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General terms and conditions for collective daily allowance insurance in case of illness under LCA/VVG

PC

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Contents

A. General principles

Art. 1 Purpose of insurance

The risk-bearing insurer is mentioned in the policy. It guarantees coverage of the economic consequences of an incapacity resulting from illness or accident, or from leave following maternity, according to the definitions in these terms and conditions of insurance, 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, as well as the relevant health questionnaires.
3. The Federal Law on Insurance Contracts (LCA/VVG).
4. The Law on Data Protection (LPD/DSG), which the Insurer duly observes when processing data.

Art. 3 Definitions

1. LAVS/AHVG: Federal Law on Old-Age and Survivors Insurance
   LAI/IVG: Federal Law on Disability Insurance
   LPP/BVG: Federal Law on Occupational Pension Schemes
   LAMal/KVG: Federal Law on Health Insurance
   LAA/UVG: Federal Law on Accident Insurance
   LAM/MVG: Federal Law on Military Insurance

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LAPG/EOG: Federal Law on Compensation for Loss of Income in case of Service and Maternity
LAFam/FamZG: Federal Law on Family Allowances
LACI/AVIG: Swiss Law on Compulsory Unemployment Insurance and Insolvency Benefits
CO: Swiss Code of Obligations

2. Health impairment
   The term «health impairment» encompasses illnesses and/or accidents.
3. Illness
   Illness means any medically and objectively detectable, involuntary impairment of the insured person's physical, mental or psychological health that is not the result of an accident or its consequences, and which requires medical examination or medical treatment, or which causes incapacity. Pregnancy complications are equated with an illness.
4. Accident
   Accident means any damaging, sudden and involuntary injury to the human body which is prejudicial to physical, mental or psychological health or leads to death, is objectively detectable 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.
5. Maternity leave
   Maternity leave means an uninterrupted period from the date of childbirth until the end of the longest period provided for both by the Federal Law on Compensation for Loss of Income (LAPG/EOG) and the relevant cantonal law.
6. Incapacity
   Unless otherwise provided, incapacity is both incapacity for work and earning incapacity.
7. 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 incapacity for work exceeding six months, the entitlement to benefits depends on the earning incapacity.
8. Earning incapacity
   a. Earning incapacity means any reduction, be it full or partial, of an insured's earning capacity within a balanced labour market.
   b. Only the medical limitations due to the health impairment are taken into account to assess the existence of earning incapacity.
   c. Earning incapacity is determined by the difference between the income earned before the incapacity for work in one's previous profession and the average income that, from a medical point of view, could be earned in another activity, taking into account the level of competency of the insured, according to the Swiss Earnings Structure Survey (ESS).
9. Insurance case
   Insurance case means the occurrence of incapacity which qualifies the insured for benefits and was caused by one or more health impairments.
10. Relapse / new insurance case
    Incapacity which is medically linked to a prior insurance case is equated with a relapse. A relapse will only be regarded as a new case after 365 days have lapsed since the end of the entitlement to benefits of the previous insurance case.
11. Employee posted abroad
    The insured person working abroad for a Swiss employer and the insured person who is abroad for training purposes while simultaneously being paid by his Swiss employer, will be entitled to daily allowance benefits.

B. Scope of insurance

Art. 4 Insurance policy

The insurance policy sets out the details of the insurance coverage, including the insured risks, the amount of the maximum salary considered for calculating the benefits, the percentage of the insured salary, the waiting period, the duration of benefits and any special terms and conditions.

Art. 5 Insured persons

1. The circle of insured persons is mentioned in the policy.
2. Insured persons may include:
   – employees;
   – the owner of a sole proprietorship and his family members if they are mentioned by name in the policy;
   – the shareholders mentioned in the policy.
3. Unless explicitly mentioned in the policy, the person who is fully or partially unable to work when the contract comes into force, or at the beginning of the employment relationship, will not be insured. This person will be covered as soon as he has recovered his full ability to work for at least 30 days. The agreement regulating free transfer of coverage is reserved.
4. A person who receives disability benefits is insured for the income obtained through his remaining work capacity from which he will take advantage substantially and permanently. Extended coverage provisions are reserved for cases where benefits are exhausted.

Art. 6 Art. Insurance coverage

1. Claims for cases arising during the term of collective coverage shall be charged to the collective policy.
2. The policyholder may choose between two coverage plans:
   a. Alternative 1:
      Benefits are granted on a case-by-case basis for no longer than 730 days, in LPP/BVG coordination.
   b. Alternative 2:
      The term of entitlement to benefits is 730 days within a period of 900 consecutive days for one or several cases of incapacity.

Art. 7 Affiliation with risk assessment

A health examination is mandatory where the insurance proposal or contract so requires.

C. Start and end of insurance contract

Art. 8 Start and end of insurance contract

1. Effective date
   The policy indicates the effective date as well as the expiry date which is on 31 December of a calendar year.
2. Automatic renewal of the contract
   Upon termination of the contract and 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. End of contract
   The contract will end:
   a. if the company ceases its business activities or if the company goes into bankruptcy;
   b. if premiums are not paid in accordance with Article 21(7) of these General Terms and Conditions;
   c. when the headquarters or the place of residence of the policyholder is transferred abroad;
   d. in case of termination by the policyholder or by the Insurer;
   e. in case of termination following a premium increase within the meaning of Art. 22 of these General Terms and Conditions;
   f. if the Insurer has not fulfilled its obligation to inform, pursuant to Article 3 LCA/VVG.

Art. 9 Termination following a loss

1. 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.
2. The Insurer expressly waives his right, under LCA/VVG, 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 Fraudulent claim

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

D. Insurance coverage

Art. 11 Start and end of insurance coverage and entitlement to benefits

1. Start of insurance coverage
   For each insured, coverage starts on the day of entry into force of the employment contract, but not before the policy comes into effect.
2. End of insurance coverage
   For each insured, insurance coverage ceases:
   a. at the end of the employment contract;
   b. if premiums are not paid in accordance with Article 21 of these General Terms and Conditions;
   c. on termination or suspension of the insurance contract;
   d. no later than the end of the month coinciding with the insured's 70th birthday;
   e. at the end of the LAA/UVG accident coverage for the worker posted abroad.
3. End of entitlement to benefits
   For each insured, the entitlement to benefits ceases:
   a. on suspension of the insurance coverage following non-payment of the premiums;
   b. when the maximum entitlement to benefits is exhausted;
   c. at the end of the month coinciding with the insured's 70th birthday;
   d. at the end of employment lasting three months or less;
   e. upon termination of the policy, subject to the ongoing case not being covered by another insurer.

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, without a new medical exclusion. The insured must claim his transfer right within 90 days of leaving the circle of insureds. The transferring person has the same rights and obligations than in case of termination of the policy, subject to Art. 12, para. 6 of these terms and conditions.
2. A cross-border worker who no longer belongs to the circle of insureds has the right to maintain coverage on an individual basis without a new medical exclusion being pronounced, if he remains employed in Switzerland. The insured must claim his transfer right within 90 days of leaving the circle of insureds. The transferring person has the same rights and obligations than in case of termination of the policy, subject to Art. 12, para. 6 of these terms and conditions.
3. When transferring to individual coverage, the Insurer guarantees coverage up to the maximum amount of the daily allowance, the waiting period and duration of benefits provided for by the collective contract. The daily allowance shall be reduced proportionally if the amount of the new income or unemployment benefits is lower.
4. The prevailing general terms and conditions for individual insurance will apply.

5. The age of the insured person upon entering the collective contract is decisive in calculating the premium.
6. There is no right to transfer to individual coverage in the following cases:
   a. if the collective insurance is terminated and coverage is transferred to another insurer for the same circle of insured persons or parts thereof;
   b. for self-employed individuals, employers and their family members who are not subject to AVS/AHV contributions;
   c. for persons employed for three months or less, as well as for irregular auxiliary staff;
   d. if the insured leaves his job and is covered under the daily allowance insurance of his new employer;
   e. for insureds who have reached AVS/AHV retirement age or who have retired.

E. Daily allowance

Art. 13 Insured benefits

1. Partial incapacity
   a. Daily allowance benefits are granted for a degree of incapacity of at least 25%. Days with a lower degree of incapacity are not taken into account in calculating the duration of benefits and waiting period.
   b. Each day of partial incapacity is paid as a full day.
2. Notification of incapacity
   a. Each full or partial incapacity must be notified to the Insurer within 15 days of its occurrence. After this time limit, the day of receipt by the Insurer is deemed the first day of incapacity.
   b. If the notification was made late for excusable reasons, the payment of daily allowance benefits is limited to 180 days preceding the day of the notification.
3. Medical certificate of incapacity
   a. If the initial certificate was issued more than three days after the start of the incapacity, the Insurer reserves the right to consider the date of issuance of the certificate as the first day of incapacity.
   b. The Insurer will pay compensation for an incapacity which is medically certified and proved. A doctor's certificate, based on regular medical visits, must be sent to the Insurer at least once a month.
4. Entitlement to benefits during maternity leave
   The obligation to pay benefits is suspended during maternity leave, subject to having taken out supplemental maternity daily allowance for loss of earning allowance during maternity.
5. Loss coverage / fixed-sum insurance
   Unless otherwise provided, daily allowances are paid within the scope of the loss insurance.
6. Entitlement to benefits after AVS/AHV retirement age
   After the AVS/AHV retirement age, a person who continues to belong to the circle of insureds, shall be entitled to 180 daily allowance benefits for one or more cases of incapacity. However, if a case of incapacity started before the insured reached AVS/AHV retirement age and provided that maintaining the employment contract was decided before the incapacity, the maximum entitlement after AVS/AHV retirement age shall be limited to the balance of benefits provided for in the policy if the balance is less than 180 days.
7. Exhaustion of benefits
   The insured must not try to prevent the exhaustion of his entitlement to daily allowance benefits by renouncing his right to a daily allowance. Should this be the case, the Insurer shall pay benefits at the discretion of the medical advisor.
8. Calculation of the daily allowance
   a. The insured daily allowance is calculated based on the information provided by the employer using the declaration forms provided by the Insurer. Family allowances are taken into account if they are no longer received by a beneficiary.
   b. 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.
9. Variations in income
   If the insured's income is subject to significant variation (e.g. work on commission, irregular auxiliary work or temporary employment), the daily allowance is set by dividing by 365 the salary earned in the 12 months immediately preceding the incapacity.
10. Salary increase
    A salary increase during an incapacity can be taken into account if it was agreed before the incapacity or if is provided for by a collective work agreement.
11. Waiting period
    a. The insured daily allowance is payable on expiry of the agreed waiting period, for each day of incapacity (Sundays and public holidays included).
    b. If the waiting period per incapacity is provided for in the policy, it applies to each case of incapacity entitling to benefits. In case of a relapse, only the possible residual waiting period will be applied.
    c. If the policy provides for a waiting period per calendar year, it will apply once per calendar year for one or several cases of incapacity entitling to benefits. In case of an uninterrupted case of incapacity over several years, the annual waiting period will only apply once.

d. When the ongoing incapacity is no longer the result of an accident but of an illness, or vice versa, the waiting period will apply to the new risk (accident, illness), except when both risks are covered by the same insurer.
e. The waiting period will be deducted from the term of entitlement to benefits.

Art. 14 Unpaid leave of absence

1. Before the departure of the insured, the employer shall notify the Insurer in writing of the duration of the unpaid leave agreed contractually if it exceeds 1 month. Coverage shall be maintained for a maximum of 12 months. Otherwise, coverage will be suspended.
2. The entitlement to a daily allowance will first resume on the day the employee is scheduled to return to work. The waiting period shall run from the first day of incapacity.

Art. 15 Benefits in the event of death

Should the insured person die from the cause of the incapacity 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.

Art. 16 Benefits abroad

1. Subject to paragraph 3, during a stay abroad, or outside the vicinity of the home for cross-border workers (radius of 100 km), no benefits are paid. Benefits will be granted upon the duly certified return of the insured to Switzerland, or in the vicinity of the home of the cross-border worker. However, benefits are granted during the period in which the insured is hospitalised provided that repatriation is not possible.
2. The employee posted abroad will be entitled to the same benefits for as long as he remains covered under LAA/UVG accident insurance, but no longer than six years and, afterwards, upon his return to Switzerland.
3. During his incapacity, the insured person who wishes to travel abroad, or the cross-border worker who wishes to leave the vicinity of his home (radius of 100 km), must inform the Insurer prior to departure. In this case, the Insurer reserves the right to continue granting daily allowance benefits during a limited stay, after having assessed the situation. In the absence of an agreement with the Insurer, benefits will be refused during the stay abroad.

Art. 17 Incapacity due to negligence

The Insurer waives its legal right to reduce its benefits for illnesses caused voluntarily or for gross misconduct of the insured person.

Art. 18 Limitation of entitlement to benefits

1. Benefits will be refused:
   a. if there is an exclusion and in case of non-disclosure;
   b. if the incapacity is the result of voluntary plastic surgery not covered by the compulsory health insurance;
   c. in case of incapacity due to earthquakes;
   d. in case of incapacity due to events of war:
      – in Switzerland;
      – abroad, unless events caught the insured by surprise in the country where he was staying and provided the incapacity arises no later than three months after the start of the events;
   e. in case of fraud or insurance fraud attempts;
   f. for health damages caused by ionising rays and health damages caused by nuclear radiation, except for health impairments following a medical treatment;
   g. in case of incapacity during military service abroad.
2. Benefits may be reduced or refused temporarily or definitively:
   a. if the accident is caused by the fault of the insured, in case of extraordinary dangers and hazardous activities within the meaning of the LAA/UVG;
   b. if the policyholder or the insured does not respect its obligations under Articles 25 and 26 of these General Terms and Conditions;
   c. 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 to demand that any benefits already paid be refunded and to bill the insured for the missed medical appointment;
   d. if the insured refuses to provide all information on the facts which could serve, to his knowledge, to determine the entitlement to benefits;
   e. 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.

F. Supplemental maternity allowance

Art. 19 Insured benefits

This coverage is granted if it is included in the policy.

1. Payment of a supplemental 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) or cantonal laws.
2. Coverage options as well as the duration of the additional allowance in case of maternity are set out in the policy.
3. Federal maternity benefits under the Federal Law on Compensation for Loss of Earnings (LAPG/EOG) and/or cantonal maternity benefits are deducted from the amount to be paid by the Insurer.

G. Extended loss of earnings coverage

Art. 20 Scope of coverage

1. If it is included in the policy, extended loss of earnings coverage insures the income obtained through the insured's capacity for work which is useful to the company, substantially and permanently, in cases where the entitlement to benefits has been exhausted. For the same insurance case, the insured will then be entitled to a new coverage of 180 days within a period of five years starting from the date of exhaustion of benefits.
2. The waiting period applies to each case of incapacity but is not deducted from the 180-day term.
3. An employee cannot be entitled to extended coverage more than once.
4. If, at the end of the five-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 main coverage stipulated in the policy, within the meaning of Article 6 of these General Terms and Conditions of Insurance.

H. Premiums

Art. 21 Payment of premiums

1. The policyholder is the debtor of the premiums.
2. Unless specifically agreed in the policy, premiums are fixed for each calendar year.
3. Premiums are payable within the time limit specified in the policy.
4. Provisional premiums may be adjusted at any time by the Insurer.
5. 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.
6. 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.
   - For ongoing claims, payment will resume once the premium arrears have been paid.
7. 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.
8. During suspension periods, the days of incapacity will be deducted from the term of entitlement to benefits.

Art. 22 Adjustment of premium rates

1. Unless specifically agreed in the policy, the Insurer may adjust the premium each year to allow for trends in claims or if premium rates are changed. Premiums shall be adjusted as of 1 January of each year.
2. Premiums may be adjusted 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, provided that variations in payroll are more or less 10 %.
3. The Insurer shall inform the policyholder of the new premium rate no later than 25 days before the expiry of the current year.
4. Changes are considered approved if the Insurer does not receive a termination notice by registered mail before the end of the calendar year.

Art. 23 Premium statements

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 25 of these General Terms and Conditions.

Art. 24 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.
2. The accounting is done at the earliest five 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 insurance 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.

I. Other provisions

Art. 25 Obligations of the policyholder

1. The policyholder shall inform the insureds of 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 of the essential elements of the contract.

3. Each full or partial incapacity must be notified to the Insurer within 15 days of its occurrence. After this time limit, the day of receipt by the Insurer is deemed the first day of incapacity.
4. The policyholder shall notify the Insurer immediately of the termination of employment relationship of an employee who has an incapacity.
5. For the final invoicing, the policyholder shall provide the Insurer with the salary declaration form and, if requested, the insureds' AVS/AHV statements. If the salary declaration form is not supplied within 30 days of the Insurer's request, the latter shall send a formal notice to the policyholder. If the formal notice has no effect, the Insurer will then assess the rate, increasing the premium charged the preceding year. Article 21 of these General Terms and Conditions applies mutatis mutandis to the supplemental premium.
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 must notify the Insurer of any event liable to aggravate risks (e.g. change in corporate business activities or in the insured's profession).

Art. 26 Obligations of the insured

1. During the period of incapacity, 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).
2. 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 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.).
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 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.
5. The insured must 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.
6. The insured is obliged to limit damages, including cooperate with social insurance institutions (disability insurance, accident insurance, military insurance, etc.).
7. 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.
8. At the latest three days following the beginning of the incapacity, the insured shall consult a licensed doctor at his practice and follow his instructions.
9. **In this case, 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.**

Art. 27 Third-party benefits

1. The Insurer subsidiarily covers the loss of salary or loss of earning benefits which are not covered by any other social or private insurer.
2. If a third party reduces its benefits as a penalty, the Insurer shall not compensate the ensuing reduction.
3. If several private insurers subsidiarily cover the loss of salary/earnings, the aggregate benefits paid by them shall not exceed the actual loss. In this case, the Insurer will pay the loss of earnings or loss of salary benefits pro rata to the insured daily allowance proportionately to the share of the total insured benefits.
4. Upon occurrence of the insured risk, 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.
5. 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.
6. The Insurer shall continue advance payment of 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. The restituted amount shall vest with the Insurer.
7. For the calculation of the duration of benefits, the days in respect of which third party benefits are reduced shall count as full days.
8. With reference to coverage transfer agreements, the duration of any daily allowance benefits paid by preceding insurers shall be deducted from the maximum entitlement to benefits under the collective insurance.

Art. 28 Excess benefits

The benefits payable by the Insurer, or the conjunction of such benefits with those paid by other insurers, shall not result in excess benefits for the insured. Excess benefits, namely the portion of daily allowance exceeding the actual loss of income or the loss of earnings or up to the benefits provided for in the policy, must be repaid to the Insurer.

Art. 29 Assignment and pledging of benefits

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

Art. 30 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. 31 Notices

1. Notices shall be addressed to the Insurer's general administration or to one of its official agencies.
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. 32 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. 33 Jurisdiction

In case of dispute, the insured may choose the jurisdiction of the courts of his place of residence in Switzerland, or of the Insurer's registered office or, if the insured is domiciled abroad, that of his place of work in Switzerland.