

ÖKK LOSS OF EARNINGS INSURANCE (VVG)

General terms and conditions of insurance (AVB)

Edition 2011

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Where these ABV (general terms and conditions of insurance) do not expressly use the female gender, the male gender also applies to women

1. Fundamentals of the insurance

1.1. Purpose

The ÖKK loss of earnings insurance serves to cover the loss of earnings that is caused by incapacitation from work as a result of an illness. It may be used to cover the loss of earnings as a result of an accident or birth (childbirth allowance).

1.2. Insurance providers

The insurance provider is ÖKK Versicherungen AG, Landquart (referred to below as the insurer).

The insurance company listed on the insurance policy is authorized to take any action on behalf of and at the expense of ÖKK-Ver-sicherungen AG.

1.3. Fundamentals of the contract

The fundamentals of the contract include

- the insurance application, including any health declarations
- the insurance policy
- the special conditions (BB) listed in the insurance policy
- the present general terms and conditions of insurance (AVB)
- the Federal Act on Insurance Contracts (VVG) of 2 April 1908.

1.4. Insurance policy

The insurance policy states the insurance cover obtained. BB (special conditions), which differ from the AVB complement the same, are also noted in the insurance policy.

1.5. Insurance Contract Act

Insofar as the insurance contract and AVB do not have any different stipulations, the provisions of the VVG (Swiss Federal Act on Insurance Contracts) apply.

2. Insured group of persons

2.1. Policyholder

The policyholder is the business described in the insurance policy with its associated divisions.

2.2. Insured persons

2.2.1. Employees

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

- There is a working or training relationship between them and the insured company,
- they are liable for AHV contributions or would be liable if they were of relevant age or are fully fit to work when reaching the normal AHV retirement age and continue to be employed in the insured company and
- they have not yet turned 70, subject to article 2.2.4.lit c).

Frontier worker are equal to persons residing in Switzerland.

2.2.2. Insurance based on a special agreement

The following are only insured based on a special agreement

- Temporary assistants whose employment contract is limited to three months or less,
- Part-time employees and hourly wage earners who are not insured against the consequences of non work-related acci-

- dents pursuant to the Federal Law on Accident Insurance (UVG),
- Home-based workers,
- Persons resident abroad who are neither frontier workers nor expatriates nor short-term residents.
- Employees, who are employed in Switzerland but who are not members of the Swiss National Insurance Fund due to the agreement between Switzerland and the European Union or EFTA.

2.2.3. Business owners and their family members

Provided that they are listed in the policy by name and with a fixed salary, the following persons are also insured

- the business owner,
- his spouse, children, or parents, if they work for the business but are not listed in the payroll.

2.2.4. Uninsured persons

The following persons are excluded from the insurance

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

3. Geographical validity

3.1. General

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.

The insurance cover may be extended upon request, insofar as the said persons are also covered by UVG.

3.3. Stay abroad while ill

If an insured person who is entitled to benefits travels abroad while ill, then no entitlement to benefits exists during the stay abroad without the prior consent of the insurer.

This limitation does not apply to frontier commuters if they are staying in Switzerland.

4. Insurance variants

4.1. Full coverage

4.1.1. Principle

Full coverage is coordinated with BVG and aims at an unconditional loss of earnings insurance until the BVG pension starts.

4.1.2. Pre-existing illnesses and accidents

In the case of full coverage, benefits will also be paid for illnesses and consequences of accidents that already existed when insurance coverage started.

4.2. Coverage with a health declaration

4.2.1. Principle

Coverage with a health declaration aims to insure the loss of earnings as a result of an illness or consequences of accidents that occur after insurance coverage has commenced.

4.2.2. Pre-existing illnesses and accidents

In the case of illnesses and consequences of accidents that already existed at the time the insurance coverage commenced, the insured benefit will be paid for the duration of the benefit in accordance with scaled coverage. Business owners and their family members are not entitled to benefits in accordance with scaled coverage. The insured person will be informed in writing of the limitation of coverage by the insurer. It becomes effective as soon as the insurance coverage takes effect.

4.2.3. Health declaration

To check pre-existing illnesses and consequences of accidents, each new employee shall undergo a medical examination on the basis of a declaration of the insured person on the form provided by the Fund.

4.2.4. Obligation to provide information

The insured person is obligated to declare to the Fund any illnesses and consequences of accidents that exist or existed when the insurance coverage commences / commenced.

The Fund may request a medical certificate or an examination by a medical consultant. It may choose the doctor and is liable for any costs.

4.2.5. Policyholder's obligation

The policyholder shall ensure that the Fund receives all necessary details about the insured person. He is obligated to inform the insured persons when they join the group insurance scheme of the possible benefit limitations for pre-existing illnesses and consequences of accidents.

4.3. Scaled coverage

4.3.1. Principle

The scaled cover aims at an unrestricted daily allowance that is in line with the employer's legal obligation to continue paying the salary, in accordance with the Swiss Code of Obligations (OR).

4.3.2. Pre-existing illnesses and accidents

In the case of scaled coverage, benefits will also be paid for illnesses and consequences of accidents that already existed when insurance coverage commenced.

5. Commencement, duration, and cancellation of the insurance contract

5.1. Commencement of the insurance 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.

5.2. Duration of the insurance contract

5.2.1. In general

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

5.2.2. Extension of the insurance contract

Once the agreed duration of the contract has expired, the contract shall be extended tacitly by another year, unless it is terminated within the prescribed time limit.

5.3. Cancellation of the insurance contract

5.3.1. Cancellation

The insurance contract may be cancelled in writing by either contracting party, provided a three-month period of notice to the end of a calendar year is observed. The first possible cancellation date is the expiry date specified in the insurance policy.

The cancellation 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 months' cancellation period.

If the contract is not cancelled, it is extended by another year each.

5.3.2. Lapse of the insurance contract

The insurance contract will lapse effective immediately

- a) if the policyholder stops operating his business,
- b) if the registered office is transferred abroad,
- c) if bankruptcy proceedings are opened against the policyholder unless the liquidator or a third party continue to pay the insurance premiums.

5.3.3. Rescission by the insurer

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

- a) in the case 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, of which he was aware or should have been aware, or
- c) if he provides incorrect information about or fails to disclose facts in the course of the insurance contract, which would exclude or reduce the insurer's obligation to pay benefits.

5.3.4. Waiver of termination in case of damage

The insurer expressly waives his legal right to terminate the contract in case of damage.

6. Commencement, duration, and expiry of insurance coverage

6.1. Commencement of insurance coverage

Insurance coverage commences on the first day of work for the policyholder.

For persons who are not fully fit for work when insurance coverage commences, or on the first day of work, insurance coverage shall only commence once they are fully fit for work.

Partially disabled persons or handicapped employees who, as a result of their health-related limitations, only work part-time for the insured business, must be fully fit for work on the day on which they start work in the agreed part-time job.

6.2. Expiry of insurance coverage

Insurance protection expires for the insured person

- a) once the employment relationship with the policyholder ends,
- b) upon retirement,
- c) in the case of continued employment after reaching AHV retirement age upon turning 70,
- d) upon the final expiry of the entitlement to benefits,
- e) in the case of leave from work without wage entitlement.

Insurance coverage will not lapse during leave from work as the result of an illness, accident, or service in the Swiss Army, civilian service or civil defence.

If not agreed otherwise, benefits shall be payable at the earliest

on the day of the planned resumption of work. The days of working incapacity during an unpaid leave shall be added to the waiting period and the benefit period.

- f) in the event of death,
- g) upon expiry of the insurance contract.

6.3. Transfer to individual insurance

6.3.1. Right of transfer

Every person residing in Switzerland can transfer to individual insurance without any examination of their state of health

- upon ceasing to belong to the group of insured persons covered by the group insurance scheme,
- upon ceasing to receive benefits, or
- when the insurance contract expires.

The insurance company makes the decision about the affiliation into the individual insurance of frontier workers. They can refuse this without providing justification.

The right of transfer shall be asserted in writing within 90 days of being informed there of by the employer.

The period commences after the person ceases to belong to the group insurance, however, no later than upon receipt of the written notification which calls attention to the right of transfer. Should the insured person receive additional coverage (Art. 8.2.3.), the period starts after expiry of the obligation to perform. In this case, information is provided by the insurance company.

The individual insurance commences one day after ceasing to belong to the insured group of persons, 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 maximal insured daily allowance.

The provisions for additional coverage remain reserved.

6.3.2. Employer's obligation to provide information

The policyholder is obligated to inform insured persons who cease to belong to the group insurance 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, then he shall be liable for all costs associated with the resulting damage.

6.3.3. Scope of the continuation of insurance

Continuation of insurance will generally be within the scope of the current insurance coverage, but no higher than the new earned income.

A maximum income of CHF 250'000 per year is insured.

Unemployed persons may insure themselves for up to the maximum single AHV pension.

Unemployed persons as defined in the Federal Act on Compulsory Unemployment (AVIG) Insurance may convert their insurance for an appropriate premium adjustment, regardless of their state of health, into an insurance 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.

6.3.4. Imputation of benefits already drawn

Benefits already drawn

- from this group insurance scheme
- from previous insurance carriers

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

6.3.5. 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 his loss of earnings insurance scheme,
- b) if the policyholder has concluded a new insurance contract for this said 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 coverage,
- c) as long as benefits are paid within the scope of additional coverage,
- d) when the insured person retires, but upon reaching retirement age at the latest,
- e) if the insured person lives abroad,
- f) for the duration of a provisional cover note.

7. Scope of insurance

7.1. Amount of the insured daily allowance

The amount of the insured daily allowance is agreed between the policyholder and the Fund.

7.2. Basis of assessment

7.2.1. Principle

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

7.2.2. Employees

The basis of assessment for employees is the earnings lost through the insurance event. Lost earnings are the last salary liable for AHV contributions received by the policyholder before the insurance event, including any salary components that have not yet been paid and to which a legal claim exists.

Taxable or AHV-tax exemptions for persons of AHV-age do not have any influence on the extent of the basis of assessment.

Family income supplements that are paid to the employee as child benefits or education benefits pursuant to the provisions of the Family Allowance Law (FamZG) by the social security office, are considered past earned income and are co-insured as subsidiaries. Employees who are not liable for AHV payments, the agreed upon gross salary applies in place of the AHV salary, pursuant to AHV standards.

Earnings from other employment will not be taken into consideration.

7.2.3. Irregular income

If the level of earnings is subject to strong fluctuations, the average salary earned in the last 12 fully accounted for months before the employee lost his capacity to work is calculated.

If the employment is less than 12 months, the average salary since the start of employment is taken as a basis.

7.2.4. Persons with a fixed salary amount

Basis of assessment for the persons named in the insurance policy is the fixed salary amount agreed in advance.

7.2.5. Managers

Managers who are deemed to be employees as set forth in legal regulations may apply to insure a fixed payroll.

7.2.6. Increasing the insurance coverage

A health declaration is required for an application to increase an agreed fixed salary amount.

Any benefit limitations or the rejection of an application will only apply to the increased insurance coverage.

7.3. Maximum coverage

The amount of the insurable salary per person is limited to CHF 250'000.00 per year.

8. Benefits

8.1. Conditions for benefits

8.1.1. Illness

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

8.1.2. 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, which are acknowledged as accidents under the UVG, are likewise classified as accidents.

8.1.3. Inability to work

Inability to work exists if the insured person is wholly or partially unable by reason of illness, accident, or childbirth, to exercise his profession or other reasonable employment activity.

Inability 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 the physical, mental, or psychic health.

Should the period of inability to work last more than 30 days, the reasonable activity in any other profession or area of responsibility will also be considered.

Partial inability to work exists if the inability to work is at least 25 %.

8.1.4. Medical certificate

Daily allowances require a medical certificate on the insured person's inability to work. The certificate must be issued by a physician or a chiropractor who is approved by the insurer.

Medical certificates and illness or accident reports may not be backdated by more than 3 days.

8.2. Scope of benefits

8.2.1. In general

Benefits are determined in accordance with the agreed scope of insurance and the existing terms and conditions of insurance.

The total daily allowances paid may not exceed the loss of earnings suffered by the insured person through the insurance event or the agreed fixed salary amount.

8.2.2. Partial inability to work

In the event of partial inability to work, benefits are paid in accordance with the degree of inability to work.

8.2.3. Additional coverage

Persons who are wholly or partially unfit for work when the employment relationship ends are entitled to the benefit until the end of the case of illness which justifies the additional coverage, however no longer than the agreed duration of the benefit.

Relapses do not entitle them to further benefits.

This additional coverage does not apply

- if another insurer is entitled to free movement of capital in the event of an assumption of contract,
- in case of job change and transfer to the loss of earnings insurance scheme of the new employer,
- when the insured person retires, however upon reaching AHV retirement age at the latest,
- in the case of employees who move abroad, except for the duration of a stay in hospital abroad. Frontier workers are not foreign employees,
- If the employment contract has been terminated during the probationary period.
- If the work was of temporary nature lasting three or fewer months.

If the additional coverage no longer applies, the provisions on transferring to individual insurance apply.

8.2.4. Accident

If the accident risk is also insured, the benefits will be paid in accordance with the agreed scope of insurance in the policy.

If the accident insurance is included as a supplement to the insurance pursuant to UVG, daily allowances will only be paid if the UVG insurer is liable to pay.

8.2.5. Family income supplements

There is a subsidiary entitlement for children's and education allowances, which are paid by the Family Compensation office to the employees in accordance with the Family Allowance law (FAMZG).

In the event of suspension of child and education benefits by the social security office as a result of the inability to work caused by illness, accident, or maternity, these are taken into account in the amount of the insured daily allowance (in % of the insured salary) for the daily allowance benefit, provided that it is an insured event. The policyholder must apply for this benefit to the insurer in writing, with respect to the insured person, while submitting proof that the child and education benefits provided by law are discontinued.

8.2.6. Suspension of benefits in the case of maternity

For the duration of the entitlement to a maternity benefit pursuant to the Income Compensation Act for service providers or in the case of maternity (EOG) to a childbirth allowance from this insurance scheme, the obligation to pay benefits will be suspended in the case of an illness or accident.

8.2.7. Childbirth allowance

Childbirth allowance must be requested by the policyholder and is not automatically co-insured.

Family members not listed in the payroll as well as self-employed persons and company owners are not insured.

The entitlement to a parental allowance arises with the entitlement to childbirth allowances to the Federal Law on Income Compensation Act (EOG) and supplement the maternity benefit to EOG.

While receiving the maternity benefit, however for a maximum of 98 days, the difference between the maternity benefit and the insured childbirth allowance will be paid. A childbirth allowance corresponding to the insured daily allowance will be paid for 14 additional days.

No childbirth allowance will be paid if the employment relationship of the insured person with the policyholder ends before the birth. For pregnancies, which have already existed prior to the start of the contract, there is no entitlement for the supplementary parental allowance in addition to the childbirth allowance to the Income

Compensation Act (EOG) except in the case of vested benefits when taking over the contract.

8.2.8. Paternity benefit

Paternity benefit must be requested by the policyholder and is not automatically co-insured.

The prerequisite is that there is a provision for paternity leave in the policyholder's personnel regulations.

During paternity leave, a daily allowance is paid in the amount of the insured daily allowance for the benefit period agreed according to the policy.

8.3. 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 inability to work, according to the medical certificate, but no earlier than 3 days before the first medical treatment. In the absence of an agreement to the contrary, the waiting period will be recalculated for each case of illness or accident.

8.4. Duration of benefits

8.4.1. Principle

The duration of benefits is listed in the insurance policy and calculated - with the exception of scaled coverage - according to the particular insurance event. Days of partial inability to work count as full days for the purpose of calculating the duration of benefits. For persons, who have drawn the maximum benefits in the case of a partial incapacity to work, the insurance cover remains intact for a repeat case of the disease within the remaining capacity to work.

8.4.2. Imputation of the waiting period

The agreed waiting period is imputed against the duration of benefits. Waiting days are days on which an inability to work of at least 25% exists.

8.4.3. New insurance event

The recurrence of an illness or of the consequences of an accident (relapse) is classified as a new insurance event if the insured person was fully fit for work for a period of 360 days without any interruption since the last occurrence of the same illness or the same consequences of an accident.

In the event of a relapse within 360 days, the waiting period passed and the benefits paid will be imputed.

8.4.4. Scaled coverage

For scaled coverage, the duration of the benefits is calculated on the basis of the employer's obligation to continue to pay the salary in accordance with the duration of the employment relationship in the insured business. The following scale forms the basis for the calculation:

Duration of the employment relationship	Duration of the benefit
3 to 12 months	3 weeks
up to 3 years	9 weeks
up to 9 years	13 weeks
up to 15 years	17 weeks
up to 20 years	22 weeks
up to 25 years	27 weeks
up to 30 years	31 weeks
more than 30 years	36 weeks

Persons with short stay permits returning to the insured company each year shall be credited an employment period based on the total months worked there.

8.4.5. Family income supplements

Family income supplements are co-insured as a subsidiary during the entire duration of the benefit, pursuant to the provisions of the FamZG, in the event of a lapse of the obligation to payout by the cantonal social security office.

8.4.6. 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 benefit and the insured childbirth allowance, will lapse as soon as the person starts working again.

The childbirth allowance for the additional 14 days will be paid in the insured amount, insofar as an entitlement exists to a maternity benefit pursuant to the EOG on the day of the birth.

The childbirth allowance will be paid without imputing a waiting period.

The daily allowances in the event of birth will not be imputed to the maximum duration of benefits.

8.4.7. Paternity compensation

The duration of benefits is regulated in the policy.

Paternity compensation will be paid without imputing a waiting period.

Paternity compensation is not imputed to the maximum duration of benefits.

8.4.8. Insurance of salary payment in the event of death of the employee

Should an employee die as the result of an insured illness or an insured accident, the statutory obligation for continued payment of wages will be satisfied within the meaning of article 338 para. 2 of the OR.

The insurance benefit is paid without imputation of a waiting period.

8.4.9. AHV retirement age

Insured persons who upon reaching the AHV retirement age continue to work for the policyholder on a regular basis are entitled to the insured daily allowance, with imputation of the agreed waiting period, for a total of 180 days, but no later than their 70th birthday.

The same provision also applies to the business owner and his family members (spouse, children, and parents) who work in the business but are not listed on the payroll as well as persons listed by name in the policy.

8.4.10. Imputation in the case of assumption of contract

In the event of an assumption of contract or a renewal of contract, any benefits already drawn from previous insurance providers will be imputed against the duration of benefits.

8.5. Limitation of benefits

8.5.1. Exclusion of benefits

There is no entitlement to insurance benefits:

- for consequences of accidents and occupational illnesses which are to be covered by a different insurer,
- 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, unless the insured person was injured as an uninvolved bystander or while rendering assistance to a defenceless person,
- d) if the health is damaged caused by ionising radiation occurs,
- e) if the insured person temporarily leaves Switzerland while being unfit for work without the Fund's approval, coverage will cease until he returns to Switzerland.

8.5.2. Limitation of benefits

Benefits may be reduced:

- a) in the event of health damage caused by a deliberate action, i.e. if the insured person exposes himself to a particularly serious risk without taking or being able to take precautionary measures which reduce the risk to a reasonable level. Rescue operations to help people are exempt. In particular, participation in motor vehicle races or training for such races are treated as risk for the purpose of this provision,
- b) if the insured person repeatedly and seriously fails to comply with rulings of the Fund or instructions given by a doctor,
- c) if the documents required to ascertain the insurance claim are not produced within four weeks despite a written reminder to do so.

Minimum benefits (benefit duration pursuant to scaled coverage) will be paid:

- d) during a non-work related stay abroad. The insured benefits will be paid in full for a hospital stay abroad. This restriction is dropped after return to Switzerland,
- e) for illnesses and accidents that are the result of warlike events, which already broke out more than 14 days before the inability to work occurred,
- f) for the consequences of earthquakes and other natural disasters.

8.5.3. Gross carelessness

The insurer abandons the right to reduce insurance benefits according to the VVG if the insured person has caused the illness or the accident through gross carelessness.

8.5.4. Compulsory reimbursement

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

9. Obligation to participate in the event of illness or accident

9.1. Obligations in the event of damage

The policyholder must inform the Fund within five days of every incapacitation from work which might give entitlement to a daily allowance and state whether this is due to an accident or illness. In the case of agreed waiting periods of more than 21 days, the inability to work must be notified to the Fund in writing no later than 30 days after it began by way of an illness notification form. The medical certificate must be presented to the Fund no later than 10 days after the beginning of the inability to work, or in the case of waiting periods exceeding 21 days together with the illness notification form.

In the event of failure to comply without sufficient reason, the insurer only grants benefits from the date on which the report is received. The waiting period only starts with receipt of the report.

If the degree of inability to work is reduced, the Fund must be notified of this fact without delay.

The notification must be made truthfully. If benefits are claimed, the insured person or the policyholder must present the fund with all information that contains the required medical and administrative details.

9.2. Reduction of damage

The insured person must do everything in his power that can help to reduce the benefit, in particular what speeds recovery. He shall avoid doing anything that will delay it. In particular, he 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 has to provide evidence of loss of earnings. If they cannot provide evidence of loss of earnings, there is no entitlement for 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.

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

- register with the appropriate disability insurance office within six months after start of the inability to work;
- consult a doctor already on the first day of inability to work,
- agree to an examination by a second doctor or by the medical consultant of the Fund. The insurer is liable for the associated costs.

9.3. Obligation to provide information

The insured person or the policyholder must make available to the Fund in the event of an accident all the necessary information on the reasons for the accident and particulars of third parties involved in the accident.

The insured person shall release the doctors and other medical professionals treating him from the duty of non-disclosure to the Fund. If necessary, the Fund may obtain information from other insurance providers.

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

The policyholder shall enforce the insured person's obligation to provide information.

9.4. Breach of the obligation to participate

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

9.5. Withholding tax

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

10. Premiums and payments

10.1. Premium calculation

10.1.1. Principle

The insurance company calculates premiums using approved actuarial methods. Such premium calculations entail statistical principles and actuarial premium calculation models.

10.1.2. Empirical premium calculation

In the empirical premium calculation, the risk premium is calculated by multiplying the base premium (so-called «target level 0») with a risk factor. The risk factor of this calculation depends on the individual claims experience of the contract or a group of contracts as well as the scope of the contract.

10.1.3. Tariff class premium calculation

In the tariff class premium calculation, the risk premium is calculated by multiplying the base premium (so-called «target level 0») with a risk factor. The risk factor of this calculation can depend on the economic sector, the company location, the extent of the contract or other risk values for example the age or sex of the insured persons. The risk content is therefore divided into tariff classes. This procedure is applied by the insurance company for newly founded companies or when also insuring additional groups of people. They serve as a preliminary step for a subsequent introduction of empirical premium calculations.

10.2. Decisive total salary

The decisive factor for the calculation of premiums is the gross payroll of the insured person that is liable for AHV contributions and obtained from the insured business. The agreed maximum coverage is the most that can be considered per person and year. Gross salaries of persons not liable for AHV contributions are also decisive for calculating premiums provided that they belong to the scope of insured persons.

Insofar as a fixed salary amount was agreed in advance for persons named in the insurance policy, this shall be the basis for calculation.

10.3. Payment of premiums

10.3.1. Billing and due date

The insurer will bill the policyholder four times a year, twice a year or annually with a bill on account.

The policyholder is liable for the premiums in advance and must pay them within the deadline stipulated in the insurance policy. The total amount of the bill on account is calculated based on the definitive total payroll of the last completed calendar year.

10.3.2. Final bill

The Fund will supply the policyholder with a declaration form once the calendar year has come to an end. The policyholder shall return the total payroll declaration to the Fund with the necessary documents (AHV declaration, list of insured persons, payslips etc.) within one month. Based on these details, the Fund will calculate the definite premium contributions and compile a corresponding final bill. No refund will be made for balances under CHF 10. The amount is 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 numbers concerning the previous year, the insurer can stipulate future bill on account premiums by estimate.

10.3.3. Inspection of payroll accounting

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

10.3.4. Reimbursement of premiums

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

The premium for the current insurance period is payable in full if the policyholder terminates the contract in the case of damage and the contract had been in force for less than a year when it was terminated.

10.3.5. Default of payment

If the policyholder fails to meet his obligation to pay premiums, even within an extended deadline of 30 days, the insurer will issue a written reminder demanding payment of the outstanding premiums within a deadline of 14 days. The reminder makes the policyholder aware of the consequences of not meeting his obligation to pay.

If no payment is made within the extended deadline despite the reminder, the obligation to pay benefits will be suspended from the expiry of the warning period until the outstanding premiums including interest and administrative costs have been paid in full. No entitlement to benefits exists for loss of earnings while the obligation to pay benefits is suspended, even if the outstanding payments are subsequently paid.

For benefits already drawn (incl. back payments), the entitlement for the insured benefits remains intact until the originally agreed duration.

If the outstanding premium on account 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.

10.4. Waiver of premium in case of damage

As long as the employment relationship exists with the insured business, or benefits are paid within the scope of the additional coverage, the obligation to pay premiums lapses to the extent of the benefits paid from this contract.

Insured persons listed in this insurance policy as having a fixed salary amount are exempt from this provision.

Debiting of the annual agreed minimum premium according to the policy remains reserved.

10.5. Premium adjustment

A premium guarantee is given for the agreed duration of the contract.

A premium adjustment may be carried out by the insurance company at the end of a contract.

The policyholder will be notified of premium adjustments no later than 30 days before the end of a calendar year. The policyholder is entitled to terminate the insurance contract within 30 days of the said notification from when it takes effect. If no termination occurs, this will be deemed as an approval of the premium adjustment.

10.6. Surplus sharing

Surplus sharing may be agreed.

If surplus sharing has been agreed, the policyholder will receive a share of any surplus from his insurance contract after every three whole years of being insured (= accounting period).

The surplus will be determined by deducting the insurance benefits paid from the decisive premium share for the accounting period.

The decisive share of the premium and the surplus sharing system are mentioned in the insurance policy.

The bill will be compiled as soon as the premiums for the accounting period have been paid and the corresponding cases of damage have been taken care of. Any losses are not carried forward to the next accounting period.

If cases of illness or consequences of accidents, which occur in the completed accounting period, are subsequently notified or further payments are made once the bill has been sent, a new surplus sharing bill will be compiled. The insurer of the Fund may reclaim surplus shares that have already been paid to the refunded. The entitlement to have a share of the surplus lapses if the insurance contract is revoked before the end of the accounting period.

10.7. Alignment of benefits

10.7.1. Payment of daily allowances in case of illness and accident
The daily allowance will be paid upon being fully fit for work again according to the medical certificate. If the inability 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.

10.7.2. Payment of childbirth allowance

Childbirth allowances are paid to the policyholder to pass on to the insured persons after the birth, on the basis of the verification of the benefits pursuant to the EOG.

10.7.3. Payment of paternity leave

The paternity compensation shall be paid to the policyholder on the basis of verification of the completed paternity leave.

10.7.4. Billing

The insurer may pay benefits due minus any claims against the policyholder.

10.7.5. Pledge and assignment

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

10.7.6. Statutory limitation

The policyholders entitlement to benefits from the insurer will become statute-barred within two years of the fact being established which justifies the insurer's obligation to pay benefits.

11. Third-party benefits

11.1. Coordination

11.1.1. In general

If a third party is liable for a reported case of illness or an accident for legal reasons or for reasons of fault, the Fund will subsequently increase the benefits up to the amount of the insured daily allowance. Within the scope of the benefit claims against third parties, no obligation to pay benefits exists pursuant to these AVB.

11.1.2. Multiple line insurance

If several insurers are obligated to pay benefits, a calculation will be made on how much each insurer would have to pay if they were the only one who had to pay benefits. This also applies if the other insurers' obligation to pay benefits only exists subsidiarily. The

compensation payable pursuant to these AVB is limited to the share of the total sum insured that corresponds to this coverage.

11.1.3. Social insurances

If social insurance schemes are liable for 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 entitlement to benefits must be notified to the relevant social insurance scheme.

The insured person shall assign any claims for subsequent payment against social insurance schemes (KV, UV, IV, MV, AHV, AVI, EO, BV, FamZG, family income supplement in agriculture etc.) to the insurer.

11.1.4. Waiver of benefits

Where insured persons waive benefits from third parties in whole or in part without the insurer's consent, the obligation to provide benefits under these AVB shall lapse. The capitalization of a claim for benefits shall also be regarded as a waiver.

11.2. 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 his claims without success and is willing to assign his claims against third parties to the insurer within the scope of the benefits provided.

11.3. Overinsurance

11.3.1. Employees

The insured persons and the policyholder must not gain any profit from the benefits provided under these AVB when the benefits paid by third parties are taken into account. In the event of overinsurance, the benefits in case of illness and accidents are reduced accordingly. Benefits paid in excess of this amount will be reclaimed. Days with partial benefits due to a reduction because benefits are payable by a third party count as whole days for the calculation of the period of benefits and the waiting period.

11.3.2. Insured persons with a fixed salary amount

The scope of benefits corresponds to the agreed daily allowance amount. The rules on over-insurance do not apply. On the other hand, no benefits are paid if a cash entitlement (daily allowances, pensions etc) towards social insurance schemes (KV, UV, IV, MV, AHV, AVI, EO, BV, FamZG, family income supplements in agriculture etc.) exist.

11.3.3. Daily allowance insurances with other insurers

The policyholder is obligated to notify the Fund without delay of any existing or recently obtained daily allowance insurances with other insurers.

12. Data privacy

12.1. Principle

The processing of the data of insured persons complies with the provisions of the Federal Act on Insurance Contracts of 2 April 1908 and on data privacy of 19 June 1992.

12.2. Processing purpose

The insurer will only process data (e.g. personal data, information on health condition, examining the information provided in the