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General Terms and Conditions for Daily Allowance Insurance PI

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A. General principles

Handling personal data

The Insurer processes the insured person's personal data, including data pertaining to the contract, premium collection and processing claims, with all due confidentiality. Transferring data to third parties is authorised only in accordance with the exceptions provided for in the law. Data of persons living abroad can be transferred to partners domiciled abroad. Data is processed including for the purpose of risk assessment, policy management, premium calculation and processing claims. The insured authorises the Insurer and its representatives to process the necessary data related to his insurance contracts held with insurers and/or member of or managed by Groupe Mutuel. Data is stored in hard copy form and/or electronically.

Art. 1 Purpose of the insurance

The Insurer guarantees coverage against the economic consequences of incapacity arising from illness or accident, according to the definitions contained in these terms and conditions of insurance, provided the relevant risks are included in the insurance policy. Benefits are not paid during maternity leave.

Art. 2 Legal bases

The contract is based on the following legal bases:

1. These General 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 insured person, as well as the health questionnaire.
3. The Federal Law on Insurance Contracts (LCA/VVG).
4. The Law on Data Protection (LPD/DSG), duly observed by the Insurer when handling data.

Art. 3 Definitions

1. Laws
   LAVS/AHVG: Old age and survivors' pension fund
   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
   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

2. **Health impairment:**
   The term «health impairment» encompasses illness and/or accident.
3. **Illness:**
   Illness means any medically and objectively discernible involuntary impairment of a persons' physical, psychological 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. Pregnancy complications are equated with an illness.
4. **Accident:**
   Accident means any medically and objectively discernible damaging, sudden and involuntary injury to the human body, which is prejudicial to physical, psychological 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.
5. **Maternity leave:**
   Maternity leave means an uninterrupted period from the date of childbirth until the end of the longest period provided for both in the 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 is based 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 existing Swiss Earnings Structure Survey (ESS).
9. **Insurance case:**
   Insurance case means an event of incapacity entitling the insured to benefits as a result of one or more health impairments.
10. **Relapse / new insurance case**
    Incapacity, which is medically linked to a prior insurance case, is deemed a relapse. A relapse will only be regarded as a new insurance case if it occurs after a lapse of 365 days from the end of the entitlement to benefits for the previous insurance case.
11. **Free transfer:**
    Free transfer from a collective insurance concluded under Groupe Mutuel Assurances GMA SA.

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 daily allowance, the waiting period and the duration of benefits.

Art. 5 Territorial and temporal validity

1. **Territorial validity**
   Insurance coverage is granted as long as the insured lives in Switzerland. For cross-border workers, coverage continues to be granted as long as the insured can prove that his income originates from gainful employment in Switzerland.
2. **Temporal validity**
   The person who is fully or partially unable to work when the insurance contract comes into effect is not insured. He will be covered when he has recovered his full ability to work during at least 30 days. Cases of free transfer are reserved.

Art. 6 Insurance coverage

The insured can choose between two coverage plans:

Alternative 1:

Benefits are granted on a case-by-case basis for no longer than 730 days, in coordination with LPP/BVG.

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 Acceptance conditions

1. Any person domiciled or gainfully employed in Switzerland, aged between 15 and 55 years, can take out daily allowance insurance.
2. In case of free transfer, the cross-border worker with gainful employment in Switzerland or the person living in Switzerland, who has not yet reached AVS/AHV retirement age can also take out daily allowance insurance.
3. Except for transferring persons, a health examination is required.

C. Start and end of contract

Art. 8 Start and end of contract

1. **Start of contract**
   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 expiry of the contract, unless it is terminated by registered letter by 30 September of a calendar year, it will be automatically extended from one year to the next.
3. **End of contract**
   The contract will end:
   a. if gainful employment comes to stop;
   b. if premiums are not paid in accordance with Article

17, chapter 3 of these General Terms and Conditions;
   c. if the insured person living abroad no longer receives income from gainful employment in Switzerland;
   d. in case of termination by the insured or the Insurer;
   e. in case of termination following a premium increase within the meaning of Article 16;
   f. when the maximum entitlement to benefits is exhausted;
   g. at the end of the month during which the insured reaches AVS/AHV retirement age.

Art. 9 Termination following a loss

1. After each case of loss for which a claim is payable by the Insurer, the insured person may withdraw from the contract at the latest 14 days after notification that the Insurer has paid. If the insured person withdraws from the contract, coverage ceases as soon as the Insurer receives the notice of termination.
2. 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 Fraudulent claim

The Insurer may cancel or terminate the policy when the insured makes or attempts to make illegal profits causing the Insurer prejudice.

D. Insurance coverage

Art. 11 Start and end of insurance coverage

1. Coverage starts on the effective date of the policy.
2. Insurance coverage and the entitlement to benefits cease in one of the following cases:
   a. when the maximum entitlement to benefits is exhausted;
   b. if premiums are not paid in accordance with Article 17 of these General Terms and Conditions;
   c. on suspension of the insurance contract;
   d. at the end of the contract.

E. Insured benefits

Art. 12 Terms and conditions

1. The Insurer pays daily allowance benefits up to a maximum of CHF 350/day, except for insureds under free transfer.
2. 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.
3. Each day of partial incapacity counts as a full day.
   a. Each full or partial incapacity must be notified to the Insurer within 15 days following 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.
4. If the initial certificate was issued more than three days after the start of the incapacity for work, the Insurer reserves the right, in case of doubt, to consider the date of issuance of the certificate as the first day of incapacity.
5. 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.
6. Daily allowances are paid within the scope of the loss insurance. Incapacity benefits cannot exceed the actual loss of earnings.
7. The Insurer will pay compensation for an incapacity only when the loss of income or loss of earnings originates from a gainful employment in Switzerland.
8. Any daily allowance benefits paid to the insured person prior to this contract, either by preceding insurers, or under a collective insurance, will be deducted from the maximum duration of entitlement to benefits in this contract and in accordance with the coverage alternative chosen by the insured.
9. The insured cannot 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, benefits will be paid at the discretion of the medical advisor.

Art. 13 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. 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.
c. The waiting period applies to each incapacity. In case of a relapse, only the possible residual waiting period will be applied.
d. The waiting period will be deducted from the term of entitlement to benefits.

Art. 14 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 will be 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 insured who works abroad for a Swiss employer and the insured who is abroad for training purposes while being paid by his Swiss employer, will be entitled to daily allowance benefits. Insurance coverage and entitlement to benefits will end after 24 months.
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, 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. 15 Limitation of entitlement to benefits

Benefits will be refused:

a. if there is an exclusion or in case of non-disclosure;
b. if the incapacity is the result of voluntary plastic surgery not covered by 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;
h. if the incapacity is the result of a condition provoked by the insured (suicide or attempted suicide, voluntary self-mutilation);
i. if the insured does not respect his obligation to reduce damages.

Benefits may be reduced or refused:

j. If the accident is caused by the fault of the insured, in case of extraordinary dangers and hazardous activities within the meaning of LAA/UVG.
k. Benefits may be reduced or, in serious cases, refused altogether, if the insured does not respect his obligations under Article 18 of these General Terms and Conditions of Insurance.
l. Benefits may be reduced temporarily or definitively if the insured refuses to comply with the Insurers' instructions (e.g. be examined the medical expert designated by the Insurer) or to provide all information on the facts which could serve, to his knowledge, to determine the entitlement to benefits. The insured must reply completely and truthfully to the questions of the Insurer.

F. Premiums

Art. 16 Changes in premium rates

1. Premium rates may be changed for each calendar year.
2. Changes will be made as of 1 January of each calendar year.
3. The Insurer shall inform the insured of the new rate no later than 25 days before the expiry of the current year. If the insured 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 calendar year.

Art. 17 Payment of premiums

1. The insured is the debtor of the premiums.
2. 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 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.
3. If the Insurer does not chase payment of the premium in arrears and of expenses within two months following the expiry of the 14-day deadline, the contract will be regarded as terminated.
4. During the suspension periods, days of incapacity are deducted from the entitlement to benefits.

G. Other provisions

Art. 18 Obligations of the insured

1. The insured undertakes to notify each incapacity for work within 15 days following its occurrence and to provide the Insurer, automatically or at the Insurer's request, with all documents establishing his entitlement to benefits (power of attorney, medical certificates, 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.).
2. During the incapacity for work, the insured must remain available for administrative and medicals check-ups on the part of the Insurer.
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.). The insured shall follow the Insurer's instructions, provide the requested documents and answer any questions.
   If the insured fails to appear for an examination without good reason, the Insurer reserves the right to reduce or refuse benefits, or to demand that any benefits already paid out be refunded and to bill the insured for the missed medical appointment.
5. 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. If the insured fails to do so, or does not do so in good time, daily allowance benefits are suspended until the date of the application for benefits.
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 case of fraud or attempted insurance fraud, the insured will be required to pay for any investigation fees incurred for verifying his incapacity and updating his records.**

Art. 19 Third-party benefits

1. The Insurer subsidiarily covers the loss of income or loss of earnings 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 earnings, the aggregate benefits paid by them shall not exceed the actual loss.
   In this case, the Insurer will pay the loss of income or loss of earnings 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 to advance 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.

Art. 20 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 earning, must be repaid to the Insurer.

Art. 21 Assignment and pledging of benefits

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

Art. 22 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 insured.

Art. 23 Place of performance

The obligations arising from the contract shall be performed in Switzerland and in Swiss francs.

Art. 24 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, those of his place of work in Switzerland.