groupemutuel

General Terms and Conditions for SanaVista insurance

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In this document, any use of the masculine form applies to both males and females.

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Contents

Art. 1 Bases of the insurance contract

1. The insurance contract is subject to the Federal Law on Insurance Contracts of 2 April 1908 (LCA/VVG).
2. The insurance application, the insurance policy and these general terms and conditions form the basis of the contract.
3. SanaVista insurance is defined in these general terms and conditions and is subject to an individual and separate contract.

Art. 2 Risk-bearing insurer

The insurer is Groupe Mutuel Vie GMV SA (hereafter “the insurer”).

Art. 3 Purpose of the insurance

1. SanaVista insurance provides for a lump-sum in case of disability or death following illness.
2. Benefits in the event of death are covered by fixed-sum insurance.
3. Benefits in the event of disability are covered by indemnity insurance.
4. This insurance does not have a surrender or reduction value.

Art. 4 Eligibility

1. Both the policyholder and the insured person must reside in Switzerland at the time the contract is concluded.
2. SanaVista insurance is open to insured persons up to age 55.

Art. 5 Insurance proposal

1. Sending an insurance proposal is not equivalent to a request for an offer; it constitutes a formal declaration of the applicant’s intent to contract one or more supplemental insurance policies with the insurer. The applicant remains bound to the insurer in accordance with the provisions of Article 1 LCA/ VVG, during 14 days, or four weeks if medical information is needed.
2. The applicant may cancel the proposal within 14 days of the application to conclude the contract.
3. When the proposal is made by the insurer, the applicant may cancel the contract within a maximum of 14 days from the time of its acceptance by the applicant.
4. The insurance proposal can be made using the form made available by the insurer. The applicant must answer all of the questions on the insurance proposal, as well as on the health questionnaire, completely and truthfully. The applicant is responsible for the fact that replies given by a third party or by an intermediary must comply with his/her instructions. Insured persons must authorise third parties to provide the insurer with all necessary documents and information.
5. The insurer reserves the right to accept or refuse the insurance proposal. It is not obliged to give reasons for its decision.

Art. 6 Concealment

If the policyholder, when responding to the questionnaire, concealed or stated incorrectly an important fact that he knew of or may have known (concealment), the insurer has the right to terminate the contract, within four weeks from the time of becoming aware of the concealment.
The termination shall take effect when it reaches the policyholder.

Art. 7 Insurance term

1. The insurance term corresponds to one calendar year and runs from 1 January to 31 December.
2. If the contract is concluded during the course of a calendar year, the first insurance term runs from the effective date confirmed in the insurance policy until the end of the calendar year.

Art. 8 Start, duration and end of the contract

1. The contract is concluded once the insurer has delivered the policy to the policyholder.
2. The contract begins at the date of entry into force stated in the insurance policy.
3. At the end of an insurance term, the contract will be renewed automatically from year to year.
4. The policyholder may terminate the contract as from the second insurance term.
5. Any termination must be made in accordance with Article 20 of these general terms and conditions.
6. The insurer may terminate the contract in the event of non-payment of premiums, in accordance with Article 21, para. 1 LCA/VVG.
7. Insurance coverage shall cease to be effective at the end of the month in which the insured person reaches his 65th birthday.
8. The insurance contract shall end if the insured person's legal domicile is transferred abroad, on the date of departure from Switzerland.

Art. 9 Scope of the guarantees and definitions

1. This insurance covers only the risks of death and disability presumed to be permanent and definitive, following an illness.
2. Disability is presumed to be permanent and definitive where a health impairment is largely stabilised, fundamentally irreversible and which is strongly presumed that it will restrict the autonomy or earning capacity of the insured person in the long-term, entitling that person to a pension from the Federal Disability Insurance (AI/IV), since any possible rehabilitation measures will have, by definition, failed.
3. Illness means any involuntary impairment of the insured person's physical or mental health which is not the result of an accident and which requires that the insured person undergoes tests or a medical treatment, or which results in incapacity for work.
4. Accident means any damaging, sudden and involuntary injury to the human body which is prejudicial to physical, mental or psychological health or results in death and was occasioned by an extraordinary external cause.
   Bodily injuries within the meaning of Article 6 para. 2 of the Federal Law on Accident Insurance (LAA/UVG) are considered as accidents.

Art. 10 Exclusions and reduction of benefits

1. There is no insurance coverage for death and presumably permanent and definitive disability following:
   a. an accident;
   b. an illness that originated before the beginning or after the end of the insurance coverage;
   c. suicide, voluntary self-mutilation or attempts of one or the other;
   d. alcoholism or other drug addictions;
   e. damages caused by ionising rays or atomic energy;
   f. acts of war:
      – in Switzerland;
      – abroad, unless the insured person was taken by surprise by the events in the country where he/she was staying and that the illness occurs within 15 days of the beginning of these of these events;
   g. troubles whose purpose is to cause harm to persons or property and measures implemented to counteract them, unless the insured person can prove that he/she did not actively participate on the side of the perpetrators or incite them to further violence.
2. In addition, benefits for death or disability which is presumed to be definitive, are not granted as long as the beneficiary refuses, or fails to comply with, any tests or investigations considered necessary by the insurer.

Art. 11 Insured benefits

1. In the event of death following an illness, the insurer pays out the insured lump-sum, less any disability lump-sum amount that has already been paid.
2. If the insured person is a child and that its death occurs before the age of two and half years, the lump-sum amount in case of death is limited to CHF 2,500.
3. In case of disability presumed to be permanent following an illness, the insurer pays the insured lump-sum in proportion to the degree of disability determined by the Federal Disability Insurance (AI/IV): a disability of less than 25% does not entitle to compensation, whereas a disability of 70% entitles to the lump-sum amount being paid in full.
4. The insured lump-sum differs according to the insured person's age:

Men	
0-18	CHF 5,000
19-25	CHF 10,000
26-45	CHF 30,000
46-50	CHF 23,000
51-55	CHF 13,000
56-60	CHF 7,000
61-65	CHF 4,000
Women	
0-18	CHF 5,000
19-25	CHF 10,000
26-45	CHF 30,000
46-50	CHF 30,000
51-55	CHF 20,000
56-60	CHF 15,000
61-65	CHF 13,000

Art. 12 Beneficiaries

1. In case of death, the beneficiaries are as follows:
   – the surviving spouse or registered partner, or failing him or her;
   – the children, in equal parts, or failing them;
   – the fathers or mothers, in equal parts, or failing them;
   – the legal heirs, excluding the public community.
2. By way of derogation to Art. 12, para. 1, the policyholder may designate or exclude beneficiaries at the time the contract is concluded. Such a derogation may be cancelled or modified at any time by the policyholder by notifying the insurer. If the beneficiary(ies) mentioned is (are) predeceased, the provisions of Article 12, para. 1 shall apply.
3. In case of disability, the lump-sum shall be paid to the insured person.

Art. 13 Evidence of entitlements

1. In case of death, the beneficiary shall send to the insurer, at his/her own cost, the official death certificate of the insured person and a medical certificate from the attending doctor indicating the exact circumstances and causes of death.
2. In case of disability, the insured person will send to the insurer, at his/her own cost, a medical certificate specifying when the illness began, its nature, evolution and consequences. The insured will authorise the insurer to access his/her records held by the Federal Disability Insurance (AI/IV).
3. If the insurer deems it necessary in order to determine the entitlement to benefits, it reserves the right to have the insured person examined by a doctor appointed by itself and to request additional information from third parties.

Art. 14 Payment of benefits

1. In case of death, the payment of the lump-sum will take place within 30 days following the receipt of all supporting documents.
2. In case of disability, the payment of the lump-sum will take place, at the latest, after six consecutive months of a disability which is presumed to be definitive and permanent. The deadline shall start from the date the Federal Disability Insurance (AI/IV) notifies its decision to grant a pension.
3. If the disability originates in part from a congenital defect, an accident or event that can be assimilated to an accident, the insurer may reduce the benefit accordingly, even in the absence of an adequate causal link. As such, the insurer is not bound by the conclusions of the Federal Disability Insurance (AI/IV) nor by those of the accident insurance. The medical adviser of the insurer will assess, and exclude in this case, the portion of disability which does not result directly from an illness; where needed, he will request the necessary information in order to make a decision. However, if the accidental origin is deemed to be overriding in the occurrence of the insured risk, the full benefit will be denied.

Art. 15 Prescription period

Any receivables arising from the insurance contract shall be extinguished five years after the occurrence of the death or the decision notified by the Federal Disability Insurance (AI/IV) regarding the granting of a pension.

Art. 16 Premiums

1. Premiums are stated in the insurance policy.
2. Premiums are staggered according to age bracket and depending on the gender and the insured capital.
3. In Switzerland, the premiums are payable annually in advance.
4. They may also be paid in half-yearly, quarterly or monthly instalments. In this case, payment of the annual premium amount is staggered and deferred.
5. The premium invoicing period is at least one month, except for the month in which insurance begins or ends.
6. The premium is calculated in accordance with the Groupe Mutuel Vie GMV SA mortality and disability tables, GK M/F 95 and GJ M/F 95.

Art. 17 Changes in premium rates

1. The insurer may adjust the premium rates in line with the trends in claims.
2. The insurer shall inform the policyholder of the new premium at least 30 days before the expiry of the insurance term. In this case, the policyholder is entitled to terminate the insurance contract, with effect for the end of the ongoing insurance term, within 30 days of receiving the policy or being notified of the increase. Termination must have been received by the insurer within the the deadline of 30 days.
3. If the policyholder does not terminate the contract, any premium adjustments will be considered as accepted.

Art. 18 Adjustment of insurance conditions

1. The insurer has the right to adjust these terms and conditions of insurance.
2. The new conditions apply to the policyholder and the insurer if they are adjusted in accordance with the first paragraph during the period of validity of the insurance.
3. The insurer shall notify the policyholders of these adjustments. If the policyholder does not accept the changes, it may terminate the relevant contract effective the date of the adjustments. If termination is not notified to the insurer within 30 days, the new provisions are deemed to be accepted.

Art. 19 Duty to provide information

1. Any changes (name, first name, gender, marital status, place of residence, email, telephone) must be notified to the insurer without delay. In the event of a breach of his obligations, the policyholder shall bear the consequences and costs arising therefrom.
2. If an insured person transfers his legal address or residence outside Switzerland, he must notify the insurer and provide a certificate of departure from his municipality or canton. On this basis, the insurer will terminate the in-

surance contract on the departure date indicated on the certificate.
3. If the insured person forgets to do so, the insurer may, as soon as it is aware of the fact, terminate the insurance coverage effective the end of the month during which the departure from Switzerland has been notified to the relevant municipal or cantonal authorities.

Art. 20 Notices

1. Notices between the policyholder and the insurer are valid if they are sent in writing or by any other means that can be proved by written text (email or another mean of communication made available by the insurer), with the exception of social networks.
2. Notices from the policyholder must be sent to the postal or email addresses indicated on the insurer's official documents.
3. Notices from the insurer are valid if they are sent to the last postal or email address communicated to the insurer by the policyholder or the insured person.
4. The insurer may also send general communications to the policyholders via the magazine for its insured persons. The insured person who no longer wishes to receive the magazine may so request from the insurer, in which case the insurer is released from any liability for the communications published.
   These communications may also be made on the insurer's website and in a document enclosed when sending out the insurance policies each year.

Art. 21 Jurisdiction

In the event of a dispute, the policyholder or the beneficiary may choose either the courts of his legal place of residence in Switzerland, or those of the insurer's headquarters. International agreements remain reserved.

Art. 22 Data protection

Personal and sensitive data

Groupe Mutuel Services SA processes the personal and sensitive data of the policyholder, the insured person, and where applicable their beneficiaries or related persons (hereinafter: persons concerned) on behalf of Groupe Mutuel Vie GMV SA, your insurer. Data processing is entrusted to Groupe Mutuel Services SA (hereafter: Groupe Mutuel), a company under Groupe Mutuel Holding SA. Both companies are subject to the Federal Law on Data Protection (LPD/DSG). Personal data refers in particular to information relating to the persons concerned, which includes in particular information relating to the management of the insurance contract. Sensitive data refers in particular to information about the state of health of insured persons and claims. In general, the following categories of personal and sensitive data are processed: the declaratory personal data of the persons concerned, i.e. the data that Groupe Mutuel may collect from the persons concerned when they express interest and/or subscribe to products and services that it offers or distributes; personal data relating to the benefits provided or the functioning of products and services or their use, in particular when using online services; personal data from third parties, other services or public information where authorised.

Legal basis

Groupe Mutuel shall process the personal and sensitive data of the persons concerned and implement the processing operations according to the following legal grounds: the consent of the persons concerned, respectively the express consent for sensitive data; the legal provisions applicable to the activities of Groupe Mutuel (including the LPD/DSG); the contract concluded between Groupe Mutuel and the persons concerned; the overriding public interest or the overriding private interest of Groupe Mutuel or the persons concerned, within the meaning of the LPD/DSG.

Purposes

Personal and sensitive data are used in particular to assess the risks to be insured, process claims, ensure the administrative, statistical and financial follow-up of the contract, allow the management of Groupe Mutuel's activities (statistics, internal and external audit, etc.) and compliance with its legal obligations, the improvement and development of services provided, the optimisation and cost-effectiveness of insurance costs, prospecting and marketing operations, the management of unpaid debts and disputes, the fight against fraud, money laundering, terrorist financing and tax fraud. To this end, this data may be communicated, shared and exchanged between Groupe Mutuel and third parties (see below). Data used for statistical purposes is made anonymous.

Security

When personal data is processed, and with regard to the risks presented by data processing operations, Groupe Mutuel, its insurance intermediaries and other agents (for example a reinsurance company), undertake to take all necessary measures to comply with data protection law. These provisions include, in particular, the technical, physical and organisational measures required to safeguard the security of personal data and prevent its modification, damage or access by unauthorised third parties.

Data transfer

The data is processed confidentially and may be disclosed to third parties (e.g. insurance intermediaries, reinsurance companies, doctors, beneficiaries, disability insurance office (AI/IV), social security of the insured person's country of residence), including abroad. Disclosure of data takes place on the basis of legal obligations, court decisions, general insurance terms and conditions or the consent of the persons concerned. Consent must be express in the case of sensitive data. If the data processing operations are subject to a subcontracting, outsourcing or partnership contract with third parties, the latter undertake, as part of their contractual relationship with Groupe Mutuel, to comply with data protection law. Groupe Mutuel selects subcontractors who provide the necessary guarantees. The data entrusted to insurance intermediaries will be recorded and sent to Groupe Mutuel for the handling of insurance applications and for the administrative and financial follow-up between the insurance intermediary and the insurer. The latter is not responsible for the processing of personal data that the person concerned may have authorised from third parties or those that are carried out independently of Groupe Mutuel. It is up to the persons concerned to refer to the data protection policies of these third

parties in order to check the terms and conditions of the processing operations carried out, or to exercise their rights with regard to these operations.

Profiling
During its relationship with Groupe Mutuel, the person concerned may be subject to marketing profiling, so that the insurer can offer services and products that meet the person's expectations, profile and needs.

Storage period
Personal data is stored for as long as required by law, the management of the insurance contract, claims, recourse rights, debt recovery and/or any disputes between Groupe Mutuel, the insured, the insurance intermediary or third parties.

Rights of access and correction
The persons concerned have the right to access their personal data, to have their data corrected, to have their data deleted within the limits of the applicable legal provisions, to limit the processing of their data, to request that their data is transferred, to withdraw their consent to the processing of personal data, subject to the processing required for the performance of the contract, and to appeal to the competent supervisory authority.

Data Protection Officer
Groupe Mutuel has appointed a Data Protection Officer who can be contacted at the following address:
dataprotection@groupemutuel.ch.
Further information on data protection is available on the Groupe Mutuel website: www.groupemutuel.ch