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General Terms and Conditions (CGA) of the LAA/UVG Accident Insurance Contract

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A. General

Art. 1 Applicable law

1. Unless otherwise provided for by law, insurance benefits are granted for occupational and non occupational accidents. Occupational illnesses are treated like occupational accidents in accordance with the Federal Law on Accident Insurance (LAA/UVG) and the Ordinance on Accident Insurance (OLAA/UVV).
2. The legal bases of the contract are:
   a. These General Terms and Conditions of Insurance, as well as the provisions in the policy and any appendices thereto;
   b. The written statements in the proposal, other written statements of the policyholder;
   c. The Federal Law on Accident Insurance (LAA/UVG) and the relevant ordinances (OLAA/UVV);
   d. The Law on Data Protection (LPD/DSG) which the Insurer duly observes when processing data;
   e. The Federal Law on General Social Insurance Law (LPGA/ATSG) and the relevant ordinance (OPGA/ATSV).

Art. 2 Acceptance of contract, rectification right

If the contents of the policy are not consistent with the tenor of the agreements, the policyholder must request the necessary corrections within four weeks of receiving the policy, otherwise the contents of the policy shall be deemed accepted.

Art. 3 Classification and objection

For premium tariff classification purposes, this contract constitutes a decision within the meaning of Article 49 LPGA/ATSG. The policyholder may contest this decision by filing an objection within 30 days; objections may be filed in written form with the relevant Insurer or they may be presented orally at a meeting with the Insurer. Objections must be substantiated. Objections presented orally shall be recorded by the Insurer in a statement signed by the policyholder. The objection procedure is free of charge. No costs will be awarded.

B. Scope of the insurance

Art. 4 Insurance policy

The insurance policy sets out the details of the insurance coverage, including the insured persons and any special terms or conditions.

C. Start and end of the contract

Art. 5 Start and end of the contract

1. Start of the contract
   The legal validity of the contract is specified in the policy. The contract is concluded for a term of three or five years.
2. End of the contract
   At its expiry, and unless the Insurer receives a notice of termination policy by 30 September, the contract shall be automatically extended from one year to the next.
   For each insured, voluntary coverage ceases:
   a. upon termination of the contract;
   b. when he becomes subject to compulsory insurance;
   c. if he is excluded from coverage for having failed to pay his premiums or having made a false declaration;
   d. three months after he stops gainful self-employment, or working as a family member not covered by compulsory insurance.

D. Premiums

Art. 6 Obligation to pay premiums

1. The policyholder is the debtor for the premiums.
2. The employer is liable for compulsory insurance coverage for occupational accidents and illnesses. The employee is liable for compulsory non occupational accident coverage, unless otherwise agreed in the employee's favour.

Art. 7 Premium collection

1. Prepayment of the premiums
   The premiums for each calendar year are payable in advance. For an additional amount provided for under OLAA/UVV, the policyholder may stagger the payment of premiums to biannual or trimestrial rates. Premiums are payable one month after the maturity date. After the expiry of this period and according to the conditions set out in OLAA/UVV, the Insurer shall charge an interest on arrears of 0.5% per month.
2. At the request of the policyholder, the provisional premium may be modified by the Insurer.
3. Final premium statement
   a. At the end of the calendar year, premium statements are prepared based on the AVS/AHV salary provided the latter is not higher than the maximum insurable salary. The other particularities are shown in the salary declaration form. The policyholder has a deadline of one month to declare the insured salaries paid in the elapsed calendar year.
   b. If the salary declaration form is not submitted within the deadline, a formal notice shall be sent by the Insurer to the policyholder. If there is no reaction to the reminder, the Insurer shall apply an automatic taxation by increasing the annual premium of the previous financial year.
4. Lump-sum premium
   Where the policy provides for a lump-sum premium, the Insurer agrees to forgo an annual statement based on the actual salary. If the total annual salaries covered by compulsory insurance exceed CHF 10,000, the policyholder shall inform the Insurer and shall pay the applicable surcharge in accordance with the tariff, if necessary retroactively for a maximum of five years.

Art. 8 Voluntary insurance

Within the limits provided for by the LAA/UVG, the amount of the insured income is agreed to by the Insurer and the insured when the contract is concluded and can be changed at the beginning of each calendar year. Cash benefits are calculated based on the actual loss of salary.

Art. 9 Adjustment of premium rates

1. If there is a change in the premium tariff or in the classification of companies in tariff classes and levels, the Insurer shall suggest an adjustment of the policy from the next calendar year. The Insurer shall notify the policyholder at least two months prior to the adjustment becoming effective.
2. In case of an increase in net premium rates or increase in the premium surcharge for administrative expenses (in percent), the policyholder may terminate the contract within 30 days of the reception of the Insurer's notification. These provisions shall not apply to changes in other premium surcharges.

E. Various provisions

Art. 10 Obligations of the policyholder

The policyholder is required to:

- notify the Insurer immediately of any insured event which could create an entitlement to benefits;
- provide the Insurer with all necessary information and place the documents required to establish the circumstances of the accident at its disposal;
- pay the premiums;
- inform employees leaving the company of the necessary measures;
- declare the salaries;
- inform the Insurer of any significant increased risk.

Art. 11 Obligations of the insured person/the beneficiaries

The insured person/the beneficiaries is/are required to:

- notify the insured event to the employer/Insurer immediately;
- provide the employer/the Insurer with any document capable of establishing the entitlement to benefits;
- release his/their attending medical practitioners from medical and professional secrecy vis à vis the Insurer's medical advisor;
- cooperate with the Insurer and with the third parties mandated by the Insurer (claims' inspectors, officers, doctors, etc.);
- submit an application for benefits to the AI/IV disability office no later than six months from the beginning of the incapacity or, upon request of the Insurer, to another social institution;
- within reasonable limits, participate in treatment or in professional retraining measures.

Art. 12 Broker clause

If the policyholder designates a broker, the latter will conduct the business relationship with the Insurer. The broker will forward all requests and answers from one party to another, except payments. Information is considered to have reached the policyholder once it has reached the broker.

Art. 13 Notices to the Insurer

1. Notices shall be addressed to the Insurer's administrative headquarters or to one of its official agencies.
2. Notices given by the Insurer are valid if they are sent to the last address communicated to the Insurer by the policyholder or the insured.