ÖKK DAILY ALLOWANCE (KVG)

General Insurance Conditions (GIC)

Edition 2023

ÖKK

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ÖKK Kranken- und Unfallversicherungen AG
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This text is a translation. In the event of any discrepancy between the English and the German version, the original German version shall prevail.

You can find the latest versions of the Insurance Conditions under www.oekk.ch/gic or in your ÖKK agency.

1. Insurance principles

1.1 Insurer

ÖKK Kranken- und Unfallversicherungen AG, Landquart is the insurer. The insurer is specified on the policy.

1.2 Legal basis

These General Insurance Conditions (GIC) take precedence over the Health Insurance Law (KVG) and the Swiss Federal Act on the general part of the Social Insurance Law (ATSG).

1.3 Purpose

ÖKK DAILY ALLOWANCE (KVG) insures the loss of income as a result of incapacity to work as a result of an accident, illness or maternity.

2. Insurance

2.1 Insured persons

Anybody who is a resident of Switzerland and is between 15 and 64 years old may conclude a daily allowance insurance policy.

2.2 Acceptance procedure

2.2.1 Applications

Applications are made using the pre-printed form. The questions asked on the form must be answered in full and truthfully.

2.2.2 Application review

The applicant authorises the insurer to seek the information needed for the acceptance and clarification of a subsequent obligation to pay benefits from medical practitioners and other insurers.
The insurer may request a medical certificate or an examination by a medical examiner. It may designate the doctor and will pay the costs.

2.2.3 Reservation and high risk

Illnesses and consequences of accidents, which have already existed at the time of the acceptance or existed previously and in cases, where experience shows relapses to be possible, may be excluded from the insurance by stipulating reservations. In the event of higher insurance, however, any reservation applies only to the additionally insured benefits.

The insured person is notified in writing of the reservation. It is valid for five years from the commencement of insurance and then lapses without further notice.

Before the expiry of this period, the insured person is free to provide proof that an existing reservation is no longer justified. The insurer will decide on early cancellation. The insured person will bear the costs.

If existing or previous illnesses or consequences of accidents suggest a high insurance risk, the maximum insured daily allowance is that applicable to insured persons with a high risk.

If an insured person makes incorrect or incomplete indications when applying to join, a reservation may also apply retroactively or the amount of the daily allowance may be reduced retroactively to the maximum for insured persons with a high risk.

2.2.4 Insurance policy and GIC

The insured person receives an insurance policy and these GIC following acceptance.

The insurance policy contains the insurance variant chosen, the premium and other important data.

2.3 Right to transfer

Persons who join the insurer by exercising the statutory right of transfer will be accepted with the same insurance cover as before and without new reservations corresponding to their age on joining. Reservations on the part of previous insurers will be continued until they have been in force for a total of five years.

The right to transfer must be exercised within three months of receipt of the notice of entitlement to transfer. The insurance certificate from the previous insurer must be presented.

2.4 Commencement of insurance

Insurance begins on the day of acceptance confirmed by the insurer.

2.5 Change of domicile

The insurer must be notified of changes of address and change of domicile within 30 days. A change in the place of residence under civil law is regarded as a change of domicile.

2.6 Suspension of insurance

The insurance may be suspended:

a) in the event of a period of residence abroad lasting for more than three months
b) during military training or civilian service lasting for more than one month in respect of the benefits insured by the military insurance
c) on joining an insurance scheme of the employer but no later than the 45th birthday
d) on joining the insurance scheme of a training institution for the duration of the training and in respect of the benefits provided in that scheme.
e) in the event of a stay of more than three months in a penal, detention or educational institution.

Suspension provides a guarantee for the insured person that, in the event of a reactivation of the insurance, the original scope of insurance and immediate reinstatement of the entitlement to claim without new reservations and with no age group loss applies.

2.7 The end of the insurance contract

2.7.1 General

The insurance ends:

a) when notice is given
b) on relocation abroad
c) on definitive exhaustion of the entitlement to claim
d) on reaching the statutory maximum joining age unless further insurance is requested
e) on death.

The statutory reasons for exclusion in the event of infringement of the insured person's obligations are reserved.

2.7.2 Notice of termination

The insured person may give three months advance written notice of termination at any time to the end of a month.

When the new premium is announced, the insured person may give one month's notice of termination to the end of the month preceding the entry into force of the new premium.

In both cases, the date of receipt of the termination notice by the insurer is decisive (and not the date of the post mark).

2.7.3 Consequences of termination of insurance

After termination of the insurance, no further legal claims claims on the insurer exist apart from outstanding insurance benefits.

The insured person must meet any financial obligations towards the insurer.

3. Scope of insurance

3.1 Insurance variants

3.1.1 Choice of insurance variant

The applicant chooses the insurance variant.

3.1.2 Commencement of benefits

The insurer offers insurances with different benefit starting dates. If no waiting period has been agreed, the benefit is paid from the first day of incapacity to work certified by a doctor; if a waiting period of one day is agreed, the benefit is provided from the first working day after the date on which the medically certified incapacity to work is notified. If the waiting periods are longer, the payment is made from the first day after expiry of the waiting period. Insurances with a deferred start of benefits can be agreed with waiting periods of up to 730 days.

Unless otherwise agreed, waiting periods of up to 21 days are recalculated for each case of illness or accident. Longer waiting periods apply only once in any calendar year.

The waiting period is deducted from the maximum duration of benefits providing that the employer is obliged to continue to pay the salary during the waiting period.

3.1.3 Accident cover

Accident cover can be included at the request of the insured person. The daily accident allowance may also be insured separately.

3.2 Amount of insured daily allowance

3.2.1 Principle

The amount of the daily allowance is agreed between the insured person and the insurer.

The insured person's presumed loss of income or the value of the incapacity to work caused by those reasons, for which the claim is made, can be insured.

The insurer has the right to limit the maximum insurable daily allowance.

The insurable daily allowance is calculated as the 365th part of the average applicable loss of earnings in the course of a year. Daily allowance insurances held with other insurers must be declared. If they are taken out after concluding a ÖKK DAILY ALLOWANCE (KVG) they also have to be reported.

In the event of a continued excess insurance, the insurer may reduce the insured daily allowance appropriately after consultation with the insured person. The reduction is effected from the end of the month without a notice period.

3.2.2 High risk

The daily allowance for insured persons, who have a high risk when the insurance is taken out, is limited to a maximum of CHF 10 per day.

3.2.3 Employees

Insured persons whose income is derived from gainful employment by a third party may take out insurance in an amount equivalent to the gross salary liable for AHV contributions.

3.2.4 Self-employed persons

Insured persons whose income is derived from self-employment may take out insurance in an amount equivalent to their income subject to AHV payments according to the last AHV contribution ruling. In addition, insurance can be taken out for demonstrable tax deductible occupational expenses, which continue to exist during the period of incapacity. These are costs, which concern insured persons directly and are in a direct relationship to their earnings, in particular fixed costs for business rental, vehicle, insurances, depreciation of machinery and similar items.

3.2.5 Persons not in employment

Housewives and househusbands, people in education and family members working in a family company who do not receive a salary in cash may take out insurance up to the amount of the simple AHV maximum pension.

Daily allowances which exceed the amount of the single AHV minimum pension will only be paid out if the value of the work, which cannot be performed, is confirmed by the costs of third parties (e.g. domestic help, deputies etc.).

3.3 Insurance changes

3.3.1 General

The insured person may apply at any time for an increase or a reduction of the daily allowance, for a shorter or longer waiting period or inclusion or exclusion of accident cover.

In the event of a higher insurance, the conditions of the application, and in the event of a reduction of insurance, the conditions on giving notice apply.

3.3.2 Adjustment to the cost of living

The insured person may apply for the insurance to be adjusted to the annual cost of living according to the national consumer price index. The insurer grants this adjustment without verification of the risk and in the existing joining age group, provided that no incapacity to work exists and no daily allowance is being paid. Only the cost of living of the last complete calendar year applies for the adjustment.

The insured person may also request at any time for the insurance to be adjusted in line with real wage trends at the conditions applicable to higher insurance amounts.

3.3.3 Subsequent inclusion of accident cover

The insurer grants inclusion of accident cover in the same joining age group as under the existing insurance.

However, the insurer may exclude the consequences of accidents by reservations from the insurance cover or decline to include accident cover if there is an increased risk.

3.3.4 Increase in insurance

If the insured daily allowance is reduced and at the same time, the existing waiting period shortened or vice versa, the insurer grants this adjustment without any change of the joining age group providing that an equivalent premium exists.

A higher insurance may be declined if:

a) the AHV age has been passed
b) illnesses and consequences of accidents exist, including any which were pre-existing and represent a high risk
c) excessive benefits have been claimed
d) premium payments are outstanding.

The insurer may adopt other or different conditions in favour of the insured person for insurance amendments.

4. Benefits

4.1 Entitlement to claim

4.1.1 General

The entitlement to claim exists for the duration of the insurance. Benefits are determined according to the scope of insurance taken out and these GIC.

The total daily allowance payments may not exceed the presumed loss of earnings or the value of the work, which they have been unable to perform plus the statutory additional costs.

The insurer pays the daily allowance according to the chosen start of benefits after the commencement of entitlement to payment for those days on which a medically certified incapacity to work exists. Partial incapacity gives entitlement to a reduced daily allowance. The insurance cover is maintained until complete incapacity to work according to the relevant KVG provisions. No entitlement to claim exists if the degree of incapacity to work is less than 50 %.

If excess compensation occurs during the period of the claim because of payments from other insurance schemes, the daily allowance will be reduced and the period of benefits extended. The waiting period begins on the date of the medically certified incapacity to work. The waiting days are days on which at least 50 % incapacity to work exist.

4.1.2 Accidents

If the accident risk is also insured, benefits are paid in the event of accidents on the same scale as in the event of illness.

Accident cover is paid subsidiarily, i. e. the liability of third parties always takes precedence over the insurer's obligation to provide benefits.

The definition of an accident is based on the relevant ATSG provisions.

4.1.3 Unemployment

Unemployed insured persons may convert their insurance without new reservations up to the amount of the previously insured daily allowance into an insurance with a waiting period of 30 days, provided that registration with the unemployment fund has taken place.

The premium for a resulting higher insurance is calculated according to the actual age.

In the event of incapacity to work in excess of 50 % the full daily allowance is paid.

4.1.4 Maternity

Maternity benefits are paid, provided that insurance cover existed with the insurer or other insurers pursuant to KGV for at least 270 days before the birth, without interruption for more than three months.

In the event of maternity, the maximum period of benefit payment is 16 weeks, of which at least 8 weeks must be after the birth.

4.1.5 Incapacity to work abroad

In the case of private holiday travel abroad, the insured daily allowance benefits are only paid in the event of hospitalization. This rule also applies to frontier workers outside Switzerland and away from their place of residence. A stay abroad for professional reasons is reserved.

4.1.6 Stay abroad in the event of incapacity

If insured persons, who are incapable of working and entitled to benefits travels abroad without the insurer's consent, they have no entitlement to benefits during the period spent abroad. This limitation does not apply to frontier workers staying in Switzerland.

4.2 Duration of benefits

4.2.1 Principle

A maximum of 730 daily allowances within 900 consecutive days are paid out for illness and accident together.

If the daily allowance is reduced because of excess compensation, the insured person, who is incapable of working, is entitled to the equivalent of 730 daily allowances. The periods for drawing the daily allowance are lengthened in line with the reduction.

Benefits already drawn from previous insurance schemes are deducted from the overall claims.

The insured person cannot suspend exhaustion of the entitlement to benefit by waiving the insurer's benefits before termination of the need for treatment or incapacity to work.

4.2.2 On reaching the maximum joining age

If insured persons continue their insurance cover in agreement with the insurer's consent on reaching the maximum joining age, the insurer will pay the full insured daily allowance for a maximum of 90 days.

4.2.3 Self-employed persons

A maximum of 180 daily allowances are paid out for insured tax deductible occupational expenses.

4.3 Limitation of benefits

4.3.1 Reduction and cessation of the benefit

No entitlement to benefits exists:

a) for illnesses and consequences of accidents, which are the subject of an effective reservation
b) for illnesses and consequences of accidents which were deliberately withheld or not fully indicated on the application to join, in respect of the period for which insurance cover would have been excluded if the insurer had been aware of the circumstances
c) during a qualifying period
d) for the consequences of accidents which are to be covered by another insurer
e) if a treatment is not intended to remedy a health problem or its consequences. Measures which prevent the threat of the occurrence or deterioration of a health problem are reserved if the person is already ill
f) in the event of suspension of the insurance
g) on participation in acts of war and similar occurrences.

Benefits may be temporarily or permanently reduced or in serious cases withheld:

h) in the event of infringement of the legal obligation to cooperate, such as the notification requirement (e.g. with other social insurances)
i) if the insured person refuses to undergo a medical examination required by the insurer
j) if the insured person declines or opposes a reasonable treatment or incorporation into active life or fails to cooperate reasonably for that purpose
k) if the insured person exposes himself to exceptional hazards or risks
l) in the event of deliberate causation of the illness or accident and in the event of illness and accidents caused by active participation in punishable offences, fights or other acts of violence
m) for insured persons who are serving a prison sentence or other enforcement measure.

4.3.2 Obligation to repay

The insurer may request the repayment of benefits paid in error or unjustifiably.

4.4 Relationship with other insurers

4.4.1 General

If a daily allowance insurance exists with another insurer pursuant to KVG or Federal Insurance Act (VVG), the insurer is not liable or only liable at most for the part, which is not covered.

4.4.2 Other social insurances

The provisions of the ATSG, AVG and the regulation of health insurance (KVV) apply.

4.4.3 Private insurances to VVG

The provisions about recourse according to Art. 72 ff ATSG and excess benefits according to Art. 69 ATSG and Art. 122 KVV are applicable.

4.5 Procedure in the event of illness and accident

4.5.1 Compulsory notification

The insured person must notify the insurer within five days of any incapacity to work, which might give rise to a claim for payment of a daily allowance, stating if an accident or illness is involved. The certificate made out by the doctor or chiropractor must be sent to ÖKK no later than ten days after the commencement of incapacity to work. In the event of failure to do so without adequate justification, the insurer only will only grant benefits from the day of notification. The waiting period starts with the receipt of the notification. Notifications delayed for which the insured person is not at fault, are reserved. Backdating of medical certificates and illness or accident reports is not permissible. These documents must be submitted on time, even if the duration of the incapacity to work falls entirely within the agreed waiting period.

The insured person must provide evidence of uncovered loss of earnings including any tax deductible occupational expenses. If the degree of incapacity to work is reduced, the insurer has to be immediately notified.

4.5.2 Conduct during illness and accident

The insured person must do everything possible to promote a cure and desist from all actions, which may delay such a cure. He must, in particular, comply with the instructions given by medical practitioners.

The insurer is entitled to check adherence to the medical instructions and to put in place suitable inspection measures.

4.5.3 Obligation to provide information

The insured persons must provide the insurer, at their own cost, with all information required to assess the claim and determine the insurance benefits. In particular, the insured person shall notify all benefits provided by third parties in the event of illness, accident and disability and, in the case of an accident, shall supply full information about the circumstances of the accident and any third parties involved in the accident.

In the case of an entitlement to benefit, the insured person must authorise all persons and bodies, such as employers, medical practitioners, insurance companies and authorities to provide the information required to assess benefit claims, insofar as the person or bodies concerned are not already required by law provide such information.

On request, the insured person must agree to an examination by a further doctor or the insurer's medical examiner. The insurer bears the costs. The insurer may verify incapacity to work and the uncovered loss of earnings, including any tax deductible occupational expenses in every case and make such checks as it considers necessary.

The daily allowance is paid out on returning to work when the medical certificate permits this return. If the incapacity to work lasts for more than one month, the daily allowance is generally paid monthly.

If, in the case of an entitlement to benefit, the insured person fails, in an inexcusable manner to provide information or to cooperate, the insurer may either rule on the benefit claim on the basis of the documents or refrain from examining the application for benefits.

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5. Premiums and claims of ÖKK

5.1 Premium rating

5.1.1 General

The premiums are rated in an insurance tariff of the ÖKK DAILY ALLOWANCE (KVG).

The premiums may be graduated according to the joining age and region.

5.1.2 Suspended insurance

In the event of suspension of the insurance pursuant to section 2.6 of these GIC a reduced premium is charged.

5.2 Premium payment

5.2.1 Due date and payment period

Premiums are payable in advance. The shortest payment period is the calendar month. Premiums must be paid without interruption, i. e. including during periods of illness, accident, incapacity to work or when the entitlement to claim lies dormant. If membership begins or ends in the course of a calendar month, the premium is due for the whole month.

5.2.2 Payment fees

The insured person has various options for paying their premiums and cost-sharing amounts without any additional fees. The insurer may pass on any fees, such as those incurred when making a payment at the post office, to the insured person.

5.2.3 Late payment

If insured persons do not pay outstanding premiums or cost sharing amounts, the insurer shall send them a request for payment after at least one written reminder. In this reminder, the insurer shall stipulate an extension to the due date of thirty days and inform the insured person of the consequences of delayed payments.

If, despite this request for payment, the insured person does not pay the premiums, cost sharing amounts and interest on arrears within the deadline stipulated, the insurance cover for new claims shall cease to apply and the insured person shall not be entitled to any benefits with regard to ongoing claims. If payment is subsequently made, the cover for new claims and the insured person's entitlement to benefits for new claims shall again apply, but not on a retroactive basis. Furthermore, the insurer has the right to withdraw from the contract immediately after the deadline stipulated in the payment request expires without payment being received.

In any case, all reminder and collection costs shall be charged to the insured person.

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6. Group insurance

The insurer may conclude collective insurance contracts pursuant to Art. 67 para. 3 KVG for specific groups of persons.

The insurance conditions can differ from these GIC. The conditions of the collective insurance contract take precedence over these GIC.

7. Judicature

7.1 Ruling

If an insured person or an applicant disagrees with a decision, the insurer will issue a reasoned written ruling with instructions on the possibility of appeal on request within 30 days.

7.2 Objection

An objection against this ruling may be addressed to the insurer within 30 days of notification. The insurer will check the objection and issue a reasoned written decision on the objection with the right to appeal.

7.3 Cantonal insurance tribunal

Appeals against the decisions on objections can be made to the cantonal insurance tribunal within 30 days of the date of the decision on the objection.

Appeals may be submitted by those, who are affected by the contested ruling or the decision on the objection and has an interest, which deserves to be safeguarded, in their removal or amendment.

The insurance tribunal at the place of residence of the insured person or the appellant third party shall have jurisdiction. An appeal may also be made to the insurance tribunal if the insurer fails to issue a ruling or a decision on an objection within the stipulated period.

Where the place of residence of the insured person or the appellant third party is situated abroad, the insurance tribunal of the canton, in which the last Swiss place of residence was situated or in which the last Swiss employer has its registered office; if neither of these places can be determined, the insurance tribunal at the place where the insurer has its registered office is responsible.

7.4 Legal force

The insurer's ruling or decision on the objection is duly enforceable if no further action is taken within the period allowed for objection or appeal or if the appeal has been rejected by an enforceable ruling. Rulings involving monetary payments are enforceable court orders in the sense of Art. 80 of the Law on Debt Collection and Bankruptcy (SchKG).

7.5 Extra contributions

In periods of exceptional claim levels, the insurer may require extra contributions.

8. Final provisions

8.1 Amendments

The insured person is notified about amendments to these GIC by written notice in the member's journal or by way of official publication.

8.2 Entry into force

These GIC enter into force on 1 January 2023 and replace all previous versions.

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