grape

Daily Sickness Allowance Insurance (VVG)

General Insurance Conditions (GIC)

2025 Edition

grape

This text is a translation. In the event of any discrepancy between the English and the German version, the original German version shall prevail.

Please contact us if you have any questions about your current insurance conditions, or visit www.grapehealth.ch/en.

1 Insurance Fundamentals

1.1 Purpose

grape daily sickness allowance insurance (VVG) covers the loss of income that is caused by an incapacity to work as a result of an illness.

Coverage for loss of income due to childbirth (childbirth allowance) as a supplement to maternity insurance and due to paternity (paternity allowance) as a supplement to paternity insurance can be included, as can the payment of a salary in the event of death within the meaning of Article 338(2) of the Swiss Code of Obligations (CO).

The obligation to pay benefits extends to the actual loss incurred (indemnity insurance), up to the maximum agreed sum insured.

1.2 Insurance Provider

The insurance provider is the company listed in the insurance policy. grape insurance AG is authorized to take all actions in the name and for the account of the insurance provider.

1.3 Contractual Basis

The fundamentals of the contract include

- the insurance application,
- the insurance policy,
- Special Conditions (SC) listed in the insurance policy,
- these General Insurance Conditions (GIC),
- the Federal Act on Insurance Policies (Versicherungsvertragsgesetz, VVG) of April 2, 1908.

1.4 Insurance Policy

The insurance policy states the insurance cover obtained. Special conditions or agreements that deviate from or supplement the GIC are also noted in the insurance policy.

1.5 Federal Act on Insurance Policies

Unless otherwise stipulated in the insurance contract and the GIC, the provisions of the VVG apply.

2 Insured Group of Persons

2.1 Policyholder

The policyholder is the company described in the insurance policy with its associated divisions or the natural person who concludes the contract.

2.2 Insured Persons

2.2.1 Employees

The natural persons or groups of persons listed in the insurance policy are insured if

a) there is a working or training relationship between them and the insured company,

b) they are liable for AHV contributions or would be liable if they were of relevant age or when reaching the AHV retirement age continue to be employed in the insured company, and

c) they have not yet turned 70, subject to Section 2.2.2.(c).

These include:

- temporary assistants whose employment contract is limited to three months or less, subject to Section 7.4.9. (3)(f)
- part-time employees and hourly wage earners subject to compulsory accident insurance against the consequences of non-work-related accidents under the Federal Act on Accident Insurance (Unfallversicherungsgesetz, UVG),
- homeworkers within the meaning of Article 351 CO.

Persons with a cross-border commuter permit (G permit) are treated as equivalent to persons resident in Switzerland.

2.2.2 Uninsured Persons

The insurance does not include

a) any staff lent to the policyholder by third-party companies,
b) persons who work for the insured company as part of a contractual relationship,
c) persons who have reached the normal AHV retirement age on joining the company.

3 Geographical Validity

3.1 General Information

The insurance applies worldwide with the following exceptions.

3.2 Expatriate Employees

For expatriate employees, the insurance applies from the time they leave for a period of 24 months, insofar as the said persons are also covered by UVG. The insurance coverage may be extended upon request.

3.3 Stay Abroad while Ill

If an insured person who is ill and entitled to benefits goes abroad, there is no entitlement to benefits during the period of the stay abroad until said insured person returns to Switzerland. The same applies to persons resident abroad who leave their previous place of residence. Any exceptions can be checked by the insurer if the insured person submits their application with a medical certificate at least 4 weeks prior to departure. The insurer reserves the right to additionally obtain a recommendation from the consulting physician.

4 Commencement, Duration, and Cancellation of the Insurance Contract

4.1 Commencement of the Contract

Insurance coverage will commence on the date agreed in the insurance policy. The insurance may be taken out at any time, also during the calendar year.

4.2 Duration of the Contract

4.2.1 General Information

The insurance contract is concluded for the duration specified in the insurance policy. The minimum duration of the contract is one calendar year.

4.2.2 Extension of the Contract

After the agreed duration of the contract, the insurance contract will automatically be renewed for another calendar year unless it is terminated by the stipulated deadline.

4.3 Cancellation of the Contract

4.3.1 Termination

The insurance contract may be terminated in writing by either contracting party, provided a three-month period of notice to the end of a calendar year is given. The first possible termination date is the expiry date specified in the insurance policy. The termination is only valid if it is received in writing and within the prescribed time limit, that is, no later than the last working day prior to the start of the three-month termination period. If the insurance contract is terminated, the insurer can provide the policyholder with a new insurance offer with a new duration.

4.3.2 Lapse of the Insurance Contract

The insurance contract will lapse immediately

a) if the policyholder ceases their business activities, or
b) if the registered office is transferred abroad.

4.3.3 Rescission by the Insurer

The insurer is not bound to the insurance contract and may annul it

a) in the event of premium arrears as set forth in the provisions on default of payment,
b) if, upon concluding the insurance contract, the policyholder provided incorrect information about or failed to disclose a significant source of risk which they were aware of or should have been aware, or
c) if the policyholder provides incorrect information about or fails to disclose facts in the course of the insurance contract that would exclude or reduce the insurer's obligation to pay benefits.

4.3.4 Waiver of Termination in the Event of a Claim

The insurer expressly waives its legal right to terminate the insurance contract in the event of a claim. The right to terminate the contract upon expiry thereof remains reserved.

5 Commencement, Duration, and Cancellation of the Insurance Coverage

5.1 Commencement of Insurance Coverage

The insurance coverage commences on the day on which the employment relationship begins, but at the earliest on the start date specified in the insurance policy.

Admission to the insurance is unconditional and without any health declaration. The insurance also covers preexisting health conditions. Persons who are not fully fit to work upon commencement of the insurance or on the date of commencement of employment will only be insured once they are fully fit to work again within the scope of their employment contract.

5.2 End and Interruption of Insurance Coverage

5.2.1 End of Insurance Coverage

Insurance coverage expires for the insured person

a) once the employment relationship with the policyholder ends,

b) at the time of retirement, including early retirement,
c) in the case of continued employment after reaching the AHV retirement age upon turning 70,
d) upon the final expiry of the entitlement to benefits, in accordance with the agreed duration of benefits in the insurance policy, without applying any remaining capacity to work,
e) upon the death of the insured person,
f) upon cancellation of the insurance contract,
g) during the suspension of the obligation to pay benefits due to a delay in payment on the part of the policyholder.

5.2.2 Suspension of Obligation to Pay Benefits in the Case of an Interruption to Employment

If there is a voluntary interruption to employment (e.g. unpaid leave) without entitlement to salary, the insurance coverage remains in place. During this period, however, there is no obligation to pay benefits and no premium is owed. This is not the case for involuntary interruptions to employment, in particular in the event of illness, maternity, paternity, service in the Swiss Army, or civil protection.

For the duration of any period of unpaid leave, the insurance remains in force for up to 180 days as long as the employment relationship continues.

Unless agreed otherwise, benefits will be payable at the earliest on the day of the planned resumption of work. The days of incapacity to work during the unpaid leave will be taken into account for the waiting period and the duration of benefits. The obligation to cooperate in the event of a claim pursuant to these GIC applies. This provision also applies mutatis mutandis in the event of interruptions to employment due to the execution of penalties or measures.

5.3 Transfer to Individual Insurance

5.3.1 Right of Transfer

Every person residing in Switzerland can transfer to individual insurance without any examination of their state of health
a) upon ceasing to belong to the group of insured persons covered by the collective insurance scheme,
b) upon ceasing to receive benefits, or
c) when the insurance contract expires.

The right of transfer must be asserted in writing within 90 days of being informed thereof by the employer. The individual insurance commences one day after ceasing to belong to the insured group of persons covered by the collective insurance scheme, after ceasing to receive benefits, or after the insurance contract has expired.

The conditions and rates of the individual insurance apply that are applicable at the time of the transfer, including the provisions on the maximum insured daily allowance. The provisions for continued benefits remain reserved.

5.3.2 Employer's Obligation to Provide Information

The policyholder is obliged to inform insured persons who cease to belong to the collective insurance scheme in writing of the right of transfer and of the deadline for transferring to individual insurance in time.

If the policyholder does not meet this obligation to provide information, they will be liable for all costs associated with the resulting claim.

5.3.3 Scope of the Continuation of Insurance

The continuation of insurance will generally be within the scope of the current insurance coverage. The amount of the daily allowance is limited to the salary earned after the transfer, up to a maximum of the benefits insured so far.

A maximum income of CHF 300,000 per year is insured. Unemployed persons may insure themselves for up to the maximum simple AHV pension.

Unemployed persons as defined in the Federal Act on Mandatory Unemployment Insurance (Arbeitslosenversicherungsgesetz, AVIG) may convert their insurance for an appropriate premium adjustment, regardless of their state of health, into an insurance policy with a 30-day waiting period.

The amount of the insured daily allowance is reduced to the level of the unemployment benefit at the beginning of unemployment.

5.3.4 Imputation of Benefits Already Drawn

Benefits already drawn

- from this collective insurance scheme
- from previous insurers

are imputed to the duration of benefits of the individual insurance.

5.3.5 Exclusion of the Right of Transfer

No right of transfer exists:

a) in the case of a new job with a new employer and transfer to its daily sickness allowance insurance scheme,

b) if the policyholder has concluded a new insurance contract for this group of persons with another insurer and the latter must, due to the agreement on the free movement of persons, guarantee the continuation of insurance,

c) as long as benefits are paid within the scope of continued benefits,

d) when the insured person retires, but upon reaching the AHV retirement age at the latest,

e) if the insured person is domiciled abroad,

f) for the duration of a provisional cover note,

g) if the benefits in the collective contract have been exhausted and there is no remaining capacity to work,

h) for persons with a fixed-term employment relationship of three months or less, unless they are deemed to be unemployed within the meaning of Article 10 of the AVIG immediately after leaving the group of insured persons,

i) in the event of attempted or completed insurance fraud or failure to disclose on the part of the insured person.

The provisions set out in Article 100(2) of the VVG apply to unemployed persons within the meaning of Article 10 of the AVIG.

6 Scope of Insurance

6.1 Principle

The daily allowance is calculated as one 365th of the insured loss of earnings in any one year. The calculated daily allowances are paid for every calendar day.

It is an indemnity insurance policy.

6.2 Insured Earnings

6.2.1 AHV Salary Amount

The basis for calculating the daily allowance is the last salary subject to AHV contributions received from the policyholder prior to the insured event, including salary components not yet paid to which there is a legal entitlement. The basis for the calculation also includes salaries that are not subject to AHV contributions due to the age of the insured person. Earnings from other employment will not be taken into consideration.

Salary increases and salary reductions due to a change in the level of employment or general salary adjustments (e.g. by collective employment contracts) will only be taken into account if there is a legal entitlement or if these were already agreed in writing before the onset of incapacity to work. The sum insured is deemed to be the calculation basis for the payment of salary in the event of death.

6.2.2 Irregular Income

If earnings are subject to significant fluctuations (e.g. commissions, profit sharing, irregular temporary work, etc.), the salary earned in the 12 months prior to the incapacity to work will be divided by 365 to calculate the daily allowance. If the period prior to the incapacity to work is less than 12 months, the daily allowance will be calculated accordingly.

6.3 Maximum Coverage

The maximum insured salary per person and year is specified in the contract and is generally limited to CHF 300,000.

---

7 Insurance Benefits

7.1 Conditions for Benefits

7.1.1 Principle

Benefits are covered provided there is a medically necessary, objectifiable incapacity to work as a result of illness.

The insurer is entitled to reject a benefit claim if the inability to work is primarily a result of non-medical factors or the diagnosis provided does not justify an incapacity to work.

7.1.2 Illness

Illness means any impairment of physical or mental health that is not the consequence of an accident and that necessitates a medical examination or treatment or that results in an incapacity to work.

7.1.3 Accident

Accident means the sudden, unintentional, harmful influence of an exceptional external factor to the human body, resulting in an impairment of physical or mental health or death.

Occupational illnesses that are acknowledged as accidents under the UVG are likewise classified as accidents.

7.1.4 Incapacity to Work

An incapacity to work is the complete or partial inability to perform reasonable work in the previous profession or area of responsibility by reason of an impairment of physical, mental, or psychiatric health.

Should the period of incapacity to work exceed 90 days, reasonable activity in any other profession or area of responsibility will also be considered.

A partial incapacity to work exists if the incapacity to work is at least 25%.

7.1.5 Occupational Disability

Occupational disability is the complete or partial inability to perform work in the balanced employment market in question, which is caused by an impairment of physical, mental, or psychiatric health and still remains following suitable treatment and reintegration into work.

Only the consequences of the health impairment are taken into account when assessing whether an occupational disability exists. An occupational disability is only deemed to exist if this occupational disability cannot objectively be overcome.

7.1.6 Medical Certificate

A medical certificate must be provided in order to confirm incapacity to work. The certificate must be issued by a physician or a chiropractor who is approved by the insurer. A medical certificate must be submitted at least every four weeks.

Medical certificates and illness reports may not be backdated by more than three days.

7.2 Scope of Services

7.2.1 General Information

Benefits are determined in accordance with the agreed scope of insurance and these GIC. The total daily allowances paid may not exceed the loss of earnings suffered by the insured person through the insured event.

7.2.2 Daily Allowance

The insured daily allowance is paid out for the duration of the medically certified incapacity to work after the contractual waiting period has expired.

The total daily allowance may not exceed the loss of earnings of the insured person caused by the insured event.

7.2.3 Partial Incapacity to Work

In the event of a partial incapacity to work, the daily allowance is paid in accordance with the degree of incapacity to work. Days of partial incapacity to work count as full days for the purpose of calculating the duration of benefits.

7.2.4 Family Allowances

Child and education allowances from the Family Allowances Office are included in the insurance free of charge as part of the insured income. The entitlement to benefits begins after expiry of the waiting period agreed in the policy, but no sooner than the fifth calendar month.

The policyholder or insured person must apply to the insurer in writing for this benefit, providing evidence that the statutory child and education allowances from the Family Allowances Office are being discontinued.

7.2.5 Suspension of the Obligation to Pay Benefits

During the period of entitlement to maternity compensation or paternity compensation under the Federal Loss of Earnings Compensation Act (Erwerbsersatzgesetz, EOG) or to childbirth or paternity allowances under this insurance, the obligation to pay benefits due to illness is suspended.

7.2.6 Childbirth Allowance

The childbirth allowance must be requested by the policyholder and is not automatically insured.

The entitlement to the childbirth allowance arises with the entitlement to maternity compensation under the EOG and supplements the maternity compensation under the EOG.

During the period in which the maternity compensation is received, but for a maximum of 98 days, the difference

between the maternity compensation and the insured childbirth allowance will be paid. Childbirth allowance corresponding to the insured daily allowance will be paid for a maximum of 14 additional days.

The childbirth allowance will be paid without a waiting period and will not be offset against the agreed maximum duration of benefits in the event of illness.

The entitlement to childbirth allowance ends in any case if the insured person resumes employment before the end of the duration of benefits.

No childbirth allowance will be paid if the employment relationship with the policyholder ends before the birth.

For pregnancies that existed prior to the commencement of the contract, there is no entitlement to childbirth allowance in addition to the maternity compensation under the EOG, except within the scope of vested benefits in the event of an assumption of contract.

The policyholder can request that it be examined whether additional benefits can be added on. To do so, the policyholder's HR regulations must include provisions governing maternity leave.

7.2.7 Paternity Allowance

The paternity allowance must be requested by the policyholder and is not automatically insured.

The entitlement to the paternity allowance arises with the entitlement to the paternity compensation under the EOG and supplements the paternity compensation under the EOG.

During the period in which the paternity compensation is received, but for a maximum of 14 days, the difference between the paternity compensation and the insured paternity allowance will be paid.

The paternity allowance will be paid without a waiting period and will not be offset against the agreed maximum duration of benefits in the event of illness.

The entitlement to paternity allowance ends in any case if the insured person resumes employment before the end of the duration of benefits.

No paternity allowance will be paid if the insured person's employment relationship with the policyholder ends before the paternity leave.

If the paternity leave began prior to the commencement of the contract, there is no entitlement to paternity allowance in addition to the paternity compensation under the EOG, except within the scope of vested benefits in the event of an assumption of contract.

The policyholder can request that it be examined whether additional benefits can be added on. To do so, the policyholder's HR regulations must include provisions governing paternity leave.

7.2.7 Payment of Salary in the Event of Death

If an insured person dies as a result of an insured illness, the insurer will assume the statutory obligation to continue paying the salary due from the policyholder within the meaning of Article 338(2) CO, insofar as this is included in the scope of cover.

The insurance benefit is paid without a waiting period.

Any commitment made by the policyholder to continue payment of the salary, in extension of the statutory provisions, for a longer period of time will not be taken into account.

7.3 Commencement of Benefits

The entitlement to a benefit begins once the agreed waiting period has passed. The waiting period begins on the first day of incapacity to work, according to the medical certificate, but no earlier than three days before the first medical treatment. The waiting period is calculated per insured event.

7.4 Duration of Benefits

7.4.1 Principle

The duration of benefits is listed in the insurance policy and calculated according to the particular insured event. Days of partial incapacity to work count as full days for the purpose of calculating the duration of benefits.

The insured person may not stall the expiry of the entitlement to benefits by not claiming the daily allowances.

If, after the agreed duration of benefits has expired, a new insured event occurs, this event will be covered by the insurance if the insured person has completely or partially made use of his remaining capacity to work. The insurance coverage is limited to the remaining capacity to work.

7.4.2 Offsetting the Waiting Period

The agreed waiting period counts towards the duration of benefits. Waiting time is considered to be days on which an incapacity to work of at least 25% exists.

7.4.3 Relapse

The recurrence of an illness (relapse) is classified as a new insured event if the insured person was fully fit for work for an uninterrupted period of 365 days since the last occurrence of the same illness.

In the event of a relapse within 365 days, the waiting period passed and the benefits paid will be imputed.

7.4.4 Additional Insured Event

If an additional insured event occurs during an ongoing insurance event, the daily allowances already received for the first event will be credited toward the duration of benefits for the second event.

7.4.5 Duration of Benefits in the Event of Birth

The maximum duration of benefits in the event of birth is 112 days.

The childbirth allowance amount, which is the difference between the maternity compensation and the insured childbirth allowance, ends when the insured person restarts work.

The childbirth allowance will not count toward the maximum duration of benefits.

7.4.6 Duration of Benefits in the Event of Paternity

The maximum duration of benefits in the event of paternity is 14 days.

The paternity allowance, which is the difference between the paternity compensation and the insured paternity allowance, ends when the insured person restarts work.

The paternity allowance will not count toward the maximum duration of benefits.

7.4.7 Duration of Benefits after Reaching AHV Retirement Age

For insured persons who remain in gainful employment upon reaching the regular AHV retirement age or after early retirement, there is an entitlement to the insured daily allowance until the statutory obligation to continue paying the salary on the part of the employer is satisfied, but for a maximum period of 180 days from normal or early retirement and up to a maximum of 70 years of age. The waiting period counts towards the duration of benefits.

In the event of an ongoing benefit claim, the daily allowance will be paid out for a maximum of 180 days from retirement, but up to a maximum period of the agreed duration of benefits.

7.4.8 Imputation in the Case of an Assumption of Contract

In the case of an assumption of contract or a renewal of contract, any benefits already drawn from previous insurers will count toward the duration of benefits.

7.4.9 Continued benefits

Insured persons who are wholly or partially unfit for work when the employment relationship ends or the insurance contract is rescinded are entitled to benefits until the end of the case of illness which justifies the continued benefits, but no longer than the agreed duration of the benefit.

Relapses do not give rise to an entitlement to further benefits.

This continued benefits does not apply:

a) in the event of entitlement to vested benefits from another insurer in the case of an assumption of contract,
b) in the event of a job change and transfer to the daily sickness allowance or occupational disability insurance scheme of the new employer,
c) when the insured person retires, but upon reaching the AHV retirement age at the latest,
d) if the insured person moves abroad. Cross-border workers' country of residence is considered equivalent to Switzerland,
e) if the employment contract has been terminated during the probationary period, or
f) if the work was of a temporary nature lasting three or fewer months. In the case of temporary work lasting more than three months, the entitlement to benefits only lasts for as long as the employment relationship would have lasted.

If the continued benefits lapse, the provisions regarding the transition to individual insurance shall apply.

7.5 Limitation of Benefits

7.5.1 Exclusion of Benefits

There is no entitlement to insurance benefits

a) for consequences of accidents and occupational illnesses which are to be covered by a different insurer,
b) in the case of participation in warlike actions, unrest and similar events, and during military service abroad,
c) in the case of illnesses and accidents as a consequence of active participation in punishable actions, fights, and other acts of violence,
d) if the person's health is damaged as a result of non-medically prescribed ionizing radiation,
e) if the insured person temporarily leaves Switzerland or his country of residence while being unfit for work without the insurer's approval, coverage will cease until they return to Switzerland or his country of residence,
f) if the insured person falls ill during a stay abroad until they return to Switzerland or to their country of residence. This restriction does not apply to the duration of an unavoidable hospital stay or for the duration of the inability to travel certified by a doctor,
g) if, during a period of incapacity to work, the insured person is placed in custody or is the subject of a criminal sentence or measures,
h) in the event of incapacity to work resulting from operations that are not medically necessary (e. g. cosmetic surgery),
i) if the certificate of incapacity to work was issued by an unauthorized doctor or chiropractor.

7.5.2 Restrictions on Benefits

Benefits may be reduced

a) if the insured person repeatedly and seriously fails to comply with rulings of the insurer or instructions given by a doctor,
b) if the documents required to ascertain the insurance claim are not produced within four weeks despite a written reminder to do so, whereby the waiting period is not interrupted as a result,
c) for illnesses that are the result of warlike events that broke out more than 14 days before the incapacity to work occurred.

7.5.3 Gross Negligence

The insurer forgoes the right to reduce insurance benefits according to the VVG if the insured person caused the

illness through gross negligence.

7.5.4 Duty to Reimburse

Benefits drawn erroneously or unjustifiably must be returned to the insurer by the policyholder.

8 Obligation to Cooperate in the Event of Illness

8.1 Obligations in the Event of a Claim

If incapacity to work is likely to result in insurance benefits, the insurer must be notified in writing by means of an illness notification form within five days at the latest or five days after the waiting period has expired.

In the case of agreed waiting periods of more than 29 days, the incapacity to work must be notified to the insurer in writing no later than 30 days after it began by way of an illness notification form. The doctor's certificate must be enclosed with the illness notification form.

If the illness notification form is received late, the waiting period first begins with receipt of the report of the incapacity to work. However, the duration of benefits begins on the first day of the incapacity to work.

If the degree of incapacity to work is reduced, the insurer must be notified of this fact without delay. The notification must be made truthfully. If benefits are claimed, the insured person and the policyholder must present the insurer with all information that contains the required medical and administrative details.

8.2 Loss Mitigation

The insured person must do everything in their power that can help to reduce the benefit, in particular to promote their recovery. They must avoid doing anything that will delay it. In particular, they must follow the instructions of medical professionals. The insurance company is entitled to check that the medical instructions are complied with and can put in place suitable corrective measures.

The insured person must provide evidence of loss of earnings. If they cannot provide evidence of loss of earnings, there is no entitlement to benefits.

The insured person who is likely to remain wholly or partially unfit for work is obligated to make use of any remaining fitness for work they may have in a different profession or field of activity. The insurer will ask the insured person to adapt their current activity or to change jobs or occupation, subject to a reasonable period of time.

Upon request by the insurer or the policyholder, the insured person must

a) register with the appropriate disability insurance office within six months after the commencement of the incapacity to work. Entitlement to benefits will be interrupted if the insured person does not comply with this registration request. The entitlement will recommence after the insured person has registered. The duration of the interruption is offset for the entire duration of benefits,

b) consult a doctor on the first day of the incapacity to work, and

c) agree to an examination by a second doctor or by the insurer's independent medical examiner. The insurer is liable for the associated costs. The order for the examination by the medical practitioner will be deemed to have been delivered on the seventh day following the failure to collect it at the post office. If the insured person is located abroad or their place of residence there, the insurer may request that the examination take place in Switzerland. The insured person will bear any travel costs incurred.

8.3 Obligation to Provide Information

In all cases where a benefit claim is asserted by the insurer, the insured person or the policyholder shall provide the insurer with all the information required to assess the obligation to pay benefits, the benefit amount, or the duration of benefits.

The insured person shall release the doctors and other medical professionals treating them from the duty of nondisclosure to the insurer. If necessary, the insurer may obtain information from other insurers.

Without being requested to do so, the insured person and the policyholder shall provide the insurer with information on all benefits received by third parties in the event of an illness, accident, or disability. Upon request, the insurer must be provided with bills by third parties.

If any of the submitted doctor's certificates and reports are not in German, French, Italian, or English and a notarized translation is not attached, these will be translated at the cost of the insured person where the insurer requires this.

8.4 Breach of the Obligation to Cooperate

Insurance benefits can be reduced or withheld if the insured person or the policyholder breaches the obligations from these GIC.

If the insured person fails to attend a medical examination required by the insurer without excuse, the insurer reserves the right to invoice the insured person for the fee for the missed consultation.

8.5 Withholding Tax

If daily allowances are given to the policyholder to pass on to the insured person, the policyholder will be liable for the legal settlement and payment of the withholding tax.

9 Premiums and Payments

9.1 Applicable Payroll

Premiums are calculated on the basis of the gross payroll for the insured persons that is subject to AHV contributions and is obtained from the insured company, but no more than the maximum insured income agreed in the policy per person per year.

Gross salaries of persons not liable for AHV contributions are also used to calculate premiums, provided that they belong to the scope of insured persons.

9.2 Payment of Premiums

9.2.1 Billing and Due Date

The policyholder is liable for the premiums in advance and must pay them by the deadline stipulated in the insurance policy.

The total amount of the bill on account is calculated based on the definitive payroll of the last completed calendar year.

9.2.2 Final Bill

The insurer will provide the policyholder with a declaration form once the calendar year has come to an end. The policyholder must return the payroll declaration to the insurer with the necessary documents (AHV declaration, list of insured persons, pay stubs, etc.) within one month. Based on these details, the insurer will calculate the definite premium contributions and compile a corresponding final bill. No additional payments or reimbursements will be made for balances under CHF 20. The amount will be carried over to the next statement.

If the policyholder does not comply with the obligation to provide the payroll declaration, or if there are no figures for the previous year, the insurer may determine the premium contributions based on an estimate.

9.2.3 Inspection of Payroll Accounting

The insurer has the right to inspect the policyholder's payroll accounting.

9.2.4 Reimbursement of Premiums

If the premium was paid in advance for a particular contract duration and if the insurance contract lapses for legal or contractual reasons before the agreed contract duration expires, the insurer will reimburse the premium that is due for the contract duration that has not expired or will no longer request payment of premiums that are due at a later time.

The premiums for the current insurance period will be owed in full if the policyholder terminates the contract in the event of a claim and the contract has been in force for less than one year at the time it was terminated.

9.2.5 Default of Payment

If the policyholder fails to meet their obligations to pay premiums, even within an extended deadline of 14 days, the insurer will issue a written reminder demanding payment of the outstanding premiums within a deadline of 14 days. The reminder will make the policyholder aware of the consequences of not meeting the obligation to pay.

Any expenses relating to reminders or collection proceedings resulting from defaults of payment will be borne by the policyholder.

If no payment is made despite the reminder and by the expiry of the reminder period, the obligation to pay benefits will be suspended from the expiry of the reminder period until the outstanding premiums have been paid in full, including interest and administrative costs.

There is no entitlement to benefits for claims that occur during the suspension of the obligation to pay benefits, even if the premium in arrears is paid retrospectively.

For benefit claims that already occurred (including additional benefits), the entitlement to the insured benefits remains safeguarded until the originally agreed period.

If the outstanding premium or final bill is not collected with due legal effect within two months of the expiry of the reminder period, the insurance contract will lapse.

9.3 Waiver of Premium in the Event of a Claim

The salary of a daily allowance recipient is not subject to premium. As long as the employment relationship exists with the insured company or benefits are paid within the scope of the continued benefits, the obligation to pay premiums lapses to the extent of the benefits paid from this contract. The right to charge the minimum annual premium in accordance with Section 9.7 remains reserved.

9.4 Premium Adjustment

The insurer has the right to adjust premiums for the following calendar year as a result of changes in costs for the risk pool and as a result of the individual claims history of individual contracts.

Policyholders are notified of any premium adjustments no later than 30 days before the end of a calendar year. The policyholder has the right to terminate the insurance contract within 30 days of notification of any such adjustment until the end of the current insurance year. If no notice of termination is issued, the policyholder will be deemed to have accepted the premium adjustment. Otherwise, the insurance contract and its term will remain unchanged.

9.5 Surplus Participation

Surplus participation can be agreed upon.

If surplus participation is agreed upon, the policyholder will participate in any surplus under its insurance contract after a minimum of three full insurance years or in accordance with the accounting period specified in the insurance contract. Tacit renewals of the contract also form part of an accounting period.

The surplus is calculated by deducting the insurance benefits provided and reserves from the relevant portion of the premium attributable to the accounting period. The applicable portion of the premium and the surplus participation system are mentioned in the insurance policy.

The statement is prepared as soon as the premiums attributable to the accounting period have been paid and the corresponding claims have been settled. Any losses are not carried forward to the next accounting period.

If, after the statement is prepared, cases of illness are subsequently reported or further payments are made that fall within the concluded accounting period, a new statement of the surplus participation may be prepared. The insurer may reclaim surplus participation that has already been paid out.

The entitlement to surplus participation expires if the insurance contract is canceled before the end of the accounting period.

9.6 Payment of Benefits

9.6.1 Payment of Daily Allowances in the Event of Illness

The daily allowance will be paid once the insured person is fit to return to work according to the medical certificate. If the incapacity to work lasts for more than one month, the daily allowance will be paid in arrears on a monthly basis.

The daily allowances will be paid to the policyholder to pass on to the insured persons, provided that the latter are employed by the policyholder.

9.6.2 Payment of Childbirth Allowance

Childbirth allowance will be paid to the policyholder to pass on to the insured person after the birth, on the basis of the verification of the benefits pursuant to the EOG.

9.6.3 Payment of Paternity Compensation

Paternity compensation will be paid to the policyholder to pass on to the insured person, on the basis of the verification of the benefits pursuant to the EOG.

9.6.4 Payment of Salary in the Event of Death

The insured salary in the event of death will be paid to the policyholder to pass on to the relatives of the deceased person after receipt of the official certificate.

9.6.5 Offsetting

The insurer may offset benefits due against any claims against the policyholder.

9.6.6 Pledging and Assignment

Claims against the insurer cannot be pledged or assigned without its consent.

9.6.7 Statutory Limitation Period

The policyholder’s entitlement to benefits from the insurer will become statute-barred after two years of the occurrence of the event that justifies the insurer’s obligation to pay benefits.

9.7 Minimum Premium

The annual minimum premium is CHF 1’200.00.

10 Benefit Coordination

10.1 Reduction, Overcompensation, and Repayment

10.1.1 General Provisions regarding the Reduction, Overcompensation, and Repayment of Benefits

If a third party is liable for a reported case of illness, whether as a result of unlawful acts, under the contract, or under legal provisions, the insurer will subsequently supplement the benefits up to the amount of the insured daily allowance.

When calculating the duration of benefits and waiting period, days with reduced benefits will be treated as whole days. This also applies if the reduction results in the insurer not providing any benefits.

Within the scope of the benefit claims against third parties, no obligation to pay benefits exists.

10.1.2 Reductions in the Case of Social Insurance Benefits

If social insurers are obligated to pay benefits, the insured daily allowances will be reduced by the amount received in the form of benefits from social insurance schemes (daily allowances, pensions, etc.).

The insured person shall assign any claims for additional payments against social insurance schemes (KV, UV, IV, MV, AHV, AVI, EO, BV, FamZG, FLG, etc.) to the insurer.

10.1.3 Reductions in the Case of Multiple Insurance Policies

If several insurers are obligated to pay benefits, the insurer will be liable for losses in the proportion that its sum insured bears to the total amount of all sums insured.

The policyholder shall notify the insurer immediately of any existing or newly concluded daily allowance insurance policies with other insurers.

10.1.4 Annulment in the Case of Multiple Insurance Policies

If the policyholder did not know that multiple insurance policies were in place when they concluded the subsequent contract, they can terminate this contract in writing. This must be done within four weeks of the policyholder becoming aware of the multiple insurance policies.

If the policyholder intentionally failed to report this or took out multiple insurance policies with the intention of making an illegal pecuniary gain, the insurer is not bound by the contract with the policyholder.

10.1.5 Overcompensation

Overcompensation exists if the total amount of benefits provided by the insurer, third parties, and social insurance schemes exceeds the amount of the insured daily allowance. In such a case, the benefits will be reduced accordingly, and overpayments can be recovered or offset directly against benefits from social security providers, in particular with Swiss Federal Disability Insurance.

When calculating the duration of benefits and waiting period, days with reduced daily allowance benefits will be treated as whole days.

10.1.6 Waiver of Benefits

If insured persons waive benefits from third parties in whole or in part without the insurer's consent, the obligation to provide benefits will lapse. A capitalization of a claim to benefits or the failure to assert claims against third parties will also be regarded as a waiver, in particular if the insured person does not register for disability insurance despite being requested to do so by the insurer.

10.2 Advance Payment of Benefits and Recourse

Advance payment may be made by the insurer in relation to third parties.

A requirement is that the insured person must have made reasonable efforts to enforce their claims without success and is willing to assign their claims against third parties to the insurer within the scope of the benefits provided.

11 Data Protection

11.1 Principle

The processing of the data of insured persons complies with the provisions of the Swiss Insurance Policies Act and the Federal Act on Data Protection (Datenschutzgesetz, DSG).

11.2 Purpose of Processing

The insurer will only process data (e.g. personal data, information on health conditions, examining the information provided in the application, collection, benefit processing) that are required for processing the insurance contract pursuant to the VVG. If there is consent, information may also be obtained from third parties (insurers, doctors, hospitals, etc.).

11.3 Transfer of Data to Third Parties

The data protection provisions are taken into account during processing. Data is processed solely by persons who are in an employment relationship with the insurance provider or by persons who are authorized to do so within the scope of a processing obligation. Personal data will not be transferred to third parties. This does not apply to cases where data transfer is permissible by law or if the insured person has given their consent.

11.4 Data Storage

The data is retained physically and/or electronically within the scope of the statutory retention obligation and protected against unauthorized access by appropriate technical and organizational measures. In addition to the statutory retention obligation, personal data will only be retained if this is necessary for the enforcement and defense of legal claims.

The retention period depends, among other things, on the statutory retention periods or the duration during which claims can be asserted against the insurer. Upon expiry of the statutory retention obligation or extraordinary retention, the personal data will be destroyed/erased.

11.5 Right to Information

The insured person has the right to request the information required by law about the processing of their data.

11.6 Revocation of Consent

Consent to data processing can be withdrawn at any time.

12 Notifications

Notifications from the insurer are made with legal validity in writing to the insured person or the policyholder.

The insurer must be informed within 30 days in writing of any changes that are important for the insurance scheme, in particular changes in relation to the composition of the insured group of persons or the regulation of occupational pensions (BVG) provisions.

Where these GIC require notification in writing, it is sufficient to provide notification in another form that also provides evidence in text form.

13 Place of Jurisdiction

In the event of any disputes arising out of the insurance contract, the claimant may choose to have their case heard before the court at the insured person's place of residence in Switzerland or the insured person's place of work in Switzerland or the insurer's registered office.