively – after the outstanding premium has been collected.
7. With regard to insurance coverage as an individual member, if membership starts or ends in the course of a month, premiums are due for the full calendar month.

Art. 23 Adjustment of premium rates

1. The Insurer may adjust the premium each year to allow for trends in claims. Premiums shall be adjusted as of 1 January of each calendar year.
2. Notwithstanding, premiums may be adjusted immediately in the event of a change in circumstances (e.g. in the case of a merger, spin off or take over) or if there is a decisive change in the composition of the circle of insureds.
3. If premium rates are changed during the insurance term, the Insurer may demand an adjustment of the policy from the beginning of the next calendar year.
4. The Insurer shall inform the policyholder of the new rate no later than 25 days before the expiry of the current year. If the policyholder objects to the change, he may terminate the contract for the end of the year.
5. Changes are considered approved if the Insurer does not receive a termination notice by registered mail before the end of the year.
6. If, after the premium is set, the Insurer receives belated notifications of cases of incapacity for work, he shall be entitled to retroactively alter the premium rate to allow for the actual loss rate. Retroactive adjustments shall be deemed approved if the Insurer does not receive a notice of termination by registered mail within 30 days of the notification of the change in premium. Termination shall be effective at the earliest at the end of the month in which the Insurer receives the termination notice.
7. Claims for cases arising during the term of collective coverage shall be charged to the collective policy.

Art. 24 Premium statements

1. The final premium statement will be prepared at the end of the year corresponding to the calendar year, based on the documentation provided by the policyholder pursuant to Article 26 of these General Terms and Conditions.
2. Premiums cannot be waived in the case of individual insurance.

Art. 25 Surplus sharing

1. The agreed share of any surplus proceeding from the contract shall be paid to the policyholder, in accordance with the terms and conditions of the contract, at the end of the contractual accounting period of minimum three years expiring on 31 December.
2. The accounting is done at the earliest 5 months after the end of the accounting period but not before all losses during the period have been settled and indemnified.
3. If the losses for a closed accounting period are declared or indemnified after the accounting statement has been drawn up, a new surplus-sharing statement will be prepared. The Insurer shall claim restitution of any excess surplus payments made.
4. Surplus-sharing payments are made subject to the condition that the collective policy remains in force until the end of the accounting period.
5. When profit-sharing is calculated, claims for cases arising during the term of collective coverage will be charged to the collective policy.
6. Premiums and benefits for LAPG/EOG supplemental maternity allowances are not taken into account in the surplus-sharing calculations.

G. Other provisions

Art. 26 Obligations of the policyholder

1. The policyholder shall inform the insureds about their rights and obligations under the insurance contract, indicating in particular that they have the possibility of maintaining their insurance coverage if they leave the circle of insureds or on expiry of the policy.
2. Pursuant to the obligation to inform (Article 3 LCA/VVG), the policyholder is also required to inform insureds about the essential elements of the contract. The Insurer shall provide explanatory notes to the policyholder for that purpose.
3. The policyholder shall notify the Insurer immediately if an insured with an incapacity for work withdraws from the collective contract.
4. For each final invoicing, the policyholder shall provide the Insurer with the insureds' AVS/AHV statements or, by default, with a list of insureds, containing for each insured his name, date of birth, AVS/AHV number, gender, salary and period of work.

5. If the requisite information is not supplied within 30 days of the Insurer's request, the latter shall send the policyholder a formal notice, giving him an additional 14 days from the date of the notice to comply.
6. If the formal notice has no effect, the Insurer shall then assess the rate itself, increasing the premium charged the preceding year. Article 22 of these General Terms and Conditions applies mutatis mutandis to the supplemental premium.
7. The policyholder shall afford the Insurer, or the Insurer's agents, access to the company's books and accounting documentation, and to the documentation sent to the AVS/AHV Compensation Fund, failing which the Insurer reserves the right to suspend its obligations.
8. The policyholder undertakes to notify the Insurer of the occurrence of any insured events and to provide, automatically or at the Insurer's request, any document capable of establishing the loss of earnings or salary (medical certificates, employer's certificates, AVS/AHV or fiscal calculations and statements, birth certificates, etc.).The Insurer reserves the right to check the plausibility of the declared salary.
9. The waiting period is for the employer's account.

Art. 27 Obligations of the insured

1. The beneficiary is required to remit to the Insurer all requisite substantiation, including a power of attorney authorising the Insurer to obtain information from third parties, enabling the Insurer to verify that his claim is well-founded, failing which he shall forfeit his entitlement to any benefits.
2. Changes in the degree of incapacity for work must be promptly notified to the Insurer.
3. The insured shall release his attending practitioners from medical and professional secrecy vis à vis the Insurer's medical advisor.
4. The insured must cooperate with the medical visitors and doctors mandated by the Insurer. The insured shall follow their instructions. He shall be obliged to inform them and answer their questions. If the insured fails to appear for a medical examination on the appointed date without good reason, the Insurer reserves the right to reduce or refuse benefits, or to demand that any benefits already paid be refunded and to bill the insured for the missed medical appointment.
5. In case of incapacity for work, the insured shall consult a licensed practitioner from the outset, and shall duly follow his instructions. He shall avoid doing anything liable to hinder his recovery or to prolong his incapacity.
6. Within reasonable limits, the insured shall participate in treatment or in professional retraining measures designed to significantly improve his capacity for work or offer new earnings prospects.
7. In order to receive LAPG/EOG supplemental maternity allowance benefits, the insured shall if necessary provide the corresponding statement from the relevant Compensation Fund.

Art. 28 Third-party benefits

1. In the context of the early detection procedure, the Insurer shall be allowed to declare an insured to the AI/IV office. The insured shall be notified in advance in that case.
2. Given the obligation to limit damages, the Insurer may instruct the insured to apply for disability benefits.
3. If the Insurer advises the insured to apply to the competent social insurance institution for disability benefits, or to follow any measures, it may make the payment of benefits conditional to the insured's actual application. If the insured refuses to comply, the Insurer reserves the right to claim reimbursement of any benefits paid after the aforesaid instructions.
4. The Insurer subsidiarily covers, within the limits specified in the policy, the portion of loss of earnings or loss of salary benefits which are not covered by any social insurance.
5. If a third party reduces its benefits as a penalty, the Insurer shall not compensate the ensuing reduction.
6. If several private insurers jointly and severally cover the loss of earnings, the aggregate benefits paid by them shall not exceed the actual loss. The Insurer is only liable proportionately to its share of the total benefits insured by all the insurers.
7. Upon occurrence of an insured event, the Insurer is subrogated, within the limits of its contractual benefits, to the rights of the insured and his survivors against any liable third party.
8. If the insured concludes an agreement, without the Insurer's consent, by virtue of which the insured fully or totally renounces the benefits or compensation due from a third party liable for benefits, the Insurer's contractual benefits will be reduced accordingly.
9. The Insurer shall continue advancing reduced earnings benefits until the Federal Disability Insurance (LAI/IVG), an accident insurance (LAA/UVG), the military insurance (LAM/MVG), a pension fund (LPP/BVG) or a private or foreign insurer establishes that the insured is entitled to a pension. As soon as a pension is granted by one or more of the aforesaid institutions, the Insurer shall be entitled to claim restitution of the advances paid directly from the latter or from another third party. Any restituted surplus amounts shall vest with the Insurer.
10. For the calculation of the duration of benefits, the days in respect of which third-party benefits are reduced shall count as full days.
11. With reference to coverage transfer agreements, the duration of any daily allowances benefits paid by preceding insurers shall be deducted from the maximum entitlement to benefits under the collective insurance.

Art. 29 Excess benefits and overinsurance

1. The benefits payable by the Insurer, or the conjunction of

such benefits with those paid by other insurers, including social insurances such as the AI/IV, LAPG/EOG, LAA/UVG and LPP/BVG, shall not result in excess benefits for the insured. Excess benefits, namely the portion of daily allowance exceeding the benefits stipulated in the policy, must be repaid to the Insurer.

2. Overinsurance, i.e. where the amount insured is higher than the earnings from gainful employment or from unemployment benefits, is not allowed. In the event of overinsurance, the insured daily allowance benefit shall be reduced to equal the earnings from gainful employment or unemployment benefits at the beginning of the month when the oversinsurance was established. The premiums for the period before the overinsurance was declared shall vest with the Insurer.
3. If the declared salary on a claim for incapacity for work benefits is higher than the insured earnings or the actual loss of earnings suffered by the insured, the Insurer reserves the right to claim restitution of the excess daily allowances paid.
4. For insureds with a fixed-sum salary, the scope of benefits corresponds to the agreed daily allowance. Overinsurance does not apply in that case. However, if daily allowances are payable in conjunction with social insur-ance benefits from the Federal Disability Insurance, an accident insurance or military insurance, the allowances shall be deducted from the amounts paid by such social insurances.

Art. 30 Set-off

1. The Insurer can offset benefits due against amounts receivable from the policyholder or the insured for his share of the premium.
2. The policyholder has no right of offset against the Insurer.

Art. 31 Assignment and pledging of benefits

The policyholder may not assign or pledge its claims against the Insurer without the latter's consent.

Art. 32 Notices

1. Notices shall be addressed to the Insurer's general administration or to one of its official agencies at the addresses on the list provided by the Insurer.
2. Notices made by the Insurer are valid if they are sent to the last Swiss address communicated to the Insurer by the policyholder or the insured.

Art. 33 Place of performance and jurisdiction

1. Save any special provisions to the contrary, the obligations arising from the contract shall be performed in Switzerland and in Swiss francs.
2. In case of dispute, the policyholder or the beneficiary may choose the jurisdiction of the courts of his place of residence in Switzerland, or of the Insurer's registered office. If the policyholder or the beneficiary is domiciled abroad, the courts of the registered office of the Insurer have exclusive jurisdiction.