

Customer information required by Article 3 VVG



This information provides you with an overview of the main content of the insurance policies covering loss of earnings in accordance with the Federal Act of 2 April 1908 on Insurance Policies (Bundesgesetz vom 2. April 1908 über den Versicherungsvertrag, VVG). The rights and obligations of the contracting parties arise in particular from the application/offer, the insurance policy, the General Insurance Conditions (GIC) and the law (VVG).

1. Who is the insurer, and what risks are insured?

The insurance provider is Quantum Leben AG (hereinafter referred to as “Quantum Leben”), Städtle 18, 9490 Vaduz (Liechtenstein). It is accordingly listed in your insurance application and insurance policy.

Unless otherwise defined in the contract, the benefits include

- daily allowances for illness in the event of incapacity to work of at least 25% for a maximum of 730 days (limited to 180 days after reaching the AHV retirement age);
- childbirth allowance in supplementation of the Federal Act of 25 September 1952 on Compensation for Loss of Earnings for Persons on Military Service or Maternity Leave (Bundesgesetz vom 25. September 1952 über den Erwerbssersatz für Dienstleistende und bei Mutterschaft, EOG);
- paternity allowance in supplementation of the EOG.
- Detailed insights into the insurer’s solvency and financial condition can be found in the following reports (SFCR): [Quantum Leben](#).
- grape insurance AG is authorized to take all actions on behalf and for the account of the insurance provider.

2. What are the contractual bases?

The bases of the insurance contract are

- the insurance application, including any health declarations;
- the insurance policy;
- the Special Conditions (SC) listed in the insurance policy;
- the GIC;
- the Federal Act of 2 April 1908 on Insurance Policies (Bundesgesetz vom 2. April 1908 über den Versicherungsvertrag, VVG).

Special conditions or agreements that deviate from or supplement the General Insurance Conditions and/or the Additional Conditions are noted in the application or in the insurance policy.

3. Who is insured?

The insured persons and categories of persons are listed in the application and in the insurance policy.

4. What is the scope of insurance cover?

Loss of earnings insurance is an individual insurance solution that is tailored to your needs. The insured risks and the benefits provided by the insurance provider and the scope of the insurance cover you request result from your application or insurance policy, the corresponding provisions of the GIC and SC and applicable laws. Unless otherwise defined in the contract, the offer includes the following:

- Daily allowance for illness.
- The daily allowance is paid for each calendar day of incapacity to work of at least 25% that has been certified by a doctor. The entitlement arises after expiry of the contractual waiting period and on condition that the insured person is still part of the group of insured persons at that time.

- Childbirth allowance in supplementation of statutory maternity insurance in accordance with the EOG.
- The insurance provider pays the agreed benefits for each birth for which benefits are paid under statutory maternity insurance.
- Paternity allowance in supplementation of statutory paternity insurance in accordance with the EOG.
- Continued payment of salary in the event of death.
- If an insured person dies due to the consequences of an insured illness, the insurance provider continues to pay the salary that is to be paid by the policyholder to the survivors within the meaning of Article 338(2) of the Swiss Code of Obligations (Obligationenrecht, OR).

It is an indemnity insurance policy.

The insurance provider waives the right to reduce the benefits in the event of an accident caused by gross negligence.

If the insurance provider provides benefits instead of third parties, there is no obligation to pay benefits to the extent of the benefit claims vis-à-vis third parties.

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.).

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

5. Among other things, what is not insured?

There is no entitlement to insurance benefits

- in the case of participation in warlike actions, unrest and similar events and during military service abroad;
- if the insured person's health is damaged as a result of non-medically prescribed ionizing radiation;

- if the insured person temporarily leaves Switzerland or their country of residence during their incapacity to work without the insurance provider's approval, until they return to Switzerland or their country of residence;
- in the case of illnesses and accidents as a consequence of active participation in punishable actions, fights and other acts of violence;
- if, during the inability to work, the insured person is placed in custody or is the subject of a criminal sentence or measures;
- in the event of incapacity to work resulting from operations that are not medically necessary (e.g. cosmetic surgery).

6. What premiums are owed?

The amount of the premium owed depends on the type of business, the chosen benefits and the individual and collective claims history. The premium owed is calculated on the basis of the AHV salary of the defined group of persons that is subject to contributions, up to the maximum salary specified in the insurance contract.

The annual salary agreed in the insurance contract for this person is decisive for the insured persons in the insurance contract. The foregoing is without prejudice to any minimum premium.

The premium is charged once a year. Details are set out in the insurance policy. In the event of premature cancellation of the daily sickness allowance insurance policy, the unused premium will be reimbursed to you as a rule.

7. What are your key obligations?

Your obligations are set out in your insurance policy, the GIC, the SC and the VVG. This means, in particular:

- You must complete all forms (e.g. application and health forms) that are part of the application truthfully and in full. Otherwise, the insurance provider may terminate the insurance contract, exclude insured persons from the insurance contract and/or refuse or reclaim benefits.

- You must inform the insured persons when they join the insurance policy about possible restrictions on benefits.
- You must promptly report changes to the facts and circumstances declared in the application and significant for the risk assessment that occur during the term of the insurance contract to the insurance provider.
- You must promptly inform the insurance provider about any existing or newly concluded daily allowance insurance policies with other insurers.
- You must pay the premiums when due. Failure to pay results in the absence of insurance cover. Even if you pay the premium after a reminder has been issued, the insurance provider may not be required to pay out any benefits for any damage that has occurred in the interim.
- After the end of the insurance year, you must report the salary declaration to the insurance provider with the required documents (AHV declaration) within a period of one month.
- You must report the benefit claims no later than 30 days after the onset of incapacity to work. The notification must be made truthfully. If the illness notification is received late, the waiting period begins with receipt of the report of the incapacity to work.
- When giving notice of the benefit claim, you must provide the insurance provider with all necessary information with the medical and administrative details.
- Upon request, you must allow the insurance provider to inspect salary records.
- Using the “Employee offboarding” fact sheet, you must inform insured persons about the right to switch to individual insurance when they leave the company.

8. When does the insurance start and end?

The start and duration of the insurance are set out in the insurance policy. If the insurance contract is not terminated at the end of the contract term, it tacitly renews for a further calendar year. The following are the most important options for terminating the insurance contract:

- You terminating the insurance contract no later than three months before the end of the agreed term.

- You terminating the insurance contract within 30 days of you receiving the notification that, at the start of the following insurance year, the insurance provider will adjust premiums to your disadvantage.
- The abandonment of the business activity or the relocation of the registered office abroad results in cancellation of the insurance contract.
- The insurance provider is not bound by the insurance contract in the following cases and is entitled to terminate it
 - in the case of premium arrears as set forth in the provisions on default of payment;
 - if, upon concluding the insurance contract, you provided incorrect information about or failed to disclose a significant source of risk of which you were aware or should have been aware;
 - if, in the course of the insurance contract, you incorrectly notify or conceal facts that would exclude or reduce the obligation of the insurance provider to pay benefits.
- You terminating the insurance contract, if you did not know that multiple insurance would arise when you concluded the later contract. Your termination must be made within four weeks of you becoming aware of the multiple insurance. If you deliberately failed to make the notification or took out the multiple insurance with the intention of obtaining an unlawful pecuniary benefit from this, the insurance provider is not bound by the contract. The insurance providers waive their statutory right to terminate the collective insurance contract with you in the event of a claim.

9. When does the insurance cover start and end?

Insurance cover for the insured person starts on the day on which the employment contract commences or the insured person is entitled to a salary for the first time, in any case, however, at the time the employee begins their journey to work.

Partially disabled persons or employees with a disability who are employed on a part-time basis only due to their health impairment in the insured company must be fully capable of working for the agreed part-time employment on the day on which the employment contract commences or the insured person is entitled to a salary for the first time, in any case, however, at the time the employee begins their journey to work.

Insurance cover expires for the insured person:

- once the employment relationship with the policyholder ends;
- in the case of continued employment after reaching AHV retirement age upon turning 70;
- 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 ability to work;
- in the event of death;
- upon expiry of the insurance contract.

10. What happens when there is a good claims history?

Surplus participation can be agreed upon. If surplus participation is agreed upon, the policyholder will participate in any surplus under its insurance contract after three full insurance years (the accounting period).

The surplus is calculated by deducting the insurance benefits provided from the relevant premium share attributable to the accounting period. The relevant share 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 and consequences of accidents are subsequently reported or further payments are made that fall within the completed accounting period, a new surplus-participation statement will be prepared. The insurer may reclaim surplus shares that have already been paid out.

11. What applies in terms of data protection?

Pursuant to Section 1, the insurance providers commission grape insurance AG to process personal data (e.g. personal details, information about health status, verification of the information provided in the application, collection, settlement of benefits) that are required for performing the insurance contract in accordance with the VVG. If there is a power of attorney, information may be obtained from third parties (insurers, doctors, hospitals, etc.).

The data protection provisions are taken into account during processing. Data are 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.

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

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

The insured person has the right to request the information required by law about the processing of their data. Consent to data processing can be withdrawn at any time.

Do you have any questions?

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