

# General Terms and Conditions of Insurance (CGA) Challenge Daily allowance coverage for the self-employed in accordance with the Federal Law on Insurance Contracts (LCA/VVG)

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## A. General

### Art. 1 Purpose of the insurance

The Insurer indicated in the policy guarantees coverage against the economic effects of incapacity for work arising from an illness or, if specifically agreed, an accident.

### 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, as well as the health questionnaire.
3. The Federal Law of 2 April 1908 on Insurance Contracts (LCA/VVG).
4. The Law on Data Protection, which the Insurer duly observes when processing data.

## Art. 3 Definitions

### 1. Illness:

Illness means any medically and objectively discernable involuntary impairment of a persons' physical or mental health which was not caused by an accident or the sequels of an accident, and which requires a medical examination or treatment or gives rise to incapacity for work. Pregnancy complications are equated with an illness.

### 2. Accident:

Accident means any medically and objectively discernable damaging, sudden and involuntary injury to the human body which is prejudicial to physical or mental health and was occasioned by an extraordinary external cause. Accident, within the meaning of the LAA/UVG, also includes the sequels of an accident or any relapses, physical lesions equated with an accident and occupational illnesses.

### 3. Health impairment:

The term «health impairment» encompasses both illnesses and accidents.

#### **4. Incapacity for work:**

Incapacity for work means the full or partial loss by the insured of the capacity to perform work which could reasonably be required of him within the limits of his profession or area of activity, provided such incapacity arises from an impairment of his physical or mental health. In case of long-term incapacity for work, the insured may also be reasonably required to perform work outside his profession or area of activity.

#### **5. Case:**

Case means an event of incapacity for work entitling the insured to benefits as a result of one or more health impairments.

#### **6. Relapse / new case:**

- Incapacity for work which is medically linked to a prior case is deemed a relapse.
- A relapse is only deemed a new insurance case if it occurs after 365 days.

## **B. Scope of insurance**

### **Art. 4 Insured risks**

1. Unless otherwise provided contractually, the Insurer covers illness by default.
2. Accidents are covered only if the policy expressly provides for such coverage. Accident benefits have the same scope as illness benefits.
3. Occupational illnesses and physical injuries equated with accidents, within the meaning of the LAA/UVG, and their sequels, are only covered if accident insurance has been contracted.
4. The Insurer grants daily allowances up to the coverage stipulated in the policy.

### **Art. 5 Insured person**

1. Insurance coverage is granted exclusively to the person indicated in the policy who must be self-employed within the meaning of the Federal Law on Retirement and Survivors' Insurance (LAVS/AHVG).
2. Persons having exhausted their entitlement to daily allowance benefits may not contract a Challenge daily allowance insurance policy.

### **Art. 6 Insurance coverage**

1. The self-employed person is insured for a set amount indicated in the policy. This reference salary is covered in the form of an assured sum subject to the provisions of Article 17 on third-party benefits.
2. Unless otherwise provided, the term of entitlement to benefits is 730 daily allowances in a period of 900 consecutive days for one or more cases of incapacity for work.

### **Art. 7 Affiliation with risk assessment**

Persons contracting Challenge insurance are required to undergo a medical exam.

### **Art. 8 Start and end of insurance contract**

1. The policy indicates the effective date as well as the expiry date which is on 31 December of a calendar year.
2. On expiry, unless the policy is terminated by registered letter by 30 September of a calendar year, it will be automatically extended from one year to the next.
3. If the insured ceases his business activity, termination will be accepted for the end of the relevant month. If the insured stops working in a self-employed capacity, loses his self-employment status or goes into bankruptcy, the Insurer must be informed within 30 days.
4. In each case of damage or loss covered by the Insurer, the policyholder may withdraw from the contract no later than 14 days after being informed that the indemnity was paid. If the insured withdraws from the contract, coverage ceases as soon as the Insurer receives the notice of termination.
5. The contract may be terminated if the insured makes or attempts to make illegal profits prejudicial to the Insurer.

### **Art. 9 Waiver of termination following a loss**

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

### **Art. 10 Start and end of insurance coverage**

1. Coverage starts on the day the insured takes up his self-employed activity but not before the effective date of the policy.
2. Insurance coverage and the entitlement to benefits cease
  - a. on termination or suspension of the insurance contract;
  - b. when the entitlement to benefits is exhausted;
  - c. if the insured gives up self-employment definitively;
  - d. at the end of the month in which the insured goes into retirement but no later than the end of the month when he reaches the AVS/AHV retirement age;
  - e. if the insured transfers his domicile abroad;
  - f. if the premiums are not paid in accordance with Article 14 of these General Terms and Conditions.

## **C. Insured benefits**

### **Art. 11 Benefits**

#### **Conditions:**

1. Daily allowance benefits are granted for a degree of incapacity for work of at least 25%.
2. In the case of a partially disabled or handicapped person, incapacity for work is calculated based on the degree of incapacity to continue his current activity.
3. In the event of total or partial incapacity for work, the Insurer must be informed by means of a medical certificate

issued by a recognised doctor no later than 7 days after the insured interrupts work. However, for waiting periods of 30 days or longer, the time limit for informing the Insurer is 15 days from the date the insured goes off work. If the medical certificate declaring the insured event (original certificate) reaches the Insurer after the time limit, the day it is produced shall be deemed the first day of incapacity for work and the relevant waiting period shall start running from that date. The entitlement to the insured daily allowance starts at the earliest after that period.

4. If the first medical visit takes place more than 3 days after the start of the incapacity for work, the Insurer reserves the right to consider the date of the medical visit as the first day of incapacity for work.
5. If the original certificate was issued more than 3 days after the start of the incapacity for work, the Insurer reserves the right to consider the date of issuance of the certificate as the first day of the incapacity for work.
6. The obligation to pay benefits is suspended during maternity leave. Maternity leave means an uninterrupted period of 14 weeks from the date of childbirth.

#### **Payment:**

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

#### **Waiting period:**

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

#### **Duration of benefits:**

14. In cases where the insured can be reasonably expected, from a medical point of view, to exploit his earning capacity in a suitable professional activity, the Insurer shall continue to pay benefits for a transitional period of between 3 and 5 months.
15. Each indemnified day of partial incapacity for work counts as a full day.

#### **Renunciation:**

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

## **Art. 12 Benefits covered abroad**

1. During a stay abroad, i.e. outside Switzerland and Liechtenstein, benefits are not granted. Benefits are granted

when the insured is duly certified as being back in Switzerland or Liechtenstein.

However, benefits shall be granted for the period in which the insured was in hospital if repatriation is not possible.

2. During his incapacity for work, the insured is required to inform the Insurer if he wishes to go abroad. Depending on the circumstances, the Insurer reserves the right to continue granting daily allowance benefits.
3. An insured who has an incapacity for work and who temporarily leaves Switzerland or Liechtenstein without the Insurer's consent is not entitled to any further benefits until his return.

## **Art. 13 Limitation of entitlement to benefits**

1. Benefits may be suspended, reduced or, in serious cases, refused altogether, if the insured does not respect his obligations under Article 16.
2. Benefits will be reduced if the insured does not comply with the doctor's orders.
3. Benefits will be refused:
  - a. if the incapacity for work is caused by a condition which is subject to an exclusion;
  - b. in case of non-disclosure;
  - c. in case of a deliberately false declaration of a health impairment;
  - d. if the incapacity for work was caused by voluntary plastic surgery;
  - e. in case of participation in brawls or fights involving two or more persons, in acts of war or terrorism or in deliberately committed crimes or attempted crimes;
  - f. if the incapacity for work results from a health impairment caused by the insured (attempted suicide, suicide or voluntary mutilation);
  - g. for damages to health caused by ionising rays and damages caused by nuclear radiation;
  - h. during earthquakes;
  - i. during military service abroad;
  - j. in case of participation in hazardous activities within the meaning of the LAA/UVG;
  - k. if the insured refuses to comply with the Insurer's instructions, in particular if he refuses to be examined by the medical expert designated by the Insurer or refuses to follow rehabilitation measures for the recovery of his working capacity;
  - l. if the insured changes doctor without the Insurer's consent after the doctor has certified him as being fit to return to work full-time or part-time;
  - m. if the insured does not respect his obligation to limit damages;
  - n. in case of damages caused by events of war:
    - in Switzerland and in the Principality of Liechtenstein;

- abroad, unless the events catch the insured by surprise in the country where he is staying and provided the incapacity for work occurs no more than 3 days after the beginning of the events;
- o. in case of incapacity for work occurring while the insured is in custody or deprived of liberty (following a criminal sentence or for assistance) and thereafter, until he recovers his full working capacity.

## D. Premiums

### Art. 14 Calculating premiums

1. Premiums are calculated based on the assured sum and the insured's age group.
2. An insured who reaches the last year of his age group is automatically transferred into the next age group at the beginning of the following calendar year.
3. Age groups are fixed up to age 45. From the 46th year to the 71st, age groups are graduated in 5-year brackets.

### Art. 15 Premium payments

1. The policyholder is liable as debtor for the premiums.
2. The premium is set contractually. It is due and payable at the end of the time limit set in the policy.
3. Premium instalments maturing in the course of an insurance calendar year shall be considered as amounts payable for the relevant time limits. Unpaid portions of the annual premium remain due.
4. If the premium is 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 the outstanding premium and costs are not paid within the new time limit, the Insurer's obligations shall be suspended upon expiry of that time limit. In this context, «suspended» means:
  - that any new claims arising during the suspension period will be disregarded;
  - that benefit payments for existing cases will be suspended for the full duration of the suspension period.
5. If the Insurer does not initiate collection proceedings for the outstanding premium and costs within two months after the end of the 14-day time limit, the contract shall be deemed terminated.
6. During suspension periods, days of incapacity for work in respect of existing cases will be deducted from the total term of entitlement to benefits. Insurance coverage and benefit payments for existing cases will resume, non retroactively, once the outstanding premium has been collected.
7. If coverage starts or ends during a calendar month, premiums are due for the full month.

### Art. 16 Adjustment of premium rates

1. The Insurer sets the premium rate for each calendar year.
2. Premiums shall be adjusted as of 1 January of each calendar year.

3. The Insurer shall inform the policyholder of the new rate no later than 25 days before the expiry of the current year. If the policyholder objects to the change, he may terminate the contract for the end of the current year.
4. Changes are considered approved if the Insurer does not receive a termination notice by registered mail before the end of the year.

## E. Other provisions

### Art. 17 Obligations of the policyholder

1. The policyholder undertakes to announce any insured events to the Insurer and to provide the Insurer, automatically or at the Insurer's request, all the documents establishing his entitlement to benefits (medical certificates and reports, etc.).
2. Changes in the degree of incapacity for work must be promptly notified to the Insurer.
3. To enable the Insurer to establish that his claim is well-founded, the beneficiary must produce all supporting documentation, including a power of attorney authorising the Insurer to obtain information from third parties, failing which the claim shall be forfeited.
4. The insured releases all the medical staff consulted by him from their obligation to observe professional secrecy vis à vis the Insurer.
5. The insured must cooperate with the Insurer's medical visitors and doctors. The insurer shall follow their instructions. He shall be obliged to inform them and answer their questions. If the insured fails to appear for a medical examination on the appointed date without good reason, the Insurer reserves the right to reduce or refuse benefits, or to demand that any benefits already paid be refunded and to charge the insured the fees for the missed medical appointment.
6. In case of incapacity for work, the insured shall consult a licensed doctor from the outset, and shall duly follow his instructions. He shall avoid any conduct liable to hinder his recovery or prolong his incapacity for work.
7. The insured shall participate, insofar as he can be reasonably required to do so, in treatment or in reasonable measures for occupational reinsertion designed to significantly improve his capacity for work or to provide him a new possibility for gainful employment.

### Art. 18 Third-party services

1. In the context of early detection procedures, the Insurer shall be allowed to declare an insured to the AI/IV office. In such cases, the insured shall be informed in advance.
2. Given the obligation to limit damages, the Insurer may encourage the insured to apply for disability benefits.
3. If the Insurer advises the insured to apply to the competent social insurance institution for disability benefits, or to follow any measures, the payment of benefits shall be conditional to the insured's actual application. If the insured refuses to comply, the Insurer reserves the right to claim reimbursement of any benefits paid after the aforesaid instructions.

4. If a third party reduces its benefits as a penalty, the Insurer shall not compensate the ensuing reduction.
5. Upon occurrence of an insured event, the Insurer is subrogated, within the limits of the benefits provided by it, to the rights of the insured and his survivors against any liable third party.
6. If the beneficiary concludes an agreement with a third-party liable for benefits waiving all or a part of the insurance benefits or indemnification due to him without the Insurer's consent, the corresponding benefits shall be reduced accordingly.
7. The Insurer shall continue advancing benefits until the Federal Disability Insurance (LAI/IVG), accident insurance (LAA/UVG), military insurance (LAM/MVG) or a foreign social insurance 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 benefits advanced directly from the latter. Any restituted surplus amounts shall vest with the Insurer.
8. In calculating benefits, days when benefit entitlements are reduced because social insurance benefits are paid count as full days.
9. However, if daily allowances are payable in conjunction with social insurance benefits from the Federal Disability Insurance, accident insurance, military insurance or LAMaI/KVG health insurance, the daily allowances will be reduced, within the limits stipulated in the policy, by the amounts paid by such social insurances.

## **Art. 19 Set-off**

1. The Insurer may set off benefits that are due against its claims on the insured.
2. The policyholder has no right of offset against the Insurer.

## **Art. 20 Assignment and pledging of benefits**

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

## **Art. 21 Notices**

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

## **Art. 22 Place of performance and jurisdiction**

1. Unless otherwise specially provided, the obligations arising from the contract shall be performed in Switzerland and in Swiss francs.
2. In case of dispute, the policyholder or the beneficiary may choose the jurisdiction of the courts of his place of residence in Switzerland, or of the registered office of the Insurer. If the policyholder is domiciled abroad, the courts of the registered office of the Insurer have exclusive jurisdiction.