Group accident insurance (supplementing LAA/UVG coverage)

Edition: 01 March 2023

Practical and legal information in accordance with the Federal Law on Insurance Contracts (LCA/VVG)

The following information provides customers with a clear and concise overview of the insurer's identity and of the most important points of the insurance contract, pursuant to Art. 3 of the Federal Law on Insurance Contracts (LCA/VVG).

Who is the insurer?
The contractual partner is Groupe Mutuel Assurances GMA SA (hereafter "the insurer"), whose headquarters are at 5, rue des Cèdres, P.O. Box, CH -1919 Martigny.

What risks are covered by the insurer?
The insurer covers the economic consequences of occupational accidents, non-occupational accidents and occupational illnesses, according to the benefits set out in the policy, which are covered by accident insurance (LAA/UVG), military insurance or group accident insurance comparable to LAA/UVG coverage.

The definitions of the three risks covered are set out in the general terms and conditions of insurance.

What benefits are covered by the insurance?
Coverage may include the following benefits:
- treatment costs depending on the selected option (indemnity insurance);
- daily allowance in the event of hospitalisation (fixed-sum insurance);
- daily allowance in the event of incapacity for work (indemnity insurance);
- daily allowance in the event of relapse and late consequences of previous accidents that were not covered (indemnity insurance);
- medical aids and appliances at the workplace (indemnity insurance);
- compensation in the event of death according to the provisions of Art. 338 CO (indemnity insurance);
- in the event of disability: lump-sum in the event of disability (fixed-sum insurance) and/or aesthetic damages (fixed-sum insurance) and/or vocational retraining costs (indemnity insurance);
- lump-sum in the event of death (fixed-sum insurance);
- benefits in the form of an LAA/UVG excess pension (indemnity insurance);
- coverage of the reduction imposed by LAA/UVG accident insurance (indemnity insurance).

Details of the scope of benefits as well as the terms and conditions of coverage and any restrictions are set out in the policy and in the general terms and conditions of insurance.

What are the premium rates?
The premium rates depend on the insured benefits. The premium is calculated based on premium rates and the salaries declared by the employer.

Who is the policyholder and who are the insured persons?
The policyholder is the employer who concluded the insurance contract.
The circle of persons qualifying for insurance is mentioned in the policy.

Insurance policy:
The insurance policy specifies the insured persons, the amount of the maximum insured salary, the insured benefits and any special terms and conditions.

What are the obligations of the policyholder?
The policyholder's obligations are set out in the insurance policy and in the general terms and conditions of insurance.
In particular, the policyholder must inform the insured persons of the main contents of the contract, its amendments and its dissolution, as well as of the possibility of maintaining insurance coverage in case of departure from the circle of insureds or upon expiry of the policy.
In addition, the policyholder is required to fulfil the following obligations:
- to notify the insurer promptly as soon as he hears that an insured person has had an accident which requires medical attention, causes an incapacity for work or results in the insured's death;
- to immediately inform the insurer of the end of the employment relationship with an employee who is unable to work;
- to submit the salary declaration form to the insurer for the final invoicing and, on request, insured persons' AVS/AHV statements;

– to authorise the insurer or designated third parties to inspect the company's books and accounts or the documents sent to the AVS/AHV compensation fund, if necessary;
– to provide any document that may serve to establish entitlement to benefits;
– to notify the insurer of any event likely to increase the risk (change in the activities of the insured company or the insured occupation).

The obligations of the policyholder are set out in the general terms and conditions of insurance.
Failure to comply with the obligations may lead to sanctions by the insurer, which may extend to the refusal of benefits.

What are the obligations of the insured person?
The insured person is required to fulfil the following obligations in particular:
– to notify his employer or the insurer promptly of any accident requiring medical attention or causing an incapacity for work. If the insured person dies as a result of the accident, this obligation is incumbent upon the survivors of the deceased who are entitled to benefits;
– to consult a licensed doctor at his practice at the latest three days following the beginning of the incapacity and follow the doctor's instructions;
– to cooperate with the insurer and with social insurance institutions;
– to do everything possible to reduce the damage;
– to remain available for any necessary administrative or medical investigations during the period of incapacity for work;
– in case of fraud or insurance fraud attempts, the insured person will be required to pay for the investigation expenses incurred by the insurer for verifying the incapacity as well as for following up the case.
The details of the obligations of the insured person are set out in the general terms and conditions of insurance.
Failure to comply with the obligations may lead to sanctions by the insurer, which may extend to the refusal of benefits.

What are the excluded benefits?
The following benefits are excluded from the insurance:
– cases of non-disclosure;
– cases of fraud or insurance fraud attempts;
– intentional damage;
– accidents caused by the insured while committing a crime;
– accidents during earthquakes;
– the consequences of events of war.
This list is not exhaustive. The general terms and conditions of insurance and the LCA/VVG contain other possible exclusions.

Under what circumstances can the insurer reduce or refuse insurance benefits?
The insurer will not reduce its benefits for all accidents insured by the policy due to gross negligence or recklessness within the meaning of the LAA/UVG, subject to the exclusions set out in the general terms and conditions of insurance.

Cash benefits will be reduced mutatis mutandis to the LAA/UVG:
– when the accident was caused while committing an offence;
– in the event of participation in brawls and fights;
– if the insured exposes himself to danger by seriously provoking a third party;
– if the insured participates in disturbances.

In particular, benefits may be reduced or refused temporarily or permanently:
– if the policyholder or the insured person does not meet his obligations;
– if the insured person refuses to comply with the insurer's instructions or fails to appear for a medical examination requested by the insurer;
– if the insured refuses to provide all information on the facts which could serve, to his knowledge, to determine the entitlement to benefits.
Any restrictions to benefits are set out in the general terms and conditions of insurance.

When does the contract begin?
The contract begins on the dated specified in the policy. It is deemed to be concluded once the insurer has notified acceptance of the proposal.

When does the insurance contract end?
The policyholder may terminate the contract in the following cases in particular:
– on expiry of the contract as set out in the policy, subject to three months' notice. The notice of termination shall be deemed valid if it is received by the insurer at the latest on 30 September. If the contract is not terminated, it shall be automatically extended from year to year:
– after each claim for which a benefit is paid out by the insurer, at the latest 14 days after having become aware of the payment of the claim by the insurer;
– when the insurer adjusts the premium rate. In this case, notice of termination must reach the insurer before the end of the calendar year.

The insurance also ends:
– when the insured company ceases its business activities;
– in case of non-payment of premiums;
– when the policyholder's registered office or place of residence is transferred abroad.

In which case can the insurer terminate the contract?
– on expiry of the contract as set out in the policy, subject to three months' notice. If the contract is not terminated, it shall be automatically extended from year to year;
– when the policyholder makes or attempts to make illegal profits causing the insurer prejudice;
– the insurer expressly waives its right under the LCA/VVG to withdraw from the contract in the event of a claim, save in case of abuse, misrepresentation, fraud, non-disclosure or attempts to do so by the policyholder, or for just cause pursuant to the LCA/VVG.

These lists only contain the most common possible reasons for termination. The general terms and conditions of insurance and the LCA/VVG contain other possible reasons.

When does the insurance coverage begin?
Coverage starts from the time the contract is effective, but not before the first day of employment or as soon as the entitlement to the first salary arises, and in any event from the moment the employee sets off to work.

When does the insurance coverage end?
For each insured person, insurance coverage ceases:
- if the insured person leaves the contract at the end of the day before starting work with a new employer, or signing up to unemployment benefits, but at the latest at the end of the 31st day following termination of the employee's entitlement to at least half a salary.
  For part-time workers, who are insured only for occupational accidents and occupational illnesses, coverage ceases on the last day of work;
- in case of non-payment of premiums;
- at the end of the insurance contract;
- at the end of the LAA/UVG accident coverage for the worker posted abroad.

How is the data processed by the insurer?
The insurer processes the personal and sensitive data of the policyholder and insured persons, in particular data relating to the contract, collection and claims management, in accordance with the legal requirements on data protection. Further details on data processing are set out in the general terms and conditions of insurance.

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General Terms and Conditions (CGA) for Group Accident Insurance (supplementing LAA/UVG coverage)

LAACGA06-E1 – Edition: 01 Mar 2023

Contents

A. General principles

Abbreviations

LAVS/AHVG:	Federal Law on Old-Age and Survivors Insurance
LAI/IVG:	Federal Law on Disability Insurance
LAMal/KVG:	Federal Law on Health Insurance
LAA/UVG:	Federal Law on Compulsory Accident Insurance
OLAA/UVV:	Ordinance on Accident Insurance
LAM/MVG:	Federal Law on Military Insurance
LACI/AVIG:	Swiss Law on Compulsory Unemployment Insurance and Insolvency Benefits
LCA/VVG:	Federal Law on Insurance Contracts
LPD/DSG:	Federal Law on Data Protection
CGA:	General terms and conditions of insurance
CO:	Swiss Code of Obligations

Art. 1 Insurer

The risk-bearing insurer is Groupe Mutuel Assurances GMA SA, hereinafter referred to as the insurer.

Art. 2 Purpose of the insurance

The insurer provides coverage for the economic consequences of occupational accidents, non-occupational accidents and occupational illnesses, according to the benefits set out in the policy, which are covered by LAA/UVG accident insurance, military insurance or group accident insurance comparable to LAA/UVG coverage.

Art. 3 Legal bases of the contract

The legal bases of the contract are:

1. These general terms and conditions (CGA), any supplemental or special terms and conditions, as well as the provisions of the policy and any endorsements.

2. The provisions and statements mentioned in the insurance proposal and any other statements of the policyholder.
3. The Federal Law on Insurance Contracts (LCA/VVG).
4. The Federal Law on Data Protection (LPD/DSG).
5. The LAA/UVG applies mutatis mutandis where provided for by these general terms and conditions.
6. The Swiss Code of Obligations (CO).

Art. 4 Definitions

1. **Occupational accidents**
   Occupational accidents are defined as accidents within the meaning of the LAA/UVG incurred by an insured person in the scope of his gainful activity. All other accidents are considered non occupational accidents.
2. **Occupational illnesses**
   Occupational illnesses are defined as illnesses within the meaning of the LAA/UVG; an occupational illness is equated with an occupational accident from the day the employee is taken ill, from the first time he requires medical treatment or from the day he is unable to work.
3. **Incapacity for work**
   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, mental or psychological impairment. In case of long-term incapacity for work, the work which could reasonably be expected of the insured may also be work in another profession of area of activity.
4. **Disability**
   Disability is defined as a full or partial earning incapacity that is likely to be permanent or to persist in the long-term.
5. **Case**
   Case means the occurrence of occupational illness or a specified accident in a particular individual.
6. **LAA/UVG salary**
   The LAA/UVG salary equates to the insured income within the meaning of the LAA/UVG and its relevant ordinances.
7. **Salary exceeding the LAA/UVG limit**
   The salary exceeding the LAA/UVG limit equates to the salary exceeding the maximum insured income within the meaning of the LAA/UVG and its relevant ordinances.
8. **Group accident insurance comparable to LAA/UVG coverage**
   The purpose of this insurance is to provide coverage based on the catalogue of benefits of compulsory accident insurance (LAA/UVG).

B. Scope of insurance

Art. 5 Insurance policy

The insurance policy sets out the details of the insurance coverage, including the insured persons, the amount of the maximum salary, the insured benefits and any special terms and conditions.

Art. 6 Insured persons

1. All persons belonging to the circle of insureds defined in the policy are insured, provided they are subject to LAA/UVG compulsory insurance for the activity defined in the policy.
2. For part-time workers who are covered by compulsory accident insurance only for occupational accidents and occupational illnesses because of their working time in the insured company, supplemental LAA/UVG coverage is also limited to occupational accidents and occupational illnesses. For these persons, accidents that occur on the way to work are considered occupational accidents.
3. Workers who are not subject to LAA/UVG but who are covered under group accident insurance comparable to LAA/UVG coverage, may also be insured.
4. Unless otherwise stipulated in the policy, the persons referred to in Art. 1a, para. 1, letter c LAA/UVG who are participating in a disability insurance scheme in the company are not insured.

C. Start and end of contract

Art. 7 Start and end of contract

1. The policy indicates the effective date and the expiry date.
2. Unless the policy is terminated by registered letter received by the insurer no later than 30 September, the contract will be automatically extended from year to year.
3. The contract will end:
   a. in case of termination by the policyholder or the insurer;
   b. if the insured company ceases its business activities;
   c. in case of termination following a loss, in accordance with Art. 8 of these general terms and conditions;
   d. in case of termination due to fraudulent claims, in accordance with Art. 9 of these general terms and conditions;
   e. if the premiums are not paid, in accordance with Art. 30 para. 5 of these general terms and conditions;
   f. when the headquarters are or the place of residence of the policyholder is transferred abroad;
   g. in case of termination following a premium increase, in accordance with Art. 31 of these general terms and conditions.

Art. 8 Termination following a loss

1. After each claim which the insurer is liable for in terms of 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 14 days after the insurer receives the notice of termination.
2. The insurer expressly waives its right under the LCA/VVG to withdraw from the contract in the event of a loss, save in case of abuse, misrepresentation, fraud, non-disclosure or attempts to do so, or of just cause pursuant to the LCA/VVG.

Art. 9 Fraudulent claim

The policy may be cancelled or terminated when the policyholder makes or attempts to make illegal profits causing prejudice to the insurer.

D. Insurance coverage

Art. 10 Start of insurance coverage

1. Benefits are payable only if the accident, bodily injury or last exposure to danger before the occupational illness was declared to have occurred during the validity of the group insurance coverage, with the exception of Art. 19 of these general terms and conditions.
   Relapses and late consequences for accidents that occurred during the insurance year are compensated provided they are covered by LAA/UVG.
2. Coverage starts on the first day of employment or when the entitlement to the first salary arises, and in any event from the moment the worker sets off to work.

Art. 11 End of insurance coverage

For each insured person, insurance coverage ceases:

a. at the end of the day before starting work with a new employer, or registration to unemployment benefits, but at the latest at the end of the 31st day following termination of the employee's entitlement to at least half a salary, subject to Art. 13 of these general terms and conditions.
   For part-time workers, who are insured only for occupational accidents and occupational illnesses, coverage ceases on the last day of work;
b. if premiums are not paid in accordance with Art. 30 para. 4 of these general terms and conditions;
c. at the end of the insurance contract or if it is suspended;
d. at the end of the LAA/UVG accident coverage for the worker posted abroad, subject to Art. 6 para. 3 of these general terms and conditions.

Art. 12 Transfer to individual coverage

1. The insured person residing in Switzerland who leaves the circle of persons qualifying for insurance has the right to maintain his coverage on an individual basis. The insured must claim his right of transfer within 90 days of leaving the circle of insureds provided that no accident occurs from the last day of work.
   Right to transfer also applies to the cross-border worker if he is pursuing employment in Switzerland.
2. The insurance will cover, at the most, the benefits for medical costs, daily allowance benefits and lump-sums that were insured until then, without a new medical examination.
3. At the time of transfer, the prevailing general terms and conditions of the individual insurance will apply. Benefits shall be reduced proportionally if the amount of the new income or unemployment benefits is lower.
4. The age of the insured person upon entering the group contract is decisive in calculating the premium.
5. There is no right to transfer to individual coverage in the following cases:
   – if the insurance contract is terminated and coverage is transferred to another insurer for the same circle of insured persons or parts thereof;
   – if the insured leaves his job and is covered under the LAA/UVG supplemental insurance of his new employer;
   – if the insured person is receiving a retirement pension from AVS/AHV insurance or from another foreign social insurance.

Art. 13 Unpaid leave

1. In case of unpaid leave, coverage shall continue for a maximum of seven months (including the extension of coverage pursuant to Art. 11 letter a of these general terms and conditions), provided the insured person is covered by the LAA/UVG insurance (including extended insurance) and his employment contract has not been terminated.
2. During the period of unpaid leave, no premium is payable.

E. Insured benefits

Art. 14 Treatment costs (healthcare benefits and reimbursement of costs)

A. Coverage

If treatment costs are insured, the insurer will pay, for the relevant coverage, the benefits listed below not covered by LAA/UVG insurance.

The insurer covers the costs of treatments that are effective, appropriate and economical.

Coverage begins on the day of the accident and for as long as healthcare benefits are paid on the basis of accident insurance under the LAA/UVG.

If the care provided in the residence country is covered by the LAA/UVG insurer in accordance with the legal and tariff positions of the residence country, the insurance compensation shall extend to the coverage of excess fees and foreign cost-sharing amounts (invoiced for outpatient treatments and by pharmacists who are not reimbursed by the social insurance of the residence country) pursuant to the agreement on the free movement of persons EU/EFTA/UK or other international social security conventions and insofar as this is not prohibited by the law of the country in question.

This coverage falls within the scope of indemnity insurance.

1. Medical treatment

Care and the costs of treatment carried out by recognised practitioners within the meaning of the LAA/UVG.

2. Medication

The cost of necessary medicines prescribed or dispensed by a doctor, with the exception of pharmaceutical products for special application (LPPA/LPPV).

3. Hospitalisation

a. Coverage

In accordance with the rates recognised by the

insurer for the relevant coverage stipulated in the policy:
- hotel services relating to accommodation and catering;
- recognised diagnosis and therapeutic measures;
- patient care in hospital;
- doctors' fees;
- fees of doctors who provide care in hospital on a self-employed basis (licensed doctors).

b. **Approved facilities**
Benefits provided by hospitals approved by the insurer are covered. Approved facilities have concluded a tariff agreement with the insurer for the corresponding wards.
The insurer shall make available a list of recognised facilities. Before each treatment, the insured must find out whether the facilities where he will be treated are recognised by the insurer.

c. **Non-approved facilities**
The insurer reserves the right to refuse or restrict the benefits provided by a healthcare provider who does not have a tariff agreement with the insurer.

d. **Deduction for room and board costs**
The deduction made by the LAA/UVG insurer for room and board costs during a stay in a hospital is also covered.

4. **Convalescence and other cures**
Prescribed treatment in a cure centre or convalescence facility recognised by the insurer. Additional costs for room and board are covered in addition to the LAA/UVG insurer up to CHF 200 per day, for a maximum of 30 days per stay, up to maximum 120 days for the same accident. The insurer shall make available a list of recognised facilities.

5. **Alternative medicine**
The cost of the following therapies provided they are administered by a qualified doctor, or a natural therapy practitioner recognised by the insurer, up to CHF 100 per session, for a maximum of CHF 2,500 per case. The insurer shall make available a list of recognised practitioners.

6. **Medical aids and appliances**
The costs of the first acquisition or rental of medically prescribed appliances which are designed to compensate a physical injury or the impairment or loss of a function (prosthesis, spectacles, hearing devices and orthopaedic auxiliary appliances), according to the list made available by the insurer.
The repair or replacement cost (new value) of aids and devices designed to physically or functionally replace a body part provided such aids or devices were damaged or destroyed during an insured accident which caused the insured a physical injury necessitating treatment.

7. **Home help and home care**
The insured person is entitled to home help and home care prescribed by a doctor, as long as they are provided by an organisation recognised according to the LAA/UVG.
Home help is provided if an insured has a medically certified incapacity of at least 50%.
Home care is covered within the limitations below and for as long as the insured person is receiving a daily allowance benefit from the LAA/UVG insurer.
The limitation for home help and home care is CHF 100 per day, at a maximum of CHF 6,000 per case.

8. **Childcare**
The insured is entitled to reimbursement of the costs of childcare for children up to the age of 12, provided that the care is provided by the Red Cross or an official institution with the same purpose.
Childcare is covered within the limitations below, insofar as it entails additional costs for the insured and as long as the insured can prove that he is at least 50% incapacitated, as certified by a doctor.
The limitation for childcare is CHF 150 per day, at a maximum of CHF 6,000 per case.

9. **Material damage**
The costs of cleaning, repairing or replacing the insured person's clothing damaged in an accident giving entitlement to compensation, as well as the costs of objects and vehicles belonging to persons who intervened to rescue and transport the insured person, up to a maximum amount of CHF 3,000 per accident.

10. **Transport costs**
The medically necessary costs of transporting the insured person to the place of treatment are reimbursed. If justified on medical or technical grounds, air transport costs are reimbursed.

11. **Body transport costs**
The cost of removing and transporting the body to the place of burial is reimbursed if the insured died as a result of an insured accident.

12. **Search operations**
The insurer shall pay in addition to the LAA/UVG insurance the necessary costs for search and rescue operations, up to CHF 100,000 per case.

B. Healthcare providers
The insurer may make available lists of recognised or excluded healthcare providers.
These lists can be updated at any time and are available on the insurer's website or on request.
The lists valid at the time of treatment are decisive.
A modification on the list does not entitle the policyholder to a right of termination.

C. Third-party benefits
If treatment costs under this article are payable by any other Swiss or foreign social insurance, the insurer shall pay supplemental benefits up to the total cost of treatment.

D. Excess benefits
If treatment costs are covered by several insurer contracts taken out with recognised insurers, the aggregate benefits may not exceed the actual total costs resulting from the accident The insurer is only liable proportionately to the ratio that the benefits insured by it bears to the total benefits insured by all insurers.

Art. 15 Hospital daily allowance

1. **Entitlement to benefits**
   The insurer will pay the daily allowance stated in the policy for the length of the insured's hospitalisation or cure provided that the hospitalisation or cure is medically necessary and was prescribed by a doctor.
   The hospital stay is medically necessary if the related medical treatment assists in improving the state of health or in preventing an unfavourable development of the latter.
   In addition, the stay in a medically controlled convalescence center will only be covered if the insured was following a medical treatment before the beginning of the cure.
   When care is provided at home upon medical prescription in order to avoid a hospital stay, the insurer will pay the corresponding daily allowance to the insured, equal to half the agreed hospital daily allowance.
2. **Duration of benefits**
   The hospital daily allowance is paid from the day of the accident:
   – for hospital stays, during a maximum of 360 days per case;
   – for cure or convalescence stays, during a maximum of 30 days per stay, up to 20 days for the same case;
   – if care is provided at home, half of the agreed daily hospital allowance is paid by the insurer during a maximum of 200 days of home care per case.
3. **Type**
   This benefit falls within the scope of fixed-sum insurance.

Art. 16 Daily allowance

1. **Entitlement to benefits**
   Provided the insured was entitled to a daily allowance benefit under the LAA/UVG insurance, the insurer shall provide the insured with a medically certified incapacity for work, the daily allowance benefit agreed in the policy, subject to Art. 26, para. 1, of these general terms and conditions The insured daily allowance is payable on expiry of the agreed waiting period.
   The waiting period begins on the day following the day the accident occurred.
   Upon receipt of an interim or final 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 unless the insurer requests an additional medical examination.
2. **Partial incapacity for work**
   In case of a partial incapacity for work, the insurer will pay a daily allowance reduced pro rata the degree of incapacity for work.
   In calculating the waiting period, each day of partial incapacity for work counts as a full day.
3. **Third-party services**
   If the insured is also entitled to benefits from the federal disability insurance or any other Swiss or foreign social insurance, the insurer shall pay supplemental benefits up to the insured's actual loss of earnings. The insurer shall pay no more than the stated daily allowance. The insurer shall be entitled to request reimbursement of the advances granted directly from those organisations or from another third party. The repaid amount shall vest with the insurer.
4. **Excess benefits**
   If the daily allowance is covered by several insurance contracts taken out with recognised insurers, the insured shall only be compensated once for his total loss of earnings. The insurer is only liable proportionately to the ratio that the benefits insured by it bears to the total benefits insured by all insurers.
5. **Type**
   This benefit falls within the scope of indemnity insurance.

Art. 17 Medical aids and appliances at the workplace

If, following an insured accident, it is necessary to acquire adaptive equipment for the workplace, the insurer will cover the costs of an assessment by a specialist appointed by it, as well as the aids and appliances recommended by the specialist, provided that:
– LAA/UVG coverage exists with the insurer;
– the benefits in accordance with Art. 14 and 16 of these general terms and conditions (treatment costs and daily allowance) are insured.

A maximum of CHF 5,000 per case will be paid. An application for coverage must be submitted to the disability insurance (AI/IV). If the application is accepted, all or part of the insurer's benefits constitute an advance payment. In this case, the insurer is entitled to request reimbursement of the advance payment directly from the AI/IV. The repaid amount shall vest with the insurer.
This benefit falls within the scope of indemnity insurance.

Art. 18 Compensation in the event of death

If provided for by the policy, in case of the death of the insured as a result of an insured accident, the insurer shall pay the salary that the policyholder is required to pay under Art. 338 CO. This benefit falls within the scope of indemnity insurance.

Art. 19 Relapses and late consequences of previous accidents

In case of a relapse and/or late consequences from a previous accident which are not or are no longer covered by the insurance under the LAA/UVG, the insurer shall pay the following benefits, provided they are mentioned in the policy:

1. **Treatment costs (if provided for in the policy)**
   The insurer will pay the costs of treatment in accordance with the relevant coverage, in addition to the health insurer or other social insurers, within the limits stipulated in Art. 14 of these general terms and conditions and for as long as this coverage remains in force.
2. **Daily allowance (if provided for in the policy)**
   In the event of recognised incapacity for work, the insurer shall pay a daily allowance of 80% of the insured earnings based on the LAA/UVG salary. The duration of benefits is limited to a maximum of 730 days per case. Art. 26, para. 1 of these general terms and conditions of insurance remains reserved.

The entitlement to a daily allowance arises on the third day following the day on which the incapacity for work was confirmed. Days of partial incapacity for work are counted as full days in calculating the duration of benefits. The modalities of Art. 16 of these general terms and conditions shall also apply.

If provided for by the policy, additional and/or excess daily allowance coverage will also be taken into account for the calculation of benefits within the limits of the maximum insured salary.

Art. 20 Disability

1. Entitlement to benefits

If provided for by the policy, the insurer pays, depending on the selected coverage:

- a lump-sum disability benefit (in accordance with para. 2(c) below); and/or,
- the cost of plastic surgery (in accordance with para. 3 below); and/or
- the cost of professional retraining (in accordance with para. 4 below).

2. Lump-sum benefits

a. Entitlement to benefits

A lump-sum disability benefit will be paid as soon as the disability is recognised as being permanent. Art. 26, para. 2 of these general terms and conditions of insurance remains reserved.

b. Degree of disability

The degree of disability is set in accordance with the scale of impairment in Annex 3 OLAA/UVV and in accordance with SUVA's tables.

In case of a partial functional disability, the percentage is reduced proportionally. If the degree of disability cannot be established in accordance with the above rules, it will be set by analogy taking into account the seriousness of the impairment based on the medical report. If several organs or parts of the body are affected by the same accident, the relevant percentages will be weighted. Notwithstanding, the degree of disability cannot exceed 100%.

c. Calculation of the lump-sum amount

The lump-sum amount in case of disability is calculated based on the degree of disability, the agreed insured amount and the chosen progression.

If the insured was already disabled before the accident, the lump-sum amount payable by the insurer is proportionate to the disability directly caused by the accident.

d. Progression

In the case the progressive disability lump-sum amount was chosen, the disability lump-sum amount is calculated in function of the degree of disability and the chosen progression in accordance with the following table:

Benefits in % of the insured sum

Disability rate (%)	Compensation no progression	according to variants A	B
100	**100**	**225**	**350**
99	99	222	345
98	98	219	340
97	97	216	335
96	96	213	330
95	**95**	**210**	**325**
94	94	207	320
93	93	204	315
92	92	201	310
91	91	198	305
90	**90**	**195**	**300**
89	89	192	295
88	88	189	290
87	87	186	285
86	86	183	280
85	**85**	**180**	**275**
84	84	177	270
83	83	174	265
82	82	171	260
81	81	168	255
80	**80**	**165**	**250**
79	79	162	245
78	78	159	240
77	77	156	235
76	76	153	230
75	**75**	**150**	**225**
74	74	147	220
73	73	144	215
72	72	141	210
71	71	138	205
70	**70**	**135**	**200**
69	69	132	195
68	68	129	190
67	67	126	185
66	66	123	180
65	**65**	**120**	**175**
64	64	117	170
63	63	114	165
62	62	111	160
61	61	108	155
60	**60**	**105**	**150**
59	59	102	145
58	58	99	140
57	57	96	135
56	56	93	130
55	**55**	**90**	**125**
54	54	87	120
53	53	84	115
52	52	81	110

Disability rate (%)	Compensation no progression	according to variants A	B
51	51	78	105
50	**50**	**75**	**100**
49	49	73	97
48	48	71	94
47	47	69	91
46	46	67	88
45	**45**	**65**	**85**
44	44	63	82
43	43	61	79
42	42	59	76
41	41	57	73
40	**40**	**55**	**70**
39	39	53	67
38	38	51	64
37	37	49	61
36	36	47	58
35	**35**	**45**	**55**
34	34	43	52
33	33	41	49
32	32	39	46
31	31	37	43
30	**30**	**35**	**40**
29	29	33	37
28	28	31	34
27	27	29	31
26	26	27	28
25	**25**	**25**	**25**
24	24	24	24
23	23	23	23
22	22	22	22
21	21	21	21
20	**20**	**20**	**20**
19	19	19	19
18	18	18	18
17	17	17	17
16	16	16	16
15	**15**	**15**	**15**
14	14	14	14
13	13	13	13
12	12	12	12
11	11	11	11
10	**10**	**10**	**10**
9	9	9	9
8	8	8	8
7	7	7	7
6	6	6	6
5	**5**	**5**	**5**

e. Type
This benefit falls within the scope of fixed-sum insurance.

3. Aesthetic damages
If in the accident the insured suffered serious and permanent aesthetic damage which does not qualify for a lump-sum disability benefit under item (a) above but nevertheless constitutes a psychological prejudice which is certain to jeopardise his economic future or social status, the insurer shall pay an indemnity equal to:
- 10% of the insured amount stipulated in the policy if the damage affects the face;
- 5% of the insured amount stipulated in the policy if the damage affects other parts of the body.

The indemnity for such damages shall not exceed CHF 20,000 per case. This benefit falls within the scope of fixed-sum insurance.

4. Cost of professional retraining
If, as a result of the same accident, the insured has to be retrained for another profession, the insurer shall be liable, upon prior agreement, in addition to the benefits under items 2 and 3, for reasonable costs not covered by other insurers; such costs may not exceed CHF 20,000 per case. This benefit falls within the scope of indemnity insurance.

Art. 21 Lump-sum in case of death

1. Entitlement to benefits
If the accident causes the death of the insured, the insurer shall pay the agreed lump-sum death benefit, subject to Art. 26, para. 3 of these general terms and conditions, to the beneficiaries in the following order:

a. Surviving spouse or registered partner;
b. Failing this, the deceased's children under 18 or, if they are still studying or in apprenticeship, under 25, are entitled to a lump-sum death benefit in equal shares.
   Children who were dependent on the deceased for their education and maintenance at the time of his death are equated with his own children provided he supported them durably and at no charge.
c. Failing this, an unmarried or unregistered physical person who is a non-relative (also applies to same-sex partners) and who cohabited uninterruptedly with the deceased in a common-law marriage or registered partnership for the last five years before the death.
d. Other survivors
   In the absence of survivors mentioned in letters a, b and c, the lump-sum amount is payable to:
   - the children of the insured person who do not meet the criteria of letter b;
   - failing this, the natural persons whom the insured person has designated as beneficiaries of this

lump-sum by will or notarial act;
- failing this, the father and mother of the insured person;
- failing this, the brothers and sisters of the insured person.

e. Absence of survivors
- If the insured person has none of the above survivors, the insurer shall only pay the share of burial costs not covered by another insurer up to the lump-sum death benefit but not more than CHF 20,000.

2. Accrual of benefits
Any disability benefits already paid for the consequences of the same accident (see Art. 20 of these general terms and conditions) shall be deducted from the death benefits.

3. Fault on the part of a survivor
Cash benefits payable to the relatives or survivors of the insured shall be reduced if the latter caused the realisation of the risk deliberately or by deliberately committing a crime or an offence.

4. Type
This benefit falls within the scope of fixed-sum insurance, except for possible burial costs, which are covered by indemnity insurance.

Art. 22 Benefits in the form of an LAA/UVG excess pension

1. Disability pension

a. If provided for in the policy, the insurer shall pay a disability allowance of 80% of the insured excess salary, in the case of total disability. In the case of partial disability, the pension is reduced proportionately.

b. Moreover, except for the provisions on supplemental pensions, the LAA/UVG is applicable. Notwithstanding, the entitlement to a pension cease when the insured reaches AVS/AHV retirement age.

c. The insurer reserves the right to redeem disability pensions of less than CHF 500 per month.

2. Survivor pensions

a. If provided for in the policy, the insurer shall pay the following survivor pensions:
- 40% of the insured excess salary to the surviving spouse, including to registered partners;
- 15% of the insured excess salary for children having lost one parent;
- 25% of the insured excess salary for children having lost both parents;
- where pensions are payable to several survivors, no more than 70% of the insured excess salary in aggregate.

b. Moreover, except for the provisions concerning supplemental pensions, the LAA/UVG shall apply.

c. The insurer reserves the right to redeem survivor pensions of less than CHF 500 per month.

3. Excess benefits

a. The conjunction of benefits paid by different social and private insurers shall not result in excess benefits for the insured (not more than the cumulative amount of 90%). Only identical benefits with the same purpose, which are provided following the harmful event, are taken into account in calculating excess benefits.

b. Excess benefits are when the social and private benefits which are legally due exceed, due to the realisation of the risk, the income that was supposedly due to the insured, additional costs and any income decreases suffered by relatives.

c. Cash benefits are reduced by the amount of the excess benefits.

4. Fault on the part of a survivor
Cash benefits payable to the relatives or survivors of the insured shall be reduced if the latter caused the realisation of the risk deliberately or by deliberately committing a crime or an offence.

5. Type
This benefit falls within the scope of indemnity insurance.

Art. 23 Coverage of the reduction imposed by LAA/UVG accident insurance

1. If agreed to in the policy, and in addition to the benefits specified therein, coverage of the reduction imposed by LAA/UVG insurance provides that the insurer will supplement the LAA/UVG cash benefits when benefits are reduced due to an accident caused by negligence or in case of hazardous activities, except in the case of offences.
2. Art. 24 of these terms and conditions remains reserved.
3. The insurer may at any time redeem, at present value, pension benefits payable under the extended coverage supplementing LAA/UVG insurance. In that case, any claims of the insured in connection with the accident will be fully extinguished.
4. Pension benefits paid under extended coverage supplementing LAA/UVG insurance are not indexed.
5. This benefit falls within the scope of indemnity insurance.

Art. 24 Excluded benefits

Are excluded from the insurance:
- cases of non-disclosure;
- cases of fraud or insurance fraud attempts;
- intentional damage;
- accidents caused unintentionally by the insured while committing an offence in particularly serious cases within the meaning of LAA/UVG insurance;
- non occupational accidents due to hazardous activities in particularly serious cases within the meaning of LAA/UVG insurance;
- accidents caused by the insured while committing a crime;
- accidents during earthquakes;
- the consequences of events of war:
  - in Switzerland;
  - abroad, unless the events catch the insured by surprise in the country where he is staying and provided the accident occurs no more than 14 days after the start of such events;
- accidents during military service abroad;

– participation in acts of terrorism or organised crime;
– damages caused by ionising rays of any kind. This exclusion does not apply to conditions caused by radiation treatments prescribed by a doctor in connection with an insured event.

Art. 25 Reduction and denial of benefits

The insurer waives its rights to reduce its benefits for all accidents insured by the policy and caused recklessly or through gross negligence within the meaning of the LAA/UVG legislation subject to Art. 24 of these general terms and conditions.

Cash benefits will be reduced mutatis mutandis to the LAA/UVG:

– when the accident was caused while committing an offence; this also includes accidents caused by driving a motor vehicle under the influence of alcohol or drugs or by particularly high speeding;
– in case of participation in brawls and fights, unless the insured person was injured (by participants in the brawl or fight) as a bystander or while attempting to assist a helpless person;
– if the insured exposes himself to danger by seriously provoking a third party;
– if the insured participates in disturbances.

Benefits may be reduced or refused temporarily or permanently:

– if the policyholder or the insured person does not comply with the obligations under Art. 34 and 35 of these general terms and conditions of insurance;
– if the insured refuses to comply with the insurers' instructions (e.g. be examined by the medical expert designated by the insurer) or fails to appear for a medical examination requested by the insurer without a good reason. In this case, the insurer also reserves the right to demand that any benefits already paid be refunded and to bill the insured for the missed medical appointment;
– if the insured refuses to provide all information on the facts which could serve, to his knowledge, to determine the entitlement to benefits;
– if the insured fails to comply with the obligation to reduce damages, the insurer may reduce the allowance to the amount it would have been reduced to if the obligation had been fulfilled;
– if the insured fails to submit, or does not do so in good time, an application for benefits to the AI/IV disability office. In this case, daily allowance benefits will be suspended until the date of the application for benefits.

During periods of suspension for non-payment of premiums as defined in Art. 30, para. 4 of these general terms and conditions, claims that have occurred are not covered.

Art. 26 Benefits for persons receiving an AVS/AHV retirement pension

As soon as the AVS/AHV old-age pension is paid, the insurer will adjust the benefits as follows for cases that are ongoing at that time or that occur afterwards:

1. **Daily allowance**
   The daily allowance is paid during a maximum of six months.
2. **Lump-sum in the event of disability**
   The insured amount is limited to the maximum LAA/UVG insured income without progression.
3. **Lump-sum in the event of death**
   The insured amount is limited to the maximum LAA/UVG insured income.

Art. 27 Territorial validity

The insurance is valid worldwide in accordance with the provisions of the LAA/UVG.

Art. 28 Recourse against liable third parties

Upon occurrence of an insured event, in the case of benefits falling within the scope of indemnity insurance, the insurer is subrogated, within the limits of the benefits provided by it, to the rights of the insured and his survivors against any third party liable for the event.

F. Premiums

Art. 29 Calculation of the premium

The premium for the LAA/UVG supplemental insurance is calculated based on the insured persons' AVS/AHV salary or agreed salary. The Federal Law on Accident Insurance (LAA/UVG) and the relevant ordinances are also applicable.

Art. 30 Payment of premiums

1. The policyholder is the debtor of the premiums.
2. Premiums are payable within the time limit specified in the policy.
3. Premium instalments due during a calendar year of insurance shall be considered as instalments to be paid within the relevant time limits. They may be adjusted at any time to allow for payroll changes in the course of the year and must correspond to the presumed effective premium.
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.
   Claims arising during the suspension period will not be covered.
5. If the insurer does not chase payment of the premium in arrears and expenses within two months following the expiry of the 14-day deadline, the contract will be deemed to be terminated.
6. If the salary declaration form is not provided within 30 days of the insurer's request, the insurer shall send a formal notice to the policyholder. If the formal notice has no effect, the insurer shall then assess the rate itself, increasing the premium charged the preceding year.

Art. 31 Adjustment of premium rates

1. The insurer may adjust premium rates to allow for trends

in costs and claims, or if there is a change in the classification of companies in tariff classes and levels pursuant to Art. 92(5) LAA/UVG; adjustments shall be effective from the start of the following year.
The insurer shall inform the policyholder of the new contractual terms no later than 25 days before the expiry of the insurance year. In the event of a premium rate increase, the policyholder may exercise his right of termination before the end of the calendar year (date of receipt by the insurer).

2. Premiums may be adjusted in the event of a change in circumstances (e.g. change in the company's activity, merger, spin-off or takeover) or in the event of restructuring, provided that variations in payroll amount to 10% or more. In the event of an increase in premium rates, the policyholder may exercise a right of termination within 30 days from the date of notification (date of receipt by the insurer).

Art. 32 Final premium statement

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 or by an assessment of the rate by the insurer itself, in accordance with Art. 34 of these general terms and conditions of insurance.

Art. 33 Surplus-sharing

1. If provided for in the policy, the policyholder will receive a share of any surplus premiums.
2. The accounting is done after the end of the accounting period but not before all losses during the period have been settled and indemnified, provided the premiums for this period have been paid in full.
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 insurance policy remains in force until the end of the accounting period.

G. Other provisions

Art. 34 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 (Art. 3 LCA/VVG), the policyholder is also required to inform the insureds about the essential elements of the contract.
3. The policyholder shall notify the insurer promptly as soon as he hears that an employee has had an accident which requires medical attention, causes an incapacity for work or results in the insured's death.
4. The policyholder shall notify the insurer immediately of the termination of the employment relationship of an employee who has an incapacity for work.
5. For the final invoicing, the policyholder shall provide the insurer with the salary declaration form and, if requested, the insureds' AVS/AHV statements.
6. 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.
7. The policyholder undertakes to provide, automatically or at the insurer's request, any document capable of establishing the entitlement to benefits (power of attorney, medical certificates, accounting or administrative documentation, etc.). The insurer reserves the right to check the plausibility of the declared salary.
8. The policyholder shall notify the insurer of any event liable to aggravate risks in accordance with Art. 36 of these general terms and conditions of insurance (e.g. change in corporate business activities or in the insured's profession).
9. Failure to comply with these obligations may result in sanctions by the insurer, which may include the refusal of benefits, pursuant to Art. 25 of these general terms and conditions of insurance.
10. The sanctions shall not apply if the breach of duty is not due to a fault or if the policyholder can prove that the breach of duty had no influence on the occurrence of the event and on the scope of benefits.

Art. 35 Obligations of the insured person

1. The insured shall notify his employer or the insurer promptly of any accident requiring medical attention or causing an incapacity for work. If the insured dies as a result of the accident, this obligation is incumbent upon the survivors of the deceased who are entitled to benefits.
2. During the period of incapacity for work, the insured person shall remain available for any necessary administrative or medical investigations of the insurer (such as be examined by a doctor designated by the insurer).
3. The insured shall provide to the insurer, automatically or at the insurer's request, any document that is necessary for determining the entitlement to benefits (power of attorney, medical certificates, medical documents, decision and/or statement of benefits from other insurers, etc.). He shall also notify the insurer immediately of any changes in his situation which could affect his entitlement to benefits (change in the degree of incapacity, registration to unemployment insurance, entitlement to third party benefits, etc.).
4. The insured shall release his attending practitioners from medical and professional secrecy vis à vis the insurer's medical advisor.
5. The insured must cooperate with the insurer and with the third parties mandated by the insurer (claims' inspectors, officers, doctors, etc.). He shall follow their instructions, provide the requested documents and answer, fully and truthfully, any questions asked by the insurer.
6. The insured must submit an application for benefits to the

AI/IV disability office for no later than six months from the beginning of the incapacity or, upon request of the insurer, with another social institution.
7. The insured is obliged to limit damages, including cooperate with social insurance institutions (disability insurance, accident insurance, military insurance, etc.).
8. 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 earning prospects.
9. At the latest three days following the beginning of the incapacity for work, the insured shall consult a licensed doctor at his practice and follow his instructions.
10. In case of fraud or insurance fraud attempts, the insured person shall pay for the investigation expenses incurred by the insurer for the verification of the incapacity as well as for the follow-up of his case.
11. Failure to comply with these obligations may result in sanctions by the insurer, which may include the refusal of benefits, pursuant to Art. 25 of these general terms and conditions of insurance.
12. The sanctions shall not apply if the breach of duty is not due to a fault or if the insured person can prove that the breach of duty had no influence on the occurrence of the event and on the scope of benefits.

Art. 36 Change in insured risks

The policyholder shall promptly notify the insurer in written form significant event (e.g. change in corporate business activities or in the insured's profession) liable to aggravate risks. If he fails to do so, the insurer shall be no longer be bound by the contract.
Aggravated risks which are duly notified by the policyholder shall be covered by the insurer. The insurer may, however, terminate the contract within 14 days of receiving the policyholder's notification. Should this be the case, coverage ceases 14 days after the insurer receives the notice of termination. Additional premiums, if any, are due from the outset of the aggravated risk.

Art. 37 Assignment and pledging of benefits

The policyholder and the insured may not assign or pledge their claims against the insurer without the latter's consent.

Art. 38 Broker clause

If the policyholder designates a broker, the latter will conduct the business relationship with the insurer. In this case, information is considered to have reached the policyholder once it has reached the broker.

Art. 39 Notices

1. All notices from the policyholder must be sent to the postal or email addresses indicated on the insurer's official documents, in writing or by any other means that can be proven by a text made available by the insurer, with the exception of social networks.
2. Notices by the insurer are valid if they are sent to the last postal or email address communicated to the insurer by the policyholder. These notices may be sent in writing or by any other means that can be proven by a text.

Art. 40 Place of performance

Save any special provisions to the contrary, the obligations arising from the contract shall be performed in Switzerland and in Swiss francs.

Art. 41 Jurisdiction

In case of dispute, the policyholder, the insured person or beneficiary may choose the jurisdiction of the courts of his place of residence in Switzerland, or of the insurer's headquarters or, if the insured is domiciled abroad, that of his place of work in Switzerland.

Art. 42 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 referred to as the "persons concerned") on behalf of Groupe Mutuel Assurances GMA SA, your insurer.
Data processing has been delegated to Groupe Mutuel Services SA (hereinafter: Groupe Mutuel), a company of 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 relating to the state of health of insured persons and to claims.

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 policyholder; 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.

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 treated 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 shall 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.

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