General Insurance Conditions (GIC)

ÖKK LIVE product line

Edition 2020

ÖKK

Common Provisions

ÖKK Versicherungen AG, Edition 1.1.2020

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1. Insurance fundamentals

1.1 Principle

Supplementary and additional insurance policies are offered in accordance with these ÖKK LIVE General Insurance Conditions (hereinafter referred to as ÖKK LIVE GIC).

1.2 Insurance providers

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

The insurer for the ÖKK PROTECT health-legal protection and the ÖKK TOURIST travel legal protection insurance is Coop Rechtsschutz AG, Aarau.

The insurer for the cancellation costs insurance as well as the ÖKK TOURIST luggage insurance is Helvetia Swiss Insurance Company Ltd, St. Gallen. These insurance policies are the responsibility of European travel insurance, branch office of Helvetia Swiss Insurance Company Ltd, domiciled in Basel.

The insurer for ÖKK risk capital insurance in the event of disability or death caused by an accident is SOLIDA Versicherungen AG, Zurich.

The insurer for ÖKK risk capital insurance in the event of disability or death caused by illness is Helvetia Swiss Life Insurance Company Ltd, Basel.

1.3 Scope of insurance

The insurance covers the financial consequences of illness, accident and maternity as well as in relation to travel incidents, personal assistance, cancellation costs, luggage and travel legal protection for the duration for which the insurance is concluded.

Provided it is stipulated in the provisions of the individual insurance products, accident insurance can be excluded.

1.4 General Insurance Conditions

Unless special conditions have been agreed in an individual contract, the ÖKK LIVE GIC govern the insurance relationship. The Common Provisions of the ÖKK LIVE GIC (hereinafter referred to as ÖKK LIVE CP) apply for all the insurance products listed below. Details concerning the benefits can be found in the provisions of the individual insurance products. If the provisions of the individual insurance products differ from the ÖKK LIVE CP, the provisions of the individual insurance products take precedence over the ÖKK LIVE CP.

1.5 Collective insurance conditions

The ÖKK LIVE GIC also apply for collective insurance policies in the area of treatment costs. Alternative conditions may be agreed in the individual collective contracts; in particular, these relate to acceptance into the policy, the scope of benefits, determining the premium, the duration of the insurance, termination and the allocation of rights and obligations between the policyholder and the insured person.

The provisions in collective contracts take precedence of the ÖKK LIVE GIC.

1.6 Insurance Contract Act

Unless the individual insurance products stipulate provisions to the contrary, the conditions of the Federal Act on Insurance Contracts (VVG) of 2 April 1908 shall apply.

2. Insurance options

2.1 Insurance products

The insurance products covered by these ÖKK LIVE GIC are as follows:

Basic module
- ÖKK START

Supplementary modules
- ÖKK HOSPITAL Benefit levels: FLEX MINI, FLEX, SEMI-PRIVATE, PRIVATE, GLOBAL
- ÖKK NATURE Benefit levels: MINI, MIDI, PLUS
- ÖKK PREVENTION
- ÖKK SMILE Benefit levels: 1,000, 1,500, 3,000, 5,000
- ÖKK PARENTS

Additional products
- ÖKK HOSPITAL PRIVATE ACCIDENT
- ÖKK TOURIST
- ÖKK PROTECT
- ÖKK risk capital in the event of death or disability caused by illness
- ÖKK risk capital in the event of death or disability caused by accident
- ÖKK COMPENSA

2.2 Combinations

The above-mentioned insurance products (basic module, supplementary modules, additional products) can be combined with each other.

The ÖKK START basic module is required for the following insurance products:
- ÖKK NATURE (MINI, MIDI, PLUS)
- ÖKK PREVENTION
- ÖKK SMILE (1,000, 1,500, 3,000, 5,000)
- ÖKK PARENTS

2.3 ÖKK OPTION 5/10

ÖKK OPTION offers guaranteed upgrade and expansion options in the future. With ÖKK OPTION, insured persons are able to conclude certain products within the agreed duration of the option (subject to the waiting period) without having to undergo another health check.

2.3.1 Conclusion of the option for the ÖKK START basic module

The ÖKK START basic module can be reserved for an option duration of five or ten years for an option fee.

Requirements for concluding the option:
In order to conclude the option, the health check must be passed; this is performed based on the details provided in the health declaration for the ÖKK START basic module. The provisions in section 4.1 apply mutatis mutandis.

2.3.2 Conclusion of options for supplementary modules and additional products

Persons with an active ÖKK START basic module (or this module guaranteed under an option) can reserve the following insurance products for an option duration of five or ten years for an option fee:
- ÖKK HOSPITAL (FLEX MINI, FLEX, SEMI-PRIVATE, PRIVATE, GLOBAL)
- ÖKK HOSPITAL PRIVATE ACCIDENT
- ÖKK NATURE (MINI, MIDI, PLUS)
- ÖKK SMILE (1,000, 1,500, 3,000, 5,000)

Requirements for concluding the option:
- An active ÖKK START basic module (or this module guaranteed under an option); and
- A successfully passed health check, which is performed based on the details provided in the health declaration for the insurance product covered by the option. The provisions in section 4.1 apply mutatis mutandis.

2.3.3 Exercising the option

The option can be exercised as of the first day of any month following prior written notification to the insurer. The option can be exercised up to 31 December of the year in which the insured person turns 60 years of age.

The option for supplementary modules and additional products can only be exercised if the option for the ÖKK START basic module is exercised at the same or the person is already actively insured with ÖKK START.

The waiting period stipulated in the policy applies from the time the option is exercised. The waiting period refers to the period of time from when the option is exercised until the start of the insurance. The waiting period does not count towards the minimum duration of the respective insurance product.

Any qualifying periods within the insurance product do not begin until the waiting period has expired.

2.3.4 Duration of the option

The option can be concluded for a duration of five or ten years.

The option can be renewed following the expiry of the selected option duration; the requirements stipulated in sections 2.3.1 and 2.3.2 apply in this regard.

2.3.5 Termination of option

Options may be terminated as of 31 December of each year subject to a written notice of termination received by no later than 30 September of said year. The termination provisions in section 5.1 apply mutatis mutandis.

This possibility of termination also applies within the waiting period of the option.

In the event of termination, the option to conclude the relevant insurance product without undergoing another health check expires.

The option also expires in the following cases:
- if the maximum option duration (five or ten years) is reached;
- if the insured person terminates the ÖKK START basic module or their option, or if ÖKK START expires for another reason (unless the ÖKK START basic module is guaranteed under an option in accordance with section 2.3.1); and
- upon reaching the age limit (i.e. on 31 December of the year in which the insured person turns 60 years of age).

2.3.6 Option fee

A fee is charged for each insurance product guaranteed under an option (option fee).

The option fee must also be paid during the waiting period. After this has expired, the premium tariff of the insurance product that the option guarantees shall apply.

The option fee is no longer charged once the option ends.

2.4 Selected insurance products

The insurance policy specifies the insurance products that have been concluded. Any special provisions or agreements that differ from those in the ÖKK LIVE GIC are also noted in the insurance policy.

3. Insured persons

3.1 Individual insurance

The persons listed in the insurance policy are insured.

3.2 Collective insurance

The collective contract specifies the group of insured/insurable persons.

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

4. Start and duration of insurance

4.1 Process for concluding insurance

4.1.1 Application

Applications to conclude insurance policies must be submitted in writing or in another form that can be evidenced in the form of text. The questions listed on the form must be answered by the person making the application completely and truthfully.

Persons without capacity to act may only be represented by their legal representatives.

4.1.2 Obligation to provide information

If, when completing the application, incorrect or incomplete information is provided, the insurer may terminate the contract within four weeks of becoming aware of the breach of the disclosure obligations.

If the contract is dissolved, the insurer's obligation to provide benefits shall also expire in respect of claims already made, the occurrence or extent of which were related to the non-disclosed/incorrectly disclosed material risk factors. The insurer has a right to be reimbursed to the extent that benefits have already been paid out.

By submitting an application to conclude insurance policies, the applicant authorises the insurer to obtain the information from medical personnel and other insurers that is necessary to conclude the insurance, clarify any subsequent obligation to provide benefits, and assert a right to recourse.

The insurer may demand a doctor's certificate or, at its cost, a medical examination.

Policyholders shall ensure that they can provide all necessary information concerning the insured persons.

4.1.3 Documentation

Upon concluding the insurance policies, the policyholder receives:
- the insurance policy; and
- the General Insurance Conditions (the latest version of the General Insurance Conditions can be found at www.oekk.ch/gic. A printed copy can be requested from any ÖKK Agency.).

4.1.4 Right of revocation

The application to conclude insurance policies may be revoked within 14 days of it being made. In providing notice of revocation, all obligations of the insurer lapse.

If the contents of the insurance policy or the appendices to the policy do not match the agreements reached, policyholders shall demand that the certificate be rectified within four weeks of receiving it; otherwise they are deemed to have accepted the contents of the contract.

4.2 Start of insurance

The insurance starts on the date specified on the insurance policy.

4.3 Duration of insurance

4.3.1 General provisions

The duration of the respective insurance products is based on the provisions of the ÖKK START basic module as well as the conditions of the individual supplementary modules.

The additional products can each be concluded for a period of one year.

4.3.2 Longer duration of insurance

If supplementary modules are concluded in addition to the ÖKK START basic module (combination as per section 2.1), the duration of insurance for the ÖKK START basic module is based on the duration of insurance of the most recently concluded supplementary module.

4.3.3 Timing of conclusion of insurance

Insurance may be concluded at any time, even during the calendar year. In such cases, premiums are calculated based on the remaining duration of insurance up to the primary expiry date of 31 December of a calendar year.

4.3.4 Extension of insurance

The insurance contract is automatically extended by one year after the expiry of the agreed duration of insurance, unless it is terminated by the policyholder subject to the standard notice period.

4.4 Changes to the insurance

4.4.1 Changes on the part of the policyholder

Applications to adjust the insurance contract with a higher level of coverage and applications for products requiring a health declaration are considered to be applications for a new insurance contract.

If the policyholder wishes to reduce the insurance cover, the termination provisions apply.

4.4.2 Changes on the part of the insurer

If, after the insurance is concluded, there are far-reaching changes to the framework conditions for insuring the financial consequences of illness, maternity and accident, the insurer is authorised to amend the GIC. These far-reaching changes include an increase in the number of medical service providers or new categories of medical service providers, an expansion of the medical benefits offered, the introduction of new, cost-intensive forms of therapy or medication, as well as similar developments or amendments to social insurance legislation.

These new GIC will be communicated to the policyholder 30 days in advance. Policyholders have the right to withdraw from the affected insurance products as of the date the changes enter into force within 30 days of being informed of such changes. If policyholders do not provide notice of termination within this period, they are deemed to have agreed to the new GIC.

4.5 Suspension of insurance

4.5.1 Requirements

An application can be made to suspend insurance in all or individual active insurance products provided it can be proved there is equivalent insurance cover in place.

The insurer reserves the right to reject the suspension application.

During the period of suspension, a reduced premium may be charged.

4.5.2 Duration and scope of suspension

After having submitted an application, the period of suspension begins no earlier than the start of the month after the grounds for suspension arise.

The suspension must be requested for at least three months, and can be concluded for a duration of up to six years. It is possible to apply for a further extension of the suspension period.

If the insurer does not agree to an extension of the suspension period, the insurance cover is reactivated in full if this is requested within 30 days. If the insurance cover is not reactivated within this deadline, the insurance lapses until further notice.

If the grounds for suspension cease to apply, the insurance cover is reactivated in full if this is requested within 30 days. If the insurance cover is not reactivated within this deadline, the insurance lapses until further notice.

When spending time outside Switzerland, a contact address in Switzerland must be given.

5. End of insurance

5.1 Termination by the policyholder

5.1.1 Standard termination

The insurance / an insurance product may be terminated following the expiry of the insurance duration as of 31 December of each year subject to a written notice of termination received by no later than 30 September of said year. This remains subject to any termination provisions in the individual insurance products to the contrary.

5.1.2 Termination in the event of a claim

After each claim for which the insurer has provided benefits, the policyholder may terminate the corresponding part of the contract in writing within 14 days of receiving payment or becoming aware that the insurer has taken responsibility for covering said benefits. In such cases, the premium will be owed up until the termination of the contract.

5.1.3 Right of transfer in the event of termination of the collective contract

Insured persons whose insurance will lapse due to the termination of the collective contract have the right to change (with the same cover) to an individual insurance policy without having to complete another health declaration.

This right of transfer must be exercised within 30 days of the termination of the collective contract. The key date in this regard is the date the insurer receives notification (not the date of the postmark).

5.1.4 Receipt of notice of termination

The key date in this regard is the date the insurer receives the notice of termination and not the date of the postmark.

5.2 Waiver of termination right by the insurer

The insurer expressly waives its legal right to terminate the contract upon expiry or to withdraw from the contract in the event of a claim. Exceptions to this are as follows:

- the right of termination of collective contracts; and
- the right to withdraw from the contract in the event of a breach of disclosure obligations or in the event of attempted or successful insurance fraud.

5.3 Other grounds for termination

The insurance also lapses in the following cases:

a) the death of the insured person;
b) moving abroad (unless the insurance has been suspended);
c) on reaching the age limit set for the insurance cover;
d) upon definitive expiry of the entitlement to all benefits for an insurance product
e) if the contract is not extended after expiry of the maximum insurance duration or in the event of suspension; and
f) in the cases stipulated by law, in particular if there are outstanding premiums or cost-sharing amounts (see also section 8.3.2).

6. Benefits

6.1 Definition of terms

6.1.1 Illness

Illness is any impairment of physical, mental or psychiatric health that is not the result of an accident and results in a medical examination or treatment, or an inability to work.

6.1.2 Accident

An accident is the sudden, unintended injurious impact of an exceptional external factor on the human body, which results in an impairment of the person's physical, mental or psychological health, or death.

The following conclusive list of physical injuries are considered equivalent to accidents, provided they were not primarily caused by illness or attrition:

a) Bone fractures
b) Dislocations of joints
c) Meniscal tears
d) Muscle tears
e) Pulled muscles
f) Tendon tears
g) Ligament lesions
h) Eardrum injuries.

Physical injuries within the meaning of the above paragraph do not include non-accident-related damages to objects which were used as a result of an illness and replace a body art or bodily function.

Accidents also include occupational illnesses which are recognised as accidents in accordance with the UVG.

6.1.3 Maternity

Maternity includes pregnancy and birth, as well as the recovery period for the mother. Benefits relating to pregnancy and birth are insured the same as for illness, provided the mother has been insured with the insurer for at least 360 days (qualifying period) at the time of the birth or, if she previously had equivalent insurance with another insurer, provided this insurance was concluded at least 360 days before the birth (and there is confirmation of this).

6.1.4 Birth defects

Birth defects are those illnesses that exist following birth.

6.1.5 Acute-care hospitals

Acute-care hospitals are those treatment facilities that can provide the medical and nursing services and have the technical infrastructure in place required to treat acute illnesses, accidents and for births that require continuous medical monitoring.

Acute treatments refer exclusively to inpatient treatments in acute-care hospitals (excl. psychiatric clinics and rehabilitation clinics).

6.1.6 Psychiatric clinics

A psychiatric clinic (also referred to as a neurological clinic) is a specialist hospital that treats mental disorders and psychiatric illnesses.

6.1.7 Rehabilitation clinic

Rehabilitation clinics are those institutions that meet the necessary medical-technical and infrastructure requirements and have sufficiently qualified medical nursing and therapeutic staff in order to carry out specific and targeted inpatient rehabilitation measures.

6.1.8 Types of acute-care hospitals, psychiatric clinics and rehabilitation clinics

6.1.8.1 List hospital

An institution that is on a cantonal hospital list in accordance with Art. 39 KVG. These institutions are recognised by the insurer.

6.1.8.2 Contractual hospital

An institution with which the insurer has entered into an agreement concerning the determination of tariffs or whose tariffs are recognised by the insurer. A list of these recognised institutions is available from the insurer on request.

6.1.8.3 Other hospital

An institution that does not appear on a cantonal hospital list and whose tariffs are not recognised by the insurer.

6.1.9 KVG doctor

Doctors are deemed to be a KVG doctor if they fulfil the eligibility requirements to charge compulsory health care insurance for their services (as per KVG). Doctors are eligible if they have a federal diploma and further training recognised by the Federal Council.

6.1.10 Dentist

Dentists are professionals who have the corresponding federal diploma (or equivalent) or have been granted approval by the canton to exercise their profession based on a scientific certificate of proficiency.

6.2 Scope of benefits

6.2.1 Geographical scope of benefits

In principle, the insurance applies for benefits in Switzerland and, in the event of emergency treatment, abroad. The provisions of the individual insurance products concerning geographical scope take precedence.

6.2.2 Period of benefits

The entitlement to benefits exists for the duration of the insurance. There is no entitlement to benefits for costs incurred before the start of or after the end of the insurance.

The key date in this regard is the date of treatment or the sate on which the insured benefit was first received.

6.3 Insured benefits

6.3.1 Scope of benefits

The insurance covers benefits as per the coverage listed on the insurance policy and in accordance with the provisions of the individual insurance products.

6.3.2 Economical treatment

Treatments are covered provided they are effective, expedient, economical and medically necessary. This means that the costs of medical and therapeutic treatments are covered if they are limited to the extent that they are in the interests of the insured person and are necessary for the purpose of treatment. The effectiveness of the treatment must be backed by scientific methods (with the exception of complementary medicine).

In order to provide optimum treatment for insured persons, the insurer may agree accompanying measures with the approved service providers with the aim of ensuring the insured persons receive the most effective, expedient and economic treatment through improved cooperation and coordination between the service providers and the insurer. The insurer may mandate a health advisor to carry out these measures.

Where the invoice is clearly for an amount that is too high, the insurer can reduce its benefits or make the payment thereof contingent on the claim for reduction being ceded.

6.3.3 Treatment from recognised medical service providers

Treatments from medical service providers are insured if they are recognised in accordance with the KVG. Benefits from other persons or institutions are insured if this is provided for in the individual insurance products.

6.4 Benefit restrictions

6.4.1 Pre-existing illnesses and accidents

The insurer may exclude illnesses and consequences of accidents from the insurance cover if they exist/existed at the time the insurance is/was concluded.

This restriction of cover is communicated to the insured person in writing.

If an insured person has opted to conclude ÖKK OPTION supplementary modules, the regulations set out in section 2.3 apply.

6.4.2 Exclusion of benefits

There is no entitlement to insurance benefits:

a) for illnesses and consequences of accidents which already existed at the time the insurance was concluded and have been excluded from the insurance by the insurer;
b) for illnesses and consequences of accidents which already existed at the time the application was made and about which insufficient/no information was provided;
c) during a qualifying period; and
d) if a treatment's aim is not to remedy a health problem or the consequences thereof. This does not apply to measures carried out to prevent the impending onset or deterioration of a health problem if the person is already sick;
e) for treatments carried out by service providers not recognised by the insurer;
f) for dental treatments if the cover is not specifically regulated in the insurance product concluded;
g) if the insurance has been suspended;
h) in the event of payment defaults, from the expiry of the reminder period until all obligations have been paid in full;
i) in the case of participation in warlike actions, terrorist acts, unrest, and similar events, and during military service abroad;
k) in the event of illnesses and accidents resulting from warlike events that had broken out more than 14 days previously;
l) in the event of illnesses and accidents resulting from actively participating in fights, brawls or other acts of violence or from actively participating in punishable actions or attempts to do so;
m) for the consequences of earthquakes and other natural catastrophes;
n) in the event of health impairments resulting from large-scale industrial emergencies or impairments caused by nuclear energy;
o) for organ transplants in accordance with the Health Care Benefits Ordinance (KLV), Appendix 1 on transplant surgery, irrespective of where the transplant is carried out;
p) for statutory and agreed cost-sharing amounts from compulsory health care insurance;
q) in the event of epidemic diseases;
r) as a consequence of abusing alcohol, medication or other drugs;
s) in the event of health impairments resulting from recklessness, i.e. if the insured person exposes themselves to a considerable risk without taking or being able to take any measures that could reduce this risk to a reasonable level. This does not include rescue operations in aid of persons. In terms of this provision, recklessness includes in particular the participation in races or training with motor vehicles; and
t) if the insured person's health is damaged intentionally, also as a suicide attempt or self-harm;
u) for cosmetic treatments and operations.

Any further benefit exclusions can be found in the provisions of the individual insurance products.

6.4.3 Benefit restrictions

Benefits are restricted:

a) if notification obligations or other duties are breached in the event of a claim;
b) in the event of grossly negligent causation of the impairment; and
c) if the supporting documentation required to assess an insurance claim is not provided within four weeks, despite a written reminder being sent.

7. Duty of cooperation in the event of illness and accident

7.1 Notification obligation

The insured person must notify the insurer of their benefits claims in due time in accordance with the provisions of the individual insurance products. The insurer must be notified of the occurrence of an accident within ten days.

The notification must be made truthfully. If benefits are claimed, the insurer must be provided with all information that contains the required medical and administrative details. Only detailed original invoices are accepted.

7.2 Reduction of damage

Insured persons must do everything in their power that can help to reduce the damage, in particular that is conducive to curing their condition, and desist from any action which may delay this.

As part of the accompanying measures carried out by the insurer, insured persons must support the case managers' work, providing them with the necessary information.

7.3 Obligation to provide information

The insured person releases the treating doctors, other medical service providers and other insurers from the duty of non-disclosure to the insurer. The insurer may obtain information.

On request, the insured person must agree to an examination by a second doctor or by the insurer's independent medical examiner. The insurer bears the costs for this.

The insured person must provide the insurer with information about all benefits received from third parties in the event of illness, accident, disability and maternity. Upon request, the insurer must be provided with bills from third parties.

For persons without capacity to act, the policyholder is responsible for fulfilling the obligation to provide information.

8. Premiums and payments

8.1 Determining the premium

8.1.1 General provisions

The premiums are determining in a premium tariff for each insurance product.

8.1.2 Level of premiums

The level of the premiums is determined in line with the risk entailed.

The insurer may stipulate a minimum premium. This is specified in the policy and applies for each insured person per insurance year.

Premium adjustments resulting from a change of the risk group are carried out automatically.

Insured persons must provide notification of any changes in personal circumstances that may impact the calculation of the premium. If they fail to do so, any potential difference in premiums are payable retroactively.

For options on insurance products (ÖKK OPTION, see section 2.3), a reduced premium will be charged compared to that charged for active insurance cover.

8.1.3 Premium discount

The insurer may grant family discounts for children and young adults up to 25 years of age.

Children and young adults who live in the same household as at least one parent and are insured with the insurer on the same family policy are eligible for the discount.

To receive the family discount, the child/young adult and the parent in question must have the following insurance cover with the insurer:
- compulsory health care insurance;
- ÖKK START; and
- at least one supplementary module in accordance with section 2.1.

The ÖKK START basic module and the supplementary modules may not be guaranteed with ÖKK OPTION.

The family discount is granted on the insured supplementary modules in accordance with section 2.1.

8.2 Adjustment of premium tariffs and cost-sharing amounts

The premium tariffs and cost-sharing amounts may be adjusted in line with changes in costs and the claims history.

The premiums are also adjusted when insured persons move into the next-highest age group.

This applies equally for the option fee.

The premium adjustments will be communicated to the policyholder 30 days in advance. Policyholders have the right to withdraw from the affected insurance product as of the date the premium adjustment enters into force within 30 days of being informed of this adjustment.

If policyholders do not provide notice of termination within this period, they are deemed to have agreed to the premium adjustment.

If insured persons lose their entitlement to a discount when the discount conditions remain in place, this is not deemed to be a premium adjustment. If the discount conditions change, insured persons have the right to terminate the insurance.

An adjustment of the tariff resulting from a change in the place of residence is not deemed to be a premium adjustment.

8.3 Premium payment

8.3.1 Due date

Premiums are to be paid in advance. Premiums are to be paid without interruption, even in the event of illness, accident, pregnancy and maternity, or an inability to work or if the entitlement to benefits is suspended.

8.3.2 Reminder and consequences of default

If premiums or cost-sharing amounts that are due are not paid within 30 days, the insurer sends the policyholder a reminder, which sets out the legal consequences of default and requests the payment of the outstanding amounts, including any reminder fees, within 14 days of the reminder being sent.

If these amounts are still not paid, the insurer's obligation to provide benefits is suspended from the expiry of the reminder deadline.

If the insurer does not demand payment of the overdue premiums within two months of the expiry of the reminder deadline, the insurer is deemed to have withdrawn from the contract. In this case, the insurer waives its rights to the payment of the overdue premiums.

If the insurer demands payment of the premiums or if the insurer subsequently takes payment of the premiums, the insurance cover is reactivated as soon as the outstanding premiums, including interest amounts and costs, are paid. Even if premiums are subsequently paid, the insured person has no entitlement to benefits for illnesses, accidents and their consequences which occurred while the obligation to provide benefits was suspended.

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

8.4 Other payment provisions

8.4.1 Offsetting

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

The insured person or the policyholder have no right to offset amounts against the insurer.

8.4.2 Pledging and assignment

Claims against the insurer may not be pledged or assigned without the consent of the latter.

8.4.3 Payment of benefits

Unless otherwise agreed between the insurer and service providers, the insured person owes the service providers the relevant costs.

If there are different contracts and tariffs in place between the insurer and service providers, the insurer pays the service providers directly. If the insurer pays the service providers directly, the insured person must reimburse the insurer the agreed cost-sharing amount within 30 days of the invoice being received.

Remuneration agreements between billers and insured persons are not binding for the insurer. An entitlement to benefits only exists within the scope of the tariff recognised by the insurer for the corresponding service provider.

Any benefits obtained wrongfully are reclaimed by the insurer.

8.4.4 Statute of limitations

The insured person's entitlement to benefits from the insurer expires two years after the event upon which the obligation to provide benefits is based.

9. Third-party benefits

9.1 Subsidiarity

9.1.1 General provisions

If a third party is liable for a reported illness or accident by law or through their fault, the insurer is either not obliged to provide benefits, or is only liable for the uncovered amount of benefits.

Within the scope of the benefit claims against third parties, there is no obligation to provide benefits in accordance with these ÖKK LIVE GIC.

9.1.2 Benefits covered by public authorities

Within the scope of the claims for benefits or reductions against cantons and municipalities, there is no obligation to provide benefits in accordance with these ÖKK LIVE GIC.

9.1.3 Multiple insurance policies

If more than one private insurer is obliged to provide benefits, a calculation is performed to determine how much each insurer would have to pay if they were solely liable for providing benefits. This also applies if the other insurers only have a subsidiary obligation to provide benefits. The payment to be made under these ÖKK LIVE GIC is limited to the proportion of the total insurance amount corresponding to this cover.

9.1.4 Waiver of benefits

If insured persons wholly or partially waive their right to benefits vis-à-vis third parties without the consent of the insurer, the obligation to provide benefits under these ÖKK LIVE GIC no longer applies. The capitalisation of an entitlement to benefits is also considered to be a waiver of benefits.

9.2 Social insurance

No benefits are covered that are paid out under social insurance schemes. Any claim to benefits must be reported to the relevant social insurance office.

9.3 Advance payment of benefits and recourse

Unlike for social insurance schemes, an advance payment of benefits can be made if the insured person is also insured with third parties. A requirement is that the insured persons must have made reasonable efforts to enforce their claims without success and is willing to assign their claims against third parties to the insurer within the scope of the benefits provided.

9.4 Overinsurance

Insured persons may not make any profit from the benefits provided under these ÖKK LIVE GIC taking into consideration the benefits provided by third parties. In the event of being overinsured, the benefits will be reduced accordingly.

10. Data protection

10.1 Legal basis

The data of insured persons is processed in accordance with the provisions of the Federal Act on Insurance Contracts (VVG) of 2 April 1908 and the Federal Act on Data Protection (FADP) of 19 June 1992.

10.2 Purpose of processing data

The insurer processes data (e.g. personal information, information on a person's health, checking the information provided in applications, collecting money owed, settling benefits) in order to execute the insurance contract in accordance with the VVG. In addition, it may use the data for regulatory evaluations as well as for personal customer consultations and to assist customers.

The insurer may also analyse the data using mathematical and statistical methods in order to improve the quality of products and services based on these findings and to inform insured persons of this.

The insurer is therefore expressly permitted, for the above-mentioned purposes, to process personal and contractual data (excl. sensitive personal data within the meaning of the Data Protection Act, in particular) as well as the client profile using information from the basic and supplementary insurance provided by the companies of the ÖKK Group and its outsourcing partners exclusively in the area of supplementary insurance.

The insurer treats the information it receives with the highest confidentiality.

10.3 Forwarding of data to third parties for processing

The insurer can fully or partially transfer responsibility for data processing to a third party (e.g. computer centre, outsourcing partner). Here the insurer shall ensure that the data is only processed in such a way as it is permitted to do itself.

In other cases, the insurer may only provide information to third parties with the consent of insured persons.

10.4 Data storage

The insurer carefully stores the data and puts in place appropriate technical and organisational measures to protect it from unauthorised access.

10.5 Right to information

Insured persons have the right to request information from the insurer about the data processed. Such requests must be in writing and contain sufficient proof of identity (copy of ID/passport).

11. Notifications

The insurer must be notified in writing of any changes to the personal circumstances of insured persons that are material with regard to the insurance (e.g. change of place of residence) within 30 days.

When spending time outside Switzerland, a contact address in Switzerland must be given.

All notifications provided by policyholders or insured persons must be sent to the responsible branch of the insurer.

Notifications from the insurer are duly sent in writing to insured persons or policyholders at their last known address or the contact address in Switzerland.

Further information is communicated to insured persons or policyholders in the customer magazine or is published on the insurer's website.

12. Place of jurisdiction

In the event of any disputes arising out of insurance policies in accordance with these ÖKK LIVE GIC and the provisions of the individual insurance products, claimants may choose to have their case heard before the court at their place of residence in Switzerland or the insurer's registered office (ÖKK Versicherungen AG, Landquart).

ÖKK TOURIST

ÖKK Versicherungen AG
Coop Rechtsschutz AG
Helvetia Swiss Insurance Company Ltd
Edition 1.1.2020

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1. Insurance providers

The insurer is the health insurer listed in the insurance policy. The insurer is the point of contact for any issues the insured persons may have, unless another company is expressly stipulated in these provisions.

The insurance provider for the treatment costs & personal assistance is ÖKK Versicherungen AG, Landquart (hereinafter referred to as ÖKK).

The insurer for the travel legal protection insurance is Coop Rechtsschutz AG, Aarau (hereinafter referred to as Coop Rechtsschutz). ÖKK has concluded a collective insurance contract with Coop Rechtsschutz as insurance provider in favour of the insured persons; this contract grants the insured persons a direct right of claim against Coop Rechtsschutz for travel legal protection insurance.

The insurer for the cancellation costs insurance as well as the luggage insurance is Helvetia Swiss Insurance Company Ltd, St. Gallen. These insurance policies are the responsibility of European travel insurance, branch office of Helvetia Swiss Insurance Company Ltd, domiciled in Basel (hereinafter referred to as ETI). ÖKK has concluded a collective insurance contract with ETI as the insurance provider in favour of the insured persons; this contract grants the insured persons a direct right of claim against ETI for cancellation costs and luggage insurance.

2. Common Provisions

Unless expressly excluded, the Common Provisions (CP) of the ÖKK UNO or ÖKK LIVE product lines specified in the insurance policy shall apply. They are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the CP, the provisions of this insurance product take precedence over the CP.

3. Purpose

Depending on the module selected, the insurance provides the following benefits for claims that arose during a holiday, business trip or stay abroad:

- Benefits to cover the uncovered costs of emergency treatment in the event of illness, accident or premature birth;
- Benefits to cover transport, search, rescue and recovery operations;
- Services;
- Contributions towards lawyer, expert and court costs (legal protection abroad);
- Cancellation costs if the insured person cannot embark upon the travel services booked; and
- Benefits in the event of theft, loss during transportation and damage to personal luggage.

The following conditions apply with regard to the insurance cover.

4. Insurance options

The following modules can be concluded within ÖKK TOURIST:

- Treatment costs & personal assistance
- Travel legal protection
- Cancellation costs
- Luggage

5. Conclusion of the insurance

This insurance may be concluded by all persons, without any age restrictions, who have compulsory health care insurance under the Swiss Health Insurance Act (KVG) and their legal place of residence in Switzerland.

In addition, the insurance may be concluded by people who have the relevant compulsory health care insurance in the Principality of Liechtenstein and also have the legal place of residence there.

6. Insured persons

The policyholder is the person with whom the insurer has concluded an insurance contract.

6.1 Individual insurance

The person listed in the insurance policy is insured.

6.2 Family insurance

The policyholder listed in the insurance policy as well as their spouse/partner and children are insured, provided they live in the same household as the policyholder.

7. Start, duration and end of insurance

The start, duration and end of the insurance are guided by the CP that apply as per the policy.

8. Dissolution of the collective contract

The insurance expires if the collective contract between Coop Rechtsschutz / ETI and ÖKK Versicherungen AG is dissolved. The insured person must be notified in writing of the dissolution of this contact by no later than one month before the expiry of the insurance cover.

9. Cost sharing

No cost sharing applies to benefits provided under ÖKK TOURIST.

10. Benefit restrictions

10.1 Principle

The regulations governing benefit restrictions in accordance with the CP applicable as per the policy do not apply for ÖKK TOURIST.

10.2 Excessive invoices

Where the invoice is clearly for an amount that is too high, the insurer can reduce its benefits or make the payment thereof contingent on the claim for reduction being ceded.

11. Statute of limitations

The insured person's entitlement to benefits from the insurer expires two years after the event upon which the obligation to provide benefits is based.

TREATMENT COSTS & PERSONAL ASSISTANCE

1. Conditions for receiving benefits

Benefits shall only be provided if the treatment is appropriate and medically necessary, and is performed by people with the required authorisation to do so.

2. Geographical scope

The insurance applies for emergency treatments outside of the canton of residence in Switzerland and worldwide.

The Principality of Liechtenstein is considered equivalent to a canton of residence, provided the insured person has their place of residence there.

3. Period of benefits

Benefits are only provided for as long as it is not medically viable for the insured person to be repatriated.

The obligation to provide benefits for illnesses and accidents that occurred during the duration of the insurance shall in any case lapse no later than 91 days after expiry of the insurance.

4. Insurance benefits

4.1 Treatment costs

Over and above the compulsory health care insurance under KVG, accident insurance under UVG and any additional insurance cover existing with the insurer or other insurance companies, the insurance pays benefits to cover treatment costs in the case of emergency treatment as an outpatient or inpatient.

With respect to other insurance companies, please refer to section 9.1.3 of the CP applicable as per the insurance policy on multiple insurance policies.

The cover extends to illness, accident or premature birth at the habitual local tariffs or the contractually agreed tariffs. A birth is regarded as premature if it is unforeseen and takes place more than six weeks before the medically attested expected birth date.

The statutory cost share applicable to Switzerland is not insured.

4.2 Transport, search, rescue and recovery operations

If an insured person suffers a serious illness or accident or dies, the insurer – based on the medical findings – provides the following benefits as organised by the ÖKK emergency call centre and pays the costs for:

a) medically necessary rescue operations and emergency transport in an appropriate means of transport to the nearest suitable place of treatment;
b) search operations undertaken with regard to rescuing or recovering the insured person as well as recovery operations up to a total of CHF 20,000 per insured person;
c) medically necessary repatriation of the insured person who has suffered an illness or accident to a suitable hospital in the canton of residence for inpatient treatment; and
d) repatriation of the deceased person to their place of residence.

4.3 Trips for visiting purposes and additional travel costs

4.3.1 Trips for visiting purposes

If an insured person suffers a serious illness or accident abroad and has to be hospitalised for more than 7 days, the ÖKK emergency call centre organises a trip for visiting purposes to the hospital for one person close to the insured person (first-class rail ticket, economy-class airfare). The costs for this are covered by the insurer.

4.3.2 Additional return trip

If, in the event of medical necessity, an insured person has to be transported back from abroad to a suitable hospital in the canton of residence for inpatient treatment, the ÖKK emergency call centre organises the additional return trips for insured family members travelling with the insured person or a close person. The additional costs incurred are covered.

If an insured person suffers an illness or accident and cannot undertake their journey home because they have to stay in hospital, the ÖKK emergency call centre organises the additional return trip for the insured person, insured family members travelling with the insured person or a close person. The additional costs incurred are covered.

4.4 Amount of coverage

4.4.1 ÖKK TOURIST 50/100

The amount of coverage for all benefits amounts to CHF 50,000 per insured person, up to a maximum of CHF 100,000 per insured family.

Insurance options duration of stay abroad:
– up to 17 days
– up to 40 days.

4.4.2 ÖKK TOURIST 250/500

The amount of coverage for all benefits amounts to CHF 250,000 per insured person, up to a maximum of CHF 500,000 per insured family.

Insurance options duration of stay abroad:
– up to 17 days
– up to 40 days
– up to 365 days.

4.5 Services

4.5.1 Payment advances to hospitals

If an insured person has to be hospitalised abroad, if necessary the insurer provides a payment advance to cover hospital costs of up to CHF 20,000. If some of this prepaid amount is not covered by the existing insurance, the difference will be invoiced to the insured person. The requested amount must be repaid within 30 days.

4.5.2 Notification of people at home

If measures are organised by the ÖKK emergency call centre, the latter notifies relatives of the insured person of the relevant facts and the measures taken.

4.5.3 Referral to hospitals and doctors abroad

If required, the ÖKK emergency call centre refers its insured persons to a doctor or hospital close to where they are staying. If there are communication problems, the ÖKK emergency call centre will provide translation assistance.

4.5.4 Medical advice from doctors

If an insured person requires medical assistance while travelling and this cannot be obtained at the place they are staying, the doctors at the ÖKK emergency call centre provide medical advice. This advice only represents a recommendation, and in no way should be considered a diagnosis.

4.6 Exclusion of benefits

There is no entitlement to insurance benefits:

a) for illnesses and consequences of accidents that existed before embarking on the journey;
b) if the insured person travelled abroad for the purposes of receiving treatment or care, or giving birth;
c) if the ÖKK emergency call centre has not given its prior approval for search operations, repatriation, visitation or additional return trips;
d) in the case of participation in warlike actions, unrest, and similar events, and during military service abroad;
e) in the case of illnesses and accidents resulting from warlike events that had broken out more than 14 days previously;
f) in the case of illnesses and accidents resulting from active participation in punishable actions, fights or other acts of violence;
g) in the case of grossly negligent causation of the illness or accident, in particular as a result of misusing alcohol, medication or other drugs;
h) in the case of health impairments resulting from recklessness, i.e. if the insured person exposes themselves to a risk without taking or being able to take any measures that could reduce this risk to a reasonable level. This does not include rescue operations in aid of persons. In terms of these provisions, recklessness includes in particular the participation in races or training with motor vehicles; and
i) if the insured person's health is damaged intentionally, also as a consequence of suicide, a suicide attempt or self-harm.

If the emergency transportation or repatriation is not possible as a result of external factors, such as strike action, turmoil, acts of violence, large-scale industrial emergencies, radioactivity, natural disasters, epidemic illnesses or force majeure, there is no right to demand that these be organised or performed.

5. Obligations in the event of a claim

5.1 Notification of ÖKK emergency call centre

In the event of sudden illness, accident or premature birth in Switzerland or abroad necessitating a period of hospitalisation, the ÖKK emergency call centre must be notified immediately in all cases.

5.2 Release from duty of professional secrecy

The insured person releases the doctors treating them and other medical personnel as well as insurers from their duty of professional secrecy vis-à-vis the ÖKK emergency call centre/insurer.

5.3 Making a claim

The insured person must submit their claim for benefits to the insurer immediately and make available all information that contains the required medical and administrative details. Only detailed original invoices are accepted. If the invoice details are insufficient and additional information is not provided upon request, the level of benefits to be provided is determined at the insurer's discretion.

5.4 Deduction of rail or flight tickets

Unused rail or flight tickets must be automatically returned to the insurer. If useless tickets are sold or reimbursed by a third party, the amounts received in this respect will be deducted from the insurance benefits. If this obligation is not met, the insurer may reclaim an amount determined at its discretion from the insured person or offset this amount against the claim for benefits.

6. Third-party benefits

6.1 General provisions

If a third party is liable for a reported illness or accident by law or through their fault, the insurer is either not obliged to provide benefits, or is only liable for the uncovered amount of benefits.

6.2 Waiver of benefits

If the insured person wholly or partially waives their right to benefits vis-à-vis third parties without the consent of the insurer, the obligation to provide benefits under these GIC no longer applies. The capitalisation of an entitlement to benefits is also considered to be a waiver of benefits.

6.3 Social insurance

No benefits are covered that are paid out under social insurance (KV, UV, IV, MV, AHV, AVI etc.). Any claim to benefits must be reported to the relevant social insurance office.

If an insured person does not have compulsory health care insurance under KVG or equivalent coverage in the Principality of Liechtenstein, benefits are provided by the insurer as if this cover were in place.

6.4 Existing insurance policies with the insurer

Other existing supplementary insurance with the insurer shall take precedence over the benefits under ÖKK TOURIST.

6.5 Air rescue service and similar organisations

If the insured person is a member (donor) of an air rescue service or similar organisations, costs are only covered to the extent that these organisations have not provided benefits. This remains subject to other contractual agreements in place.

TRAVEL LEGAL PROTECTION

1. Geographical scope

The insurance cover applies worldwide outside of Switzerland and the Principality of Liechtenstein.

2. Period of benefits

The insurance cover applies for the duration of the insurance specified in the insurance policy.

Legal protection is provided for disputes arising during the duration of the insurance specified in the insurance policy. Cases are deemed to have occurred at the time of the breach of the law; for insurance-law-related cases, at the time of the insured event.

3. Insured capacities

The insured person has legal protection in their capacity as

a) the owner, driver or renter of a motor vehicle;
b) a sportsperson, pedestrian, cyclist, motorist or passenger in any form of transport;
c) the renter of a holiday property;
d) an attendee of a course at a foreign school;
e) the contractual party to a travel contract;
f) the victim of a violent crime; and
g) the holder of a credit card.

4. Insured travel legal protection claims

The following legal protection claims are insured:

a) claims for extra-contractual compensation for damage against the perpetrator/the perpetrator's liability insurance due to a physical injury or damage to property caused;
b) legal disputes with an insurer, health insurer or pension fund in relation to an event abroad;
c) representation in proceedings brought by criminal or administrative authorities resulting from a negligent breach of foreign legislation. In the event of an official investigation due to a premeditated crime, the costs will only be covered if the insured person is acquitted or the proceedings are suspended; and
d) legal disputes arising from the following contracts under the Swiss Code of Obligations (exhaustive list), provided the insured person is affected in a capacity in accordance with section 3 above:
   – Tenancy contract
   – Repair contract
   – Freight contract
   – Contract of carriage
   – Travel contract
   – School contract
   – Credit card contract.

5. Insurance benefits

The following benefits are provided in the insured legal protection cases:

a) protection of the insured person's legal interests by the legal service of Coop Rechtsschutz;
b) payment of up to CHF 300,000 (CHF 100,000 outside Europe) per case unless a specific benefit restriction applies, in particular the
   – costs of appointed lawyers and mediators;
   – costs of appointed experts;
   – costs of legal proceedings and court costs charged to the insured person;
   – procedural costs payable to the other party;
   – travel expenses for necessary appearances before a foreign court of up to CHF 5,000;
   – translation costs of up to CHF 5,000; and
   – bail money in order to avoid custodial remand of up to CHF 100,000. This benefit is only provided in advance and must be reimbursed to Coop Rechtsschutz.

No benefits are paid for:

a) fines;
b) compensation for damage and settlements;
c) costs which a liable third party is required to cover;
d) costs for public notarisations and register entries; and
e) costs for official authorisations, permits and inspections.

The insured person must reimburse to Coop Rechtsschutz the procedural and party compensation granted to them in the amount of the benefits they receive.

6. Exclusions

No legal protection is provided:

a) in legal protection cases for insured persons in the same family policy;
b) in direct or indirect relation to a crime being intentionally committed;
c) in legal protection cases that were intentionally caused as well as any resulting disputes/proceedings under civil or administrative law;
d) in relation to lawyers, mediators, appraisers and experts who are acting or acted for an insured person in an insured legal protection case;
e) in relation to claims assigned to an insured person as well as claims transferred to insured persons as heirs; and
f) in claims against Coop Rechtsschutz or any of its executive bodies.

7. Reporting a legal protection case

The occurrence of a legal protection case must be reported to the insurer immediately, and on its request, in writing. The insurer immediately forwards the case to Coop Rechtsschutz to be processed.

The insured person must assist Coop Rechtsschutz in processing the legal protection case, provide it with the necessary powers of attorney and information, and forward any notifications they receive, in particular from authorities, with no delay.

In the case of a culpable breach of these obligations, Coop Rechtsschutz may reduce the benefits it provides by the amount of the additional costs it incurs as a result. In the case of a serious breach, the insurer may refuse to pay any benefits.

8. Processing a legal protection case

Having consulted the insured person, Coop Rechtsschutz takes the measures required to safeguard its interests.

If it is necessary to involve a lawyer, in particular in court or administrative proceedings or in the case of conflicts of interest, the insured person is free to choose a lawyer. If Coop Rechtsschutz disagrees with the insured person's choice, the latter may propose three further lawyers, which may not belong to the same law firm. Coop Rechtsschutz must accept one of these three lawyers.

Before appointing the lawyer, the insured person must obtain consent from Coop Rechtsschutz as well as a cost guarantee.

If there is no valid reason for changing lawyers, the insured person must bear any costs resulting from this change.

9. Process in the case of differences of opinion

In the case of differences of opinion, particularly in cases Coop Rechtsschutz believes have no chance of success, the insured person may request that arbitration proceedings be initiated. Both parties jointly appoint a person as the arbitrator. Furthermore, this process is based on the provisions governing arbitration in the Swiss Code of Civil Procedure (ZPO).

If an insured person takes legal action at their own cost, contractual benefits will be provided if the result in the main proceedings is more favourable than the assessment of Coop Rechtsschutz.

10. Place of jurisdiction

In the event of any disputes arising out of this travel legal protection insurance, the claimant may choose to have their case heard before the court at their place of residence in Switzerland or the insurer's registered office (Coop Rechtsschutz AG, Aarau).

CANCELLATION COSTS

1. Geographical scope

The insurance cover applies worldwide.

2. Period of benefits

The insurance cover applies for the period specified in the insurance policy.

The cover begins when the insurance is concluded or, in the case of existing insurance cover, when the travel service is booked and ends when the insured travel service ends (check-in, boarding the booked means of transport etc.).

3. Insured events

Insurance cover is provided if the insured person cannot make use of a booked travel service as a result of one of the events listed below, provided the event occurs after the insurance is concluded/the travel service is booked:

a) unforeseen serious illnesses, injuries, pregnancy complications or death of
   - an insured person;
   - a person travelling with the insured person;
   - a person not travelling with the insured person, but to whom the latter is extremely close; or
   - the insured person's deputy at their place of work, meaning that the insured person must be present there.

b) strikes (except in the case of active participation) on the planned route of travel abroad; unrest of any kind, quarantine, epidemic or force majeure at the destination of travel if this could specifically endanger the life and/or property of the insured person;

c) serious damage to the property of the insured person at their place of residence as a result of fire, force majeure, theft or water damage, meaning that they must be present in their homes;

d) the outage or delay – both as a result of technical defects or personal accidents – of the means of public transport to be used to travel to the official point of departure (airport, train station, port or coach terminal) in the country of residence;

e) if, within 30 days before departure,
   - the insured person unexpectedly starts a new permanent job with a new employer (promotions etc. are excluded); or
   - the employment contract of the insured person is terminated by the employer through no fault of their own; and

f) theft of tickets, passport or identity cards.

If the person who triggers the cancellation because of an insured event is neither related to nor related by marriage to the insured person, there is only an entitlement to benefits if the insured person would be obliged to embark upon the trip alone.

4. Insurance benefits

4.1 Principle

The entitlement to benefits is determined based on the event that triggered the cancellation of the travel services. Neither previous nor subsequent events are taken into account.

4.2 Cancellation costs

Upon occurrence of the insured event, the insurance covers the cancellation costs actually incurred (excl. security and airport taxes). In total, this benefit is restricted to the price of the travel service/the insured amount.

Excessive or repeated processing fees are not insured.

4.3 Additional costs

The insurance reimburses the additional costs for any delayed start to travel if the travel service cannot be made use of as at the scheduled time as a result of the insured event. If a claim is made for additional costs, there is no entitlement to any cancellation costs.

4.4 Unused travel services

The insurance reimburses the pro rata costs of unused travel services (excl. costs of the originally booked return journey) if the travel has to be interrupted prematurely. This benefit is restricted to the price of the travel service/the insurance amount specified in the insurance policy.

4.5 Amount of coverage

The benefits for cancellation costs are limited to CHF 20,000 per event and person/CHF 50,000 per event and family.

Benefits included in the leisure cover (day trips, training courses, concert tickets, ski passes, entry fees for runs etc.) are limited to CHF 500 per person and event.

4.6 Exclusion of benefits

Benefits are excluded:

a) if the service provider (travel company, lessor, organiser etc.) cancels the agreed service or would have to have cancelled them for objective reasons;

b) if the event had already occurred or was foreseeable at the time the insurance was concluded or the travel service booked;

c) if the complaint giving rise to the cancellation was a complication or consequence of a medical operation or treatment that was already planned at the time the insurance began/the travel service was booked;

d) if an illness or the consequences of an accident, an operation or a medical procedure already existed at the time the travel was booked and had not healed by the date of travel;

e) in the event of cancellation without medical indication or if the certificate of incapacity to work had not been issued at the time the inability to travel could first possibly be identified or if it was obtained on the basis of a telephone consultation;

f) if a cancellation as a result of an psychological or psychosomatic complaint:
   - cannot be justified on the basis of a psychiatrist's findings and a certificate issued by said psychiatrist on the day of the cancellation; and
   - cannot additionally be justified by people in employment relationship by providing a 100% absence confirmation from their employer for the duration of the medically certified inability to travel;

g) if the appraiser (expert, doctor etc.) who makes the findings is a direct beneficiary or is related/married to the insured person;

h) for events resulting from orders by public authorities (arrest or travel bans, closure of airspace etc.);

i) in the case of cancellations or travel disruptions resulting from warlike events or terrorism;

j) in the case of cancellations or travel disruptions due to events involving ionising radiation of any type, in particular the transmutation of atomic nuclei;
k) if the event that gave rise to the cancellation or travel disruption is a result of deliberate or grossly negligent acts or omissions or is a result of a failure to exercise the customary level of due care;
l) if an event that gave rise to the cancellation or travel disruption was caused when under the influence of alcohol, drugs, narcotics or medication; and
m) if the event that gave rise to the cancellation or travel disruption arose while intentionally committing criminal acts or attempting to do so.

4.7 Chronically ill persons

The chronically ill must obtain confirmation in the form of a medical certificate that they are able to travel immediately prior to booking a travel service.

If an insured person suffers from a chronic illness, but there appears to be no concern regarding the travel service upon conclusion of the insurance/booking of the travel service because of said illness, the insurance pays the insured costs incurred if the travel service has to be cancelled due to an unforeseeable, serious acute deterioration of this illness or if the insured person dies as a result of the chronic illness.

4.8 Assignment of claims

Once ETI makes a claim payment, the insured person automatically assigns their entire claim resulting from the insurance contract to ETI.

4.9 Liability of insurer

ETI only provides insurance cover to the extent that it is not in breach of any sanctions or restrictions under UN resolutions and is not in breach of any trade or economic sanctions imposed by Switzerland, the European Union or the United States of America, and in the event of claims or other benefits, is only liable to this extent.

5. Obligations regarding conduct while travelling

In principle, when assessing whether a journey to a country is feasible or not due to a strike, unrest, war, terror attacks, epidemics etc., the applicable recommendations issued by the Swiss authorities must be considered. First and foremost, this is the Federal Department of Foreign Affairs (FDFA) and the Federal Office of Public Health (FOPH).

6. Obligations in the event of a claim

In the event of a claim, the insurer must be notified immediately. The insurer forwards the case to ETI to be processed.

The place of booking (travel agency, transport company, lessor etc.) must be notified immediately upon occurrence of the event.

In the case of accident or illness, a doctor must be contacted immediately, who must be informed about the travel plans and whose instructions must be followed. The insured/entitled person must release the doctors treating them from their duty of professional secrecy to the insurer.

The following documents must be submitted to ETI, among others:
- the booking confirmation/invoice for the travel service as well as the invoices for the cancellation/subsequent travel costs (original copies);
- a detailed medical certificate/death certificate or any other official certificates; and
- a copy of the insurance policy.

7. Place of jurisdiction

In the event of any disputes arising out of this cancellation costs insurance, the claimant may choose to have their case heard before the court at their place of residence in Switzerland or the insurer's registered office (European travel insurance, Basel).

LUGGAGE

1. Geographical scope

The insurance cover applies worldwide.

2. Period of benefits

The insurance cover applies for the duration of the insurance specified in the insurance policy, and for as long and so often as the insured items are taken outside the insured person's permanent residence.

The insurance cover also applies for travel on public transport for as long as the insured items are in the custody of a transport operator.

3. Insured items

All items taken on the journey by the insured persons for their own person necessity are insured.

Sporting equipment, wheelchairs and prams/pushchairs are only covered by the insurance during travel on public transport and for as long as these items are in the custody of the transport operator.

4. Uninsured items

The insurance does not cover the following:

a) Cash and tickets (subject to section 6.1 d);
b) All types of securities, certificates and documents (subject to section 6.1 g);
c) Software;
d) Precious metals, precious stones and pearls;
e) Stamps;
f) Commercial goods and commercial samples;
g) Items of artistic or collector's value;
h) Musical instruments;
i) Surf boards;
j) Motor vehicles, trailers, caravans, boats and aircraft, including all accessories;
k) Items covered by special insurance;
l) Items bought or received as gifts during the period of travel (e.g. souvenirs) that are not personal travel necessities; and
m) Items that are taken on the journey that are not personal travel necessities (gifts, goods for third parties etc.).

5. Insured events

The following events are insured:

a) Theft and burglary
b) Robbery
c) Damage and destruction
d) Loss during travel on public transport; and
e) Delayed delivery (at least six hours) by public transport.

When camping, these events are only insured within official campsites.

6. Insurance benefits

6.1 Scope of benefits

The insurance reimburses the following:

a) in the case of total loss/write-off of insured items, the fair value; the fair value is the item's original purchase price less depreciation of at least 10% per year from the date of purchase; in total, however, a maximum of 60%;
b) in the case of partial damage, the costs of the repairs, up to a maximum of the fair value;
c) for all valuable items, up to 50% of the insurance amount;
d) cash and tickets only in the event of robbery; in such cases, up to 20% of the insurance amount, up to CHF 1,000; for replacement tickets, up to CHF 2,000;
e) breakages, up to 20% of the insurance amount;
f) glasses, contact lenses, prosthetics and wheelchairs, up to 20% of the insurance amount;
g) in the event of theft/loss of a passport, identity card, driving licence, vehicle registration documents and similar document as well as keys, the replacement costs;
h) in the event of theft/loss of credit cards and mobile telephones, the organisation (but not the costs) of having them blocked;
i) if luggage is delivered late via public transport, the costs of absolutely necessary purchases of up to CHF 1,000 per person and up to CHF 4,000 per family/per insurance confirmation and event. Insured persons are not entitled to any reimbursements when travelling back to their place of residence;
j) for non-valuable items left in a closed vehicle, boat or tent, up to 50% of the insurance amount, up to CHF 2,000 per insured journey under individual insurance policies and up to CHF 5,000 under family insurance policies.

6.2 Amount of coverage

Benefits are limited to the insured amount, up to CHF 4,000 per person and up to CHF 10,000 per family/insurance confirmation and event.

6.3 Exclusion of benefits

Benefits are excluded for loss/damage:

a) resulting from wear and tear, damage inflicted by the insured person, weather damage, insufficient or unsatisfactory quality or packaging of the items;
b) resulting from neglect, inattention, loss, dropping or negligence;
c) to items left in a publicly accessibly location outside the insured person's sphere of location, even if for just a short period of time;
d) to items whose value is not deemed sufficient for the item to be kept safe;
e) to valuable items left in a vehicle, boat or tent or handed over to a transport operator for transport, and for as long as these items are in the custody of the transport operator;
f) to items left in vehicles, boats or tents overnight (from 10 p.m. to 6 a.m.);
g) resulting from warlike events or terrorism;
h) due to events involving ionising radiation of any type, in particular the transmutation of atomic nuclei;
i) caused by deliberate or grossly negligent acts or omissions or is a result of a failure to exercise the customary level of due care;
j) arising while intentionally committing criminal acts or attempting to do so.

6.4 Assignment of claims

Once ETI makes a claim payment, the insured person automatically assigns their entire claim resulting from the insurance contract to ETI.

6.5 Liability of insurer

ETI only provides insurance cover to the extent that it is not in breach of any sanctions or restrictions under UN resolutions and is not in breach of any trade or economic sanctions imposed by Switzerland, the European Union or the United States of America, and in the event of claims or other benefits, is only liable to this extent.

7. Obligations regarding conduct while travelling

When they are not being used or worn, valuable items must:

- be handed over to the place of accommodation or a guarded cloakroom for safekeeping; or
- be stored in a locked room that is not accessible to the general public and kept under separate lock and key; bags of any kind, beauty and attaché cases, and jewellery boxes are not considered sufficient for this purpose.

Travel advice issued by the Federal Department of Foreign Affairs (FDFA) on the respective destination, in particular crime there and the associated precautionary measures to be taken, must be taken into consideration and followed.

8. Obligations in the event of a claim

In the event of a claim, the insurer must be notified immediately. The insurer forwards the case to ETI to be processed.

The insured person must

a) in the case of theft or robbery, request from the nearest police station that an official investigation be carried out and that the incident be recorded (police report, report of loss of air ticket etc.);
b) in the event of damage, delayed delivery or loss while the luggage is being transported by the responsible body (hotel management, tour leader, transport company etc.), immediately have the causes, circumstances and extent of the damage be confirmed in a report and request compensation from said body; and
c) after returning from the trip, immediately notify ETI in writing and provide justification for the claim.

The following documents must be submitted to ETI, among others:

a) the original copy of the relevant report (police report, report of loss of air ticket etc.);
b) the original confirmation, receipts purchase confirmations; and
c) a copy of the insurance policy.

Damaged goods must be made available to ETI.

9. Place of jurisdiction

In the event of any disputes arising out of this luggage insurance, the claimant may choose to have their case heard before the court at their place of residence in Switzerland or the insurer's registered office (European travel insurance, Basel).