Voluntary daily benefits insurance

pursuant to the Swiss Federal Health Insurance Act (KVG/LAMal)

General Terms of Insurance

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Insurance carrier: Sanitas Grundversicherungen AG

sanitas

General

1 Content

1 In accordance with legal requirements, daily benefits insurance provides cover for the economic consequences of incapacity from work resulting from illness, maternity or accidents. Accident coverage can be excluded.

2 The insured daily benefits and waiting period are specified in the policy.

2 Basis

The basis of this insurance cover is the Swiss Federal Act on the General Part of Social Insurance Law (ATSG/LPGA) and the Swiss Federal Health Insurance Act (KVG/LAMal) in conjunction with the related implementation regulations.

3 Maximum insured sums

Maximum insurable amounts are specified by Sanitas.

Definitions

4 Incapacity to work

Incapacity to work is defined as the complete or partial inability to perform such duties as may reasonably be expected in one's previous profession, trade or area of responsibility as a result of physical, mental or psychological health conditions. In protracted cases, the insured's ability to perform such duties as may reasonably be expected in another profession, trade or area of responsibility will also be taken into account.

5 Illness/maternity

1 Illness is defined as any impairment to the physical, mental or psychological health that is not the consequence of an accident and which requires a medical examination or treatment or results in incapacity to work.

2 Maternity includes pregnancy and childbirth and the mother's postnatal recovery period.

6 Accident

An accident is defined as the sudden, unintentional, harmful influence of an exceptional external force on the human body, resulting in the impairment of physical, mental, or psychological health, or death.

Insurance relationship

7 Insured person

The insurance covers the person specified in the policy document.

8 Insurance application

For admission to the insurance plan or in case of changes to the insurance, the appropriate application form must be completed truthfully and in full and sent to Sanitas.

9 Medical examination prior to admission

1 Prior to admission to the insurance plan, Sanitas may request a medical report or require that the insured person undergo a medical examination.

2 Sanitas also has the right to request an examination by a company-appointed medical doctor. In this case, the doctor will be chosen by Sanitas. If the applicant refuses to undergo an examination by a company-appointed medical doctor, Sanitas has the right to reject his application.

10 Admission subject to restriction

1 At the time of admission, Sanitas may impose a restriction excluding illnesses and conditions resulting from an accident that pre-existed at the time of application or that experience shows to be subject to relapse.

2 The restriction applies from commencement of insurance and ceases to apply after 5 years.

3 Before this 5-year period has elapsed, the insured may present evidence at his own cost that an existing restriction is no longer justified.

4 If, at the time the contract was concluded, the insured withheld or misrepresented a material fact regarding illnesses or conditions resulting from an accident, Sanitas may impose a restriction retroactively.

11 Transfer

1 The provisions regarding the medical exam (points 9 and 10) do not apply to insurance cover with the same benefits for persons who are legally entitled to claim transfer to the Sanitas daily benefits insurance (statutory portability). The insured must exercise his right to transfer within 3 months of receiving notification from his previous insurer or employer drawing attention to the right to transfer.

2 Existing restrictions applied by previous health insurers will be carried over and any benefits claimed included in the benefit period.

12 Commencement of insurance

1 The insurance commences at the earliest on the 1st day of the month in which the application is signed, provided that Sanitas receives the application in good time.

2 For persons entitled to statutory portability in accordance with point 11, coverage starts on commencement of the reason for transfer, provided that the former insurer or employer informs Sanitas of the insured's right to transfer in good time and has sent confirmation of previous insurance within 3 months.

13 Amendments to cover

1 Requests to increase the amount of insured daily benefits must be made in writing. Any increase will take effect from the 1st day of the following month. The provisions regarding commencement of insurance, particularly points 8–10, apply mutatis mutandis.

2 The insured can apply in writing to reduce the amount of insured daily benefits effective the end of the calendar month.

14 Conversion of insurance in case of unemployment

Within 30 days of registering for unemployment benefits, unemployed insureds can convert the current amount of their existing daily benefits insurance to insurance cover with a 30-day waiting period regardless of their state of health.

15 End of insurance coverage

Insurance coverage ends on

- giving up civil law domicile in Switzerland; for cross-border commuters on leaving employment in Switzerland;
- terminating the policy;
- initiating a statutory transfer;
- exclusion;
- reaching the maximum benefit period in the event of 100% incapacity to work;
- the death of the insured person.

16 Termination

1 The insured person may terminate his insurance with effect from the end of a calender term subject to 3 months' notice.

2 On receipt of new premiums, the insured person can terminate insurance subject to 1 month's notice effective the end of the month that precedes the validity of the new premium. Sanitas informs its customers of new premiums approved by the relevant federal office at least 2 months in advance.

3 An insured person can terminate insurance effective the end of a month if he has to transfer to an employer's mandatory daily benefits insurance scheme.

4 The termination must be made in writing and must reach Sanitas before the deadline for termination elapses.

17 Exclusion

1 The insured person can be excluded from the insurance if the terms of the insurance are violated, in case of important, inexcusable reasons, or if continuation of the insurance is untenable for Sanitas.

2 Important reasons include in particular if the insured person

- provided incomplete or incorrect information in the insurance application;
- has not fulfilled his financial obligations despite reminders;
- has made or has tried to make unlawful use of Sanitas's benefits.

Benefits

18 Entitlement to benefits

1 The insured person is entitled to daily benefits on the grounds of medically certified full or partial incapacity for work. Entitlement begins 5 days before the first medical treatment at the earliest.

2 In the event of partial incapacity to work, the daily benefits shall be proportional to the incapacity. If the incapacity to work is less than 50% there shall be no entitlement to benefits. Insurance coverage for the remaining capacity to work is retained.

3 If the incapacity to work is only partially due to an insured illness/accident, only the corresponding part of the insured daily benefits will be paid. This part will be determined by a medical certificate or medical report.

4 If the risk of accident is included, the same benefits will be paid in the event of an accident as for illness.

19 Waiting period

1 If a waiting period is agreed, no daily benefits will be paid during this period. The waiting period starts on commencement of the entitlement of daily benefits as set out under point 18.1.

2 For the purpose of calculating the waiting period, days of partial incapacity of 50% or more are counted as whole days.

3 The waiting period will only be counted once within 365 days.

20 Benefit period

1 The insured daily benefits will be paid for one or more illnesses/accidents for a maximum of 730 days within a period of 900 days.

2 If reduced daily benefits are paid as a result of partial incapacity to work, days with reduced daily benefits are counted as whole days for the purpose of calculating the benefit period.

3 The maximum benefit period is reduced by the waiting period specified in the policy, provided that the waiting period is at least 30 days and the employer is obliged to continue paying salaries.

4 The insured shall not prevent the reaching of the maximum benefit period by foregoing benefits.

21 End of entitlement to benefits

Entitlement to benefits (including benefits for existing incapacity to work) shall cease on termination of the insurance.

22 Overcompensation

1 The benefits agreed as part of this daily benefits insurance must not lead to overcompensation of the insured in connection with benefits paid by other social insurers. In calculating overcompensation, only benefits of the same type and purpose as are being paid to the insured as a result of the harmful event will be included.

2 A case of overcompensation will exist where the insurance benefits exceed the projected earnings lost as a result of the insured event plus any extra costs and loss of income suffered by family members caused by the insured event.

3 The benefits will be reduced by the amount of overcompensation calculated.

4 If the insured has taken out voluntary daily benefits insurance with other health insurers in accordance with KVG/LAMal, the overcompensation limit set out in point 22.2 applies. If benefits have to be reduced, every insurer is liable to pay benefits in proportion to the insured daily benefits provided.

5 On reduction of daily benefits following overcompensation, the insured is entitled to a payment equivalent to 730 whole days of benefits. The deadlines for drawing daily benefits are extended in accordance with the reduction.

23 Unemployment

In case of an incapacity to work of up to 50%, unemployed persons will receive half the daily benefits; in case of an incapacity to work of more than 50%, they will receive full daily benefits.

24 Maternity

1 For pregnancy and childbirth, daily benefits will be paid for a period of 16 weeks. To be entitled to this benefit, the insured must be insured for at least 270 days, without any interruption of more than 3 months, before the date of giving birth. These conditions also apply to higher benefits agreed subsequently.

2 Daily benefits for maternity will be paid after a pregnancy of at least 28 weeks, even if the pregnancy proves not to be viable. At least 8 of these 16 weeks must be after giving birth.

3 The benefit period of 16 weeks is reduced by the waiting period specified in the policy. This is subject to point 19.3.

4 Maternity benefits are not taken into account for the maximum period of benefits and are paid even once this maximum has been reached.

25 Benefits abroad

1 If incapacity to work occurs while abroad, daily benefits are only paid during hospitalisation in the country of residence. No benefits are paid in the event of transfer to or treatment in other countries.

2 No benefits are paid if the insured
- moves abroad during a period of incapacity for work;
- goes abroad for treatment, care or childbirth.

26 Restrictions on benefits

Daily benefits will be reduced or in particularly serious cases withdrawn
- if the illness or accident was intentionally caused or worsened as a result of a crime or an offence committed by the insured;
- on breach by the insured of the obligations listed under points 27, 32 and 33. The insured must first be given a warning and informed of the legal consequences.

27 Third-party benefits

1 If the insured has taken out voluntary daily benefits insurance with another health insurer in accordance with KVG/LAMal, Sanitas must be informed of this when a claim is made at the latest.

2 The insured must inform Sanitas of the type and scope of benefits he can claim or receive in payment in the event of illness or accident in tort or under statute.

3 If the insured is entitled to benefits from statutory disability insurance (IV/AS), accident insurance (UVG/LAA) or military insurance (MV/AM), Sanitas pays only benefits exceeding these social insurance benefits.

4 Sanitas only pays benefits provided that the applicable social insurers have been notified of the insurance claim in due time.

5 If the insured holds equivalent daily benefits insurance with another health insurer in accordance with KVG/LAMal, in case of overcompensation Sanitas will reduce its insured daily benefits in proportion to the insurance in place with this insurer.

6 Sanitas represents the insured vis-à-vis third parties that are liable for the insured event at the time of its occurrence to the maximum extent of the insured benefits.

7 If another health, accident or social insurer reduces its benefits for reasons that also entitle Sanitas to reduce its benefits, Sanitas shall not make up any shortfall resulting from the reduction of another insurer.

8 If, before commencement of insurance with Sanitas, the insured has received a lump-sum payment from a liable third party for an accident caused in contract, tort or under statute, Sanitas is not liable to pay benefits for the consequences of this accident even after the duration of a restriction has elapsed. This condition also applies mutatis mutandis to illness.

28 Offsetting benefits and refund obligation

1 Sanitas may offset benefits against its claims on the insured. The insured is not entitled to offset claims.

2 Any benefits drawn without entitlement by the insured must be refunded to Sanitas.

29 Prohibition of pledging and assigning benefits

Claims on Sanitas cannot be pledged or assigned to third persons.

30 Payment of benefits

If benefits are to be paid to the insured, Sanitas must be informed of a valid payment address in Switzerland. Exceptions are granted in accordance with the bilateral agreement on the free movement of persons. Payments shall be made in Swiss francs.

31 End of entitlement to benefits

Entitlement to benefits elapses 5 years after the end of the month in which benefits were due.

Obligation and entitlement

32 Obligation to cooperate and notify

1 The insured must provide proof of loss of income or losses sustained through incapacity to work. He must provide Sanitas free of charge with all the information required to determine the amount of benefits due. If the insured falls ill or has an accident, Sanitas must be furnished with a medical certificate confirming incapacity to work, proof of loss of earnings, any extra costs and loss of income suffered by family members within 5 days (or within 14 days if abroad). In individual cases, all necessary persons and authorities must be authorised to provide any information required to determine entitlement to benefits. This includes the submission of any decisions of other social insurers and documents of any private insurers.

2 In case of accident, the insured must also submit an accident report with information on
- the time, place and description of the accident;
- the doctor or hospital providing treatment;
- any liable third parties and insurance plans.

3 If notification is late without a valid reason, entitlement to benefits begins on receipt of notification at the earliest.

4 At the end of the incapacity to work, Sanitas must be provided promptly with confirmation of the degree and duration of incapacity to work.

5 The insured person is obliged to inform Sanitas promptly of any changes to his personal circumstances that affect the insurance relationship (e.g. change of residence, reduction of income).

6 Sanitas has the right to request that the insured undergo a medical examination by doctors appointed by the company.

33 Duty to mitigate loss

1 In the event of illness or accident, the insured must take all measures necessary to promote recovery and refrain from any actions that might have an adverse affect. He must comply with the instructions of the doctor providing treatment.

2 Sanitas is entitled to check compliance with the instructions of doctors, e.g. by visiting the patient.

34 Legal recourse

1 If an insured does not agree with a decision by Sanitas he may, within a period of 90 days, demand that Sanitas issue a written decision including reasons and an explanation of rights of appeal within 30 days.

2 An objection to a written decision may be lodged with Sanitas within 30 days. Sanitas shall review this objection and issue a written appeal decision including reasons and an explanation of rights of appeal.

3 An appeal against the appeal decision issued by Sanitas may be lodged with the competent cantonal insurance court – the insurance court in either the canton of residence of the insured or the canton of residence of the third party filing the appeal – within 30 days.

4 An appeal may also be lodged if Sanitas fails to issue a written decision or appeal decision in response to a request or demand that has been made.

5 An appeal against the ruling of a cantonal insurance court may be filed with the Swiss Federal Insurance Court pursuant to the Swiss Federal Supreme Court Act.

35 Data capture and processing

1 Sanitas ensures compliance with the data protection provisions of Swiss law, namely the Swiss Federal Law on Data Protection (DSG/LPD), and in particular Art. 33 of the Federal Act on the General Part of the Social Insurance Law (ATSG/LPGA) and Art. 84 ff. of the Swiss Federal Health Insurance Act (KVG/LAMal).

2 Within the limits of the statutory provisions, Sanitas may obtain information required for the provision of insurance coverage, process this information electronically, and forward it to third parties for processing.

Premiums

36 Payment of premiums and due dates

1 Premiums are due on the first day of the month in question. Payments may be made on an annual, semiannual, quarterly, bimonthly or monthly basis, with the insurance year beginning on 1 January. If bills are sent to an address outside Switzerland, payments may only be made on an annual, semiannual or quarterly basis.

2 If the insurance is terminated prematurely, the premium due for the unused period of insurance will be refunded.

3 The insured may not offset premiums due against benefits due.

37 Payment reminders and consequences of default in payment

1 If premiums due are not paid in time, Sanitas reminds the insured to pay the outstanding amount within 14 days of dispatch of the reminder, and refers to the penalties for default. If there is no response to the reminder, Sanitas waives the outstanding premium and withdraws from the contract, or institutes legal proceedings to collect the premium, including reminder fees, interest on arrears and debt collection costs.

2 The insured may submit a written request for the reinstatement of the insurance contract without a new risk assessment for up to 4 months after the reminder period expires. He must undertake to pay all outstanding amounts without interruption. In this case entitlement to benefits is reinstated for insurance claims from the day on which Sanitas receives the payment. The request can be rejected without explanation.

3 Sanitas will charge reasonable fees and interest on arrears for payment reminders and debt enforcement proceedings.

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