ÖKK LOSS OF EARNINGS INSURANCE (VVG)

General Insurance Conditions (GIC)

Edition 2024

ÖKK

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ÖKK Versicherungen AG
General Insurance Conditions (GIC)
Edition 1.1.2024

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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 oekk.ch/gic-cc or in your ÖKK agency.

1. Insurance fundamentals

1.1 Purpose

ÖKK LOSS OF EARNINGS INSURANCE (VVG) covers the loss of earnings that is caused by an incapacity to work as a result of an illness.

Cover for a loss of earnings as a result of an accident, birth (childbirth allowance) or paternity (paternity benefit) can also be included.

1.2 Insurance providers

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

The insurance company listed on the insurance policy is authorised to take any action on behalf of and at the expense of ÖKK Versicherungen AG.

1.3 Contract fundamentals

The fundamentals of the contract include

- the insurance application, including any health declarations
- the insurance policy
- Special Conditions (SC) listed in the insurance policy
- Additional Conditions (AC) listed in the insurance policy
- the present General Insurance Conditions (GIC)
- the Federal Act on Insurance Contracts (VVG) of 2 April 1908.

1.4 Insurance policy

The insurance policy states the insurance cover obtained.

SC which differ from the GIC or complement the same are also noted in the insurance policy.

1.5 Insurance Contract Act

Insofar as the insurance contract and GIC do not have any different stipulations, the provisions of the VVG apply.

1.6 Mandated third parties

If a mandated third party represents the inte-rests of the policyholder when concluding or managing this insurance contract, it is possible that the insurer pays the mandated third party a fee for their activities. If the policyholder requires more information on the scope of such a fee, they should contact the mandated third party for details.

2. Insured group of persons

2.1 Policyholder

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

2.2 Insured persons

2.2.1 Employees

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

a) there is a working or training relationship between them and the insured company,
b) they are liable for AHV contributions or would be liable if they were of relevant age or when reaching the AHV reference age continue to be employed in the insured company, and
c) they have not yet turned 70, subject to article 2.2.3 lit. c).

Cross-border workers are in principle treated equally to people who are resident in Switzerland within the scope of the treaty between Switzerland and the EU/EFTA.

2.2.2 Business owners and their family members

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

a) the business owner,
b) their spouse, children or parents, if they work for the business but are not listed in the payroll.

2.2.3 Uninsured persons

The following persons are excluded from the insurance:

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

3. Geographical validity

3.1 General

The insurance applies worldwide with the following exceptions.

3.2 Expatriate employees

For expatriate employees, the insurance applies from the time they leave for a period of 24 months. The insurance cover may be extended upon request, insofar as the said persons are also covered by UVG.

3.3 Stay abroad while ill

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

4. Insurance variants

4.1 Full coverage

4.1.1 Principle

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

4.1.2 Pre-existing illnesses and accidents

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

4.2 Coverage with a health declaration

4.2.1 Principle

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

4.2.2 Pre-existing illnesses and accidents

In the case of illnesses and consequences of accidents that already existed at the time the insurance coverage commenced, the insured benefit will be paid for the duration of the benefit in accordance with scaled coverage. Business owners and their family members are not entitled to benefits in accordance with scaled coverage.

The insured person will be informed in writing of the limitation of coverage by the insurer. It becomes effective as soon as the insurance coverage takes effect.

4.2.3 Health declaration

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

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

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

4.2.5 Policyholder's obligation
The policyholder shall ensure that the insurer receives all necessary details about the insured persons and is obligated to inform the insured persons when they join the insurance scheme of the possible benefit limitations for pre-existing illnesses and consequences of accidents.

4.3 Scaled coverage
4.3.1 Principle
Scaled coverage aims at an unrestricted daily allowance that is in line with the employer's legal obligation to continue paying the salary, in accordance with the Swiss Code of Obligations (OR).

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

5. Commencement, duration and cancellation of the insurance contract
5.1 Commencement of the insurance contract
Insurance coverage will commence on the date agreed in the insurance policy.

The insurance may be taken out at any time, also during the calendar year.

5.2 Duration of the insurance contract
5.2.1 In general
The insurance contract is concluded for the duration specified in the insurance policy. The minimum duration of the contract is one calendar year.

5.2.2 Extension of the insurance contract
After the agreed duration of the contract, the insurance contract shall automatically be renewed for another calendar year unless it is terminated within the stipulated deadline.

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

The cancellation is only valid if it is received in writing and within the prescribed time limit, that is, no later than the last working day prior to the start of the three months' cancellation period.

If the insurance contract is cancelled, the insurer can provide the policyholder with a new insurance offer with a new duration.

5.3.2 Lapse of the insurance contract
The insurance contract will lapse effective immediately

a) if the policyholder stops operating their business, or
b) if the registered office is transferred abroad.

5.3.3 Rescission by the insurer
The insurer is not bound to the insurance contract and may annul it in the following situations:

a) in the case of premium arrears as set forth in the provisions on default of payment,
b) if upon concluding the insurance contract the policyholder provided incorrect information about or failed to disclose a significant source of risk of which they were aware or should have been aware, or
c) if the policyholder provides incorrect information about or fails to disclose facts in the course of the insurance contract which would exclude or reduce the insurer's obligation to pay benefits.

5.3.4 Waiver of termination in case of a claim
The insurer expressly waives its legal right to terminate the insurance contract in case of a claim.

The right to terminate the contract upon expiry thereof remains reserved.

6. Commencement, duration and expiry of insurance coverage
6.1 Start of insurance coverage
Insurance coverage commences on the day on which the employment relationship starts, or the employee is entitled to a salary for the first time, in any case, however, at the time when the employee sets off for work.

Partially disabled persons or handicapped employees who, as a result of their health-related limitations, only work part-time for the insured business, must be fully fit for work on the day on which the employment relationship starts or the employee is entitled to a salary for the first time, in any case, however, at the time when the employee sets off for work, in the agreed part-time job.

6.2 End and interruption of insurance coverage
6.2.1 End of insurance coverage
Insurance protection expires for the insured person

a) once the employment relationship with the policyholder ends,
b) in the case of continued employment after reaching the AHV reference age upon turning 70,
c) upon the final expiry of the entitlement to benefits, in accordance with the agreed duration of benefits in the insurance policy, without applying any remaining ability to work,
d) in the event of death, or
e) upon expiry of the insurance contract.

6.2.2 Suspension of benefit obligation in the case of an interruption to employment
If there is an interruption to employment without entitlement to salary, the insurance cover remains in place. During this period, however, there is no obligation to provide benefits. This is not the case for interruptions to employment as a result of illness or accident, or when serving in the Swiss army, civilian service or civil defence.

If not agreed otherwise, benefits shall be payable at the earliest on the day of the planned resumption of work. The days of working incapacity during the unpaid leave shall be added to the waiting period and the benefit period.

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

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

Cross-border workers can transfer to individual insurance if they continue to work in Switzerland immediately after ceasing to belong to the collective daily allowance insurance and cannot transfer to another collective allowance insurance policy, or are deemed to be unemployed within the meaning of the Federal Law on Compulsory Unemployment Insurance (AVIG) and are entitled to daily allowances from unemployment insurance. If the new income is lower than the previously insured salary, the right of transfer is limited to the new income.

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

If the employer does not provide any such notice, the insured person's right of transfer shall be asserted in writing within 180 days of ceasing to belong to the collective insurance scheme.

Should the insured person receive additional coverage (article 8.2.4), the period starts after expiry of the obligation to provide benefits in the case of a medically certified ability to work of at least 50%. In this case, information is provided by the insurer. The individual insurance commences one day after ceasing to belong to the insured group of persons, after ceasing to receive benefits, or after the insurance contract has expired.

The conditions and rates of the individual insurance apply that are applicable at the time of the transfer, including the provisions on the maximal insured daily allowance.

The provisions for additional coverage remain reserved.

6.3.2 Employer's obligation to provide information
The policyholder is obligated to inform insured persons who cease to belong to the collective insurance in writing of the right of transfer and of the deadline for transferring to individual insurance in time.

If the policyholder does not meet this obligation to provide information, they shall be liable for all costs associated with the resulting claim.

6.3.3 Scope of the continuation of insurance
The continuation of insurance will generally be within the scope of the current insurance coverage, but no higher than the new earned income.

A maximum income of CHF 300,000 per year is insured.

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

Unemployed persons as defined in the Federal Act on Compulsory Unemployment (AVIG) Insurance may convert their insurance for an appropriate premium adjustment, regardless of their state of health, into an insurance policy with a 30-day waiting period.

The amount of the insured daily allowance is reduced to the level of the unemployment benefit at the beginning of unemployment.

6.3.4 Imputation of benefits already drawn
Benefits already drawn
– from this collective insurance scheme
– from previous insurers
are imputed to the duration of benefits of the individual insurance.

6.3.5 Exclusion of the right of transfer
No right of transfer exists

a) in the case of a new job with a new employer and transfer to its loss of earnings insurance scheme,
b) if the policyholder has concluded a new insurance contract for this group of persons with another insurer and the latter must, due to the agreement on the free movement of persons, guarantee the continuation of insurance coverage,
c) as long as benefits are paid within the scope of additional coverage. The exclusion is limited to the degree of the inability to work,
d) when the insured person draws an AHV pension, but upon reaching the AHV reference age at the latest,
e) if the insured person lives abroad and is not subject to the provisions concerned freedom of movement,
f) for the duration of a provisional cover note, or
g) if the benefits in the collective contract have been exhausted and there is no remaining ability to work.

7. Scope of insurance

7.1 Amount of the insured daily allowance

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

7.2 Basis of assessment

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

It is an indemnity insurance policy.

7.2.2 Employees
The basis of assessment for employees is the earnings lost through the insurance event. Lost earnings are the last salary liable for AHV contributions received by the policyholder before the insurance event, including any salary components that have not yet been paid and to which a legal claim exists. Taxable or AHV tax exemptions for persons of AHV reference age do not have any influence on the extent of the basis of assessment.

Salary adjustments resulting from a change to the degree of employment or general salary increases are only considered if there is a legal entitlement or if it can be proved that this had been agreed before the claim arose.

Family income supplements that are paid to the employee as child benefits or education benefits pursuant to the provisions of the Family Allowance Law (FamZG) and the family allowances in agriculture (FLG) by the social security office are considered past earned income and are co-insured.

For employees who are not liable for AHV payments, the agreed upon gross salary applies in place of the salary liable for AHV contributions, pursuant to AHV standards.

Earnings from other employment will not be taken into consideration.

7.2.3 Irregular income
If the level of earnings is subject to strong fluctuations, the average salary earned in the last 12 fully accounted for months before the employee lost their capacity to work is taken into consideration.

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

7.2.4 Persons with a fixed salary amount
The basis of the assessment for the persons named in the insurance policy is the fixed salary amount agreed in advance.

In the event of an insurance claim, there is no need to provide proof of income.

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

7.2.6 Increasing the insurance coverage
A health declaration is required for an application to increase an agreed fixed salary amount.

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

7.3 Maximum coverage
The amount of the insured salary per person and year is limited to CHF 300,000 for salaries from all co-insured company units.

If the total salary, when drawn from multiple co-insured company units, exceeds the maximum salary of CHF 300,000, the salary must be reduced accordingly on a percentage basis (in relation to the insured maximum salary of CHF 300,000) for the salary declaration for the relevant company units.

8. Benefits
8.1 Conditions for benefits
8.1.1 Principle
Benefits are covered provided there is a medically necessary, objectifiable inability to work as a result of illness (or accident/birth, to the extent the risk in question is covered).

The insurer is entitled to reject a benefit claim if the inability to work is primarily a result of non-medical factors or the diagnosis provided does not justify an inability to work.

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

8.1.3 Accident
Accident means the sudden, unintentional, harmful influence of an exceptional external factor to the human body, resulting in an impairment of physical or mental health or death.

Occupational illnesses which are acknowledged as accidents under the UVG are likewise classified as accidents.

8.1.4 Inability to work
An inability to work is the complete or partial inability to perform reasonable work in the previous profession or area of responsibility by reason of an impairment of the physical, mental or psychiatric health.

Should the period of inability to work last more than 90 days, the reasonable activity in any other profession or area of responsibility will also be considered.

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

8.1.5 Occupational disability
Occupational disability is the complete or partial inability to perform work in the balanced employment market in question, which is caused by an impairment of physical, mental or psychiatric health and still remains following suitable treatment and reintegration into work.

Only the consequences of the health-related inability to perform work shall be taken into account when assessing whether an inability to work exists. An inability to work is only deemed to exist if this inability cannot objectively be overcome.

8.1.6 Medical certificate
A medical certificate must be provided in order to confirm the inability to work. The certificate must be issued by a physician or a chiropractor who is approved by the insurer.

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

8.2 Scope of benefits
8.2.1 General
Benefits are determined in accordance with the agreed scope of insurance and the existing General Insurance Conditions.

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

8.2.2 Fulfilment of collective bargaining agreements (CBA)
If the employees are subject to a collective bargaining agreement (CBA) with different conditions, these only apply provided and to the extent that the policyholder has expressly agreed CBA-compliant coverage for the insured group of persons.

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

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

Relapses do not entitle them to further benefits.

This additional coverage does not apply
- if another insurer is entitled to free movement of capital in the event of an assumption of contract,
- in case of a job change and transfer to the loss of earnings insurance scheme of the new employer,
- when the insured person draws an AHV pension, but upon reaching the AHV reference age at the latest,
- if the insured person moves abroad; cross-border workers' country of residence is considered equivalent to Switzerland,
- if the employment contract has been terminated during the probationary period, or
- if the work was of a temporary nature lasting three or fewer months. In the case of temporary work lasting more than three months, the entitlement to benefits only lasts for as long as the employment relationship would have lasted.

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

The persons specifically listed in the policy with a fixed salary amount are exempt from the provisions governing additional coverage. These persons are entitled to benefits until the end of the case of illness which justifies the entitlement, however no longer than the agreed duration of the benefit. There is no premium exemption for this entitlement to benefits in accordance with article 10.4.

8.2.5 Accident

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

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

8.2.6 Family income supplements

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

In the event of suspension of child and education benefits by the social security office as a result of the inability to work caused by illness, accident, or maternity, these are taken into account in the amount of the insured daily allowance for the daily allowance benefit, provided that it is an insured event.

The policyholder must apply for this benefit to the insurer in writing, with respect to the insured person, while submitting proof that the child and education benefits provided by law are discontinued.

8.2.7 Suspension of benefit obligation in the case of maternity

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

The days spent unable to work during this period count towards the waiting period and duration of benefits.

8.2.8 Childbirth allowance

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

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

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

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

No childbirth allowance will be paid if the employment relationship of the insured person with the policyholder ends before the birth.

For pregnancies which existed prior to the start of the contract there is no entitlement for the supplementary parental allowance in addition to the childbirth allowance to the Income Compensation Act (EOG) except in the case of vested benefits when taking over the contract.

The policyholder can request that it be examined whether additional benefits can be added on. To do so, the policyholder's HR regulations must include provisions governing maternity leave.

8.2.9 Paternity benefit

The paternity benefit must be requested by the policyholder and is not automatically insured.

Family members who are not listed on the payroll, self-employed workers and company owners are not insured.

Fathers are entitled to the paternity benefit when they become entitled to the paternity allowance under the Income Compensation Act (EOG); the paternity benefit supplements the paternity allowance.

For the duration the paternity allowance is drawn, but for a maximum of 14 days, the difference between paternity allowance and the insured paternity benefit is paid. The paternity benefit is not paid if the insured person's employment relationship with the policyholder ends before the paternity leave. If the paternity leave has already begun when the contract begins, there is no entitlement to addition paternity benefit in addition to the paternity allowance under EOG, except within the scope of a vested benefit when a contract is transferred.

The policyholder can request that it be examined whether additional benefits can be added on. To do so, the policyholder's HR regulations must include provisions governing paternity leave.

8.3 Commencement of benefits

The entitlement to a benefit begins once the agreed waiting period has passed.

The waiting period begins on the first day of inability to work, according to the medical certificate, but no earlier than 3 days before the first medical treatment. In the absence of an agreement to the contrary, the waiting period will be re-determined for each case of illness or accident.

8.4 Duration of benefits

8.4.1 Principle

The duration of benefits is listed in the insurance policy and calculated – with the exception of scaled coverage – according to the particular insurance event. Days of partial inability to work count as full days for the purpose of calculating the duration of benefits.

The insured person may not stall the expiry of the entitlement to benefits by not claiming the daily allowances.

If, after the agreed duration of benefits has expired, a new insurance event occurs, this event shall be covered by the insurance if the insured person has completely or partially made use of his remaining capacity to work.

If a fixed sum has been agreed, this will be adjusted in line with the remaining capacity to work.

8.4.2 Imputation of the waiting period

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

8.4.3 New insurance event

The recurrence of an illness or of the consequences of an accident (relapse) is classified as a new insurance event if the insured person was fully fit for work for a period of 365 days without any interruption since the last occurrence of the same illness or the same consequences of an accident.

In the event of a relapse within 365 days, the waiting period passed and the benefits paid will be imputed.

8.4.4 Second insurance event

If, during an insurance event, a new insurance event occurs, the days relat-

ing to the first event for which an entitlement to benefits exists will count towards the duration of benefits for the second event.

8.4.5 Scaled coverage
With scaled coverage, the duration of benefits paid under the obligation to continue salary payments is based on the length of time the insured person has worked at the insured company. The following scale applies:

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

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

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

8.4.7 Duration of benefits in the event of birth
The maximum duration of benefits in the event of birth is 112 days.

The childbirth allowance amount, which is the difference between the maternity benefit and the insured childbirth allowance, will lapse as soon as the person starts working again.

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

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

The daily allowances in the event of birth will not count towards the maximum duration of benefits.

8.4.8 Duration of paternity benefits
The duration of paternity benefits is 14 days.

The paternity benefit amounting to the difference between paternity allowance and the insured paternity benefit ends when the insured person restarts work.

The paternity benefit is paid without a waiting period being applied.

The paternity benefit will not count towards the maximum duration of benefits.

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

The insurance benefit is paid without determining a waiting period.

8.4.10 Reference age
From when the AHV pension is drawn, but upon reaching the AHV reference age at the latest, there is an entitlement to benefits for a maximum of 180 days for all current and future insurance claims together.

In the case of an ongoing insurance event, the daily allowance will still be paid for a maximum of 180 days from when the AHV pension is drawn, but upon reaching the AHV reference age at the latest, but for no more than the agreed duration of benefits, provided the insured person or the policyholder proves to the insurer that the employment relationship would have continued if he was able to work.

8.4.11 Imputation in the case of assumption of contract
In the event of an assumption of contract or a renewal of contract, any benefits already drawn from previous insurers will count towards the duration of benefits.

8.5 Limitation of benefits

8.5.1 Exclusion of benefits
There is no entitlement to insurance benefits

a) for consequences of accidents and occupational illnesses which are to be covered by a different insurer,
b) in the case of participation in warlike actions, unrest, and similar events, and during military service abroad,
c) in the case of illnesses and accidents as a consequence of active participation in punishable actions, fights, and other acts of violence, unless the insured person was injured as an uninvolved bystander or while rendering assistance to a defenceless person,
d) if the person's health is damaged as a result of non-medically prescribed ionising radiation,
e) if the insured person temporarily leaves Switzerland or his country of residence while being unfit for work without the insurer's approval, coverage will cease until they return to Switzerland or his country of residence, or
f) if the insured person's health is damaged intentionally (also as a consequence of a suicide attempt or self-harm) and there is not an entitlement to claim under the UVG,
g) if, during the inability to work, the insured person is placed in custody or is the subject of a criminal sentence or measures, or
h) in the event of an inability to work resulting from operations that are not medically necessary (e. g. cosmetic surgery).

8.5.2 Limitation of benefits
Benefits may be reduced

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

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

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

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

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

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

9.1 Obligations in the event of a claim

The inability to work must be reported no later than five days after the expiry of the waiting period by way of an illness notification form.

In the case of agreed waiting periods of more than 29 days, the inability to work must be notified to the insurer in writing no later than 30 days after it began by way of an illness notification report. The doctor's certificate must be enclosed with the illness notification report.

The waiting period shall only begin when the notification of the inability to work has been received. However, the duration of benefits begins on the first day of the inability to work.

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

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

9.2 Reduction of damage

The insured person must do everything in their power that can help to reduce the benefit, in particular what speeds recovery. They shall avoid doing anything that will delay it. In particular, they must follow the instructions of medical professionals. The insurance company is entitled to check that the medical instructions are complied with and can put in place suitable corrective measures.

The insured person has to provide evidence of loss of earnings. If they cannot provide evidence of loss of earnings, there is no entitlement to benefits.

The insured person who is likely to remain wholly or partially unfit for work is obligated to make use of any remaining fitness for work they may have.

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

a) register with the appropriate disability insurance office within six months after the start of the inability to work,
b) consult a doctor already on the first day of the inability to work, and
c) agree to an examination by a second doctor or by the insurer's independent medical examiner. The insurer is liable for the associated costs.
d) seek specialist treatment,
e) submit the documents required to process the claim.

The entitlement to benefits is interrupted if the insured person does not comply with one of these requirements. The entitlement recommences once they are met again. The duration of the interruption is offset for the entire duration of benefits.

9.3 Obligation to provide information

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

The insured person shall release the doctors and other medical professionals treating them from the duty of non-disclosure to the insurer. If necessary, the insurer may obtain information from other insurers.

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

If any of the submitted doctor's certificates and reports are not in German, French, Italian, Romansch or English and there is not a notarised translation attached, these will be translated at the cost of the insured person where the insurer requires this.

9.4 Breach of the obligation to cooperate

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

If the insured person fails to attend a medical examination required by the insurer without excuse, the insurer reserves the right to invoice the insured person for the fee for the missed consultation.

9.5 Withholding tax

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

10. Premiums and payments

10.1 Premium calculation

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

In determining the tariff, the risk premium is calculated for a risk pool (same business types/activities) on the basis of the NOGA code.

10.1.2 Risk premium for a risk pool
The risk premium for a risk pool (same business types/activities) is recalculated every year.

10.1.3 Individual premium for individual contracts
The policyholder's risk premium is calculated based on the sector they belong to (risk pool), the size of the contract (salary amount), the individual claims history/frequency and the composition of the group of insured persons (e.g. age structure and gender). These factors can be weighted differently.

10.1.4 Business owners and their family members
For persons listed by name (e. g. business ow-ners and their family members), on joining the insurance policy, the premium will be increased on a one-time basis by an age premium from the 40th year of age.

10.2 Decisive total salary

The decisive factor for the calculation of premiums is the gross payroll of the insured person that is liable for AHV contributions and is obtained from the insured business. The agreed maximum coverage is the most that can be considered per person and year.

Gross salaries of persons not liable for AHV contributions are also decisive for calculating premiums provided that they belong to the scope of insured persons.

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

10.3 Payment of premiums

10.3.1 Billing and due date

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

The policyholder is liable for the premiums in advance and must pay them within the deadline stipulated in the insurance policy.

The total amount of the bill on account is calculated based on the definitive total payroll of the last completed calendar year.

10.3.2 Final statement

The insurer will supply the policyholder with a declaration form once the calendar year has come to an end. The policyholder shall return the total payroll declaration to the insurer with the necessary documents (AHV declaration, list of insured persons, payslips etc.) within one month. Based on these details, the insurer will calculate the definite premium contributions and compile a corresponding final bill. No subsequent payments or reimbursements shall be made for balances under CHF 20. The amount is carried over to the next statement.

If the policyholder does not comply with the obligation to provide the payroll declaration, or if there are no numbers concerning the previous year, the insurer can stipulate the future bill on account premiums by estimate.

At least the annually agreed minimum premium in accordance with the insurance policy is charged.

10.3.3 Inspection of payroll accounting

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

10.3.4 Reimbursement of premiums

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

The premiums for the current insurance period shall be owed in full if the policyholder terminates the contract in the event of a claim and the insurance contract had been in force for less than one year at the time it was terminated.

10.3.5 Default of payment

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

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

If no payment is made within the extended deadline despite the reminder, the obligation to pay benefits will be suspended from the expiry of the warning period until the outstanding premiums, including interest and administrative costs, have been paid in full.

For insurance events occurring while the obligation to pay benefits has been suspended, there shall be no entitlement to benefits even if the outstanding payments are subsequently paid.

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

If the outstanding premium on account or final bill is not collected with due legal effect within two months of the expiry of the reminder period, the insurance contract will lapse.

10.4 Waiver of premium in case of a claim

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

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

The insurer may still debit the annually agreed minimum premium in accordance with the insurance policy.

10.5 Premium rate guarantee

Taking into account various risk factors (sector, size of company, individual claims history etc.), the insurer decides whether a premium rate guarantee for the agreed contract duration is agreed with the policyholder.

The policyholder can see if such an agreement has been made in the policy under Special Conditions.

10.6 Premium adjustments

The insurer may adjust the premiums as a result of changes in costs for the risk pool or as a result of the individual claims history of individual contracts. Premiums may also be adjusted as a result of a combination of both these factors.

10.6.1 As a result of changes in costs of the risk pool

At the end of the contract, a premium adjustment may be made as a result of changes in collective costs of a risk pool (same business types/activities) on the basis of the NOGA code.

A premium adjustment may also be made if, at the time the contract is amended, the classification of the contract does not correspond to the new annually calculated risk premium rate of the risk pool (same business types/activities) on the basis of the NOGA code. This is also possible for claim-free contracts of those with low levels of claims. In such a case, a maximum of the risk premium rate (same business types/activities) is charged.

10.6.2 As a result of the individual claims history of individual contracts

At the end of the contract, a premium adjustment may be made if the total of the benefits paid out for claims (incl. provisions for ongoing claims) in the observation period is higher than the risk premiums of the individual contract.

The observation period is decisive when assessing the individual claims history. It includes the previous insurance duration, but up to a maximum of the six years preceding the adjustment.

In determining the new premium amount, the claims history/frequency and the composition of the group of insured persons (e.g. age structure and gender) is taken into account.

10.6.3 Notification deadline

Policyholders are notified of any premium adjustments by no later than 60 days before the end of a calendar year. The policyholder shall have the right to terminate the insurance contract until the end of the current year as at the time the adjustment takes effect. If no notice of termination is issued, the policyholder is deemed to have accepted the premium adjustment. Furthermore, the insurance agreements and the duration of the insurance contract remain unchanged.

10.7 Increase or reduction of risk

If there any changes to a fact material to the determination of risk (in particular the type of activity performed by the insured company/occupation, activity of the insured persons) during the duration of the contract, ÖKK must be informed immediately in writing form.

If there is an increase in risk, ÖKK may increase the premium accordingly as of the time the risk increases or terminate the contract in writing within four weeks of having received notification, with a notice period of four weeks. If the premium is increased as a result of the risk increasing, the policyholder has the right to terminate the contract in writing form within four weeks of having received notification. In both cases, ÖKK has the right to increase the premium as per the tariff from the time the risk increases until the end of the contract.

If there is a significant reduction of risk, the policyholder is entitled to terminate the contract in writing form with a notice period of four weeks or to demand that the premium be reduced. If ÖKK refuses to grant a premium reduction or if the policyholder does not agree to the reduction offered, the latter is entitled to terminate the contract in writing form within four weeks of receipt of the decision by the insurance company with a notice period of four weeks.

10.8 Surplus sharing

Surplus sharing may be agreed.

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

The surplus will be determined by deducting the insurance benefits paid from the decisive premium share for the accounting period. The applicable portion of the premium and the surplus sharing system are mentioned in the insurance policy.

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

If cases of illness or consequences of accidents which occur in the completed accounting period, are subsequently notified or further payments are made once the bill has been sent, a new surplus sharing bill will be compiled. The insurer may reclaim surplus shares that have already been refunded.

The entitlement to have a share of the surplus lapses if the insurance contract is revoked before the end of the accounting period.

10.9 Payment of benefits

10.9.1 Payment of daily allowances in case of illness and accident

The daily allowance will be paid upon being fully fit for work again according to the medical certificate. If the inability to work lasts for more than one month, the daily allowance will be paid in arrears on a monthly basis.

The daily allowances will be paid to the policyholder to pass on to the insured persons, provided that the latter are employed by the policyholder.

10.9.2 Payment of childbirth allowance

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

10.9.3 Payment of paternity leave

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

10.9.4 Billing

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

10.9.5 Pledge and assignment

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

10.9.6 Statutory limitation

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

11. Benefit coordination

11.1 Reduction, over-compensation and repayment

11.1.1 General provisions regarding the reduction, over-compensation and repayment of benefits

If a third party is liable for a reported case of illness or an accident as a result of unlawful acts, the contract or legal provisions, the insurer will subsequently increase the benefits up to the amount of the insured daily allowance.

Reductions are made in the case of benefits measured on the basis of the salary liable for AHV contributions as well as benefits paid out on the basis of a fixed salary amount.

When calculating the duration of benefits and waiting period, days with reduced benefits shall be treated as whole days. This also applies if the reduction results in the insurer not providing any benefits.

Within the scope of the benefit claims against third parties, no obligation to pay benefits exists.

11.1.2 Reductions in the case of social insurance benefits

If social insurers are liable for benefits, the insured daily allowances will be reduced by the amount received in the form of benefits from social insurance schemes (daily allowances, pensions etc.).

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

11.1.3 Reductions in the case of multiple line insurance

If several insurers are obligated to pay benefits, the insurer shall be liable for damages in line with the ratio of its insurance amount to the total amount of all insurance amounts.

The policyholder shall notify the insurer immediately of any existing or newly concluded daily allowance insurance policies with other insurers.

11.1.4 Annulment in case of multiple insurance policies

If the policyholder did not know that multiple insurance policies were in place when they concluded the subsequent contract, they can terminate this contract in writing. This must be done within four weeks of becoming aware of the multiple insurance policies.

If the policyholder intentionally failed to report this or took out multiple insurance policies with the intention of making an illegal pecuniary gain, the insurer is not bound by the contract with the policyholder.

11.1.5 Over-compensation

If, despite the possibility for benefits to be reduced, an insured person is over-compensated, the insurer may demand repayment of the benefits provided, reduce future benefits or directly offset them against social insurance benefits. In particular, the insurer may demand benefits back directly from the Swiss Federal Disability Insurance.

The over-compensation limit is the amount of the insured daily allowance.

11.1.6 Waiver of benefits

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

11.2 Advance payment of benefits and recourse

Advance payment may be made by the insurer in relation to third parties. A requirement is that the insured person must have made reasonable efforts to enforce their claims without success and is willing to assign their claims against third parties to the insurer within the scope of the benefits provided.

11.3 Overinsurance

11.3.1 AHV salary amount

Neither the policyholder nor the insured person may make any gains from benefits paid by the insurer, third parties or social insurance schemes. In the event of overinsurance, the benefits in case of illness and accidents are reduced accordingly. Benefits paid in excess of this amount will be reclaimed.

When calculating the duration of benefits and waiting period, days with reduced daily allowance benefits shall be treated as whole days.

11.3.2 Fixed salary amounts

The scope of benefits corresponds to the agreed daily allowance amount. Benefits from social insurers (KV, UV, IV, MV, AHV, AVI, EO, BV, FamZG, FLG etc.) will be taken into account.

12. Data privacy

12.1 Principle

The processing of the data of insured persons complies with the provisions of the Insurance Contracts Act and the Federal Act on Data Security.

12.2 Processing purpose

The insurer will only process data (e.g. personal data, information on health conditions, examining the information provided in the application, collection, benefit processing) that are required for processing the insurance contract pursuant to VVG. The insurer will treat all information obtained with utmost confidentiality.

12.3 Disclosure of information to third parties for processing

The insurer can transfer data processing wholly or in part to a third party (e.g. data processing centre). In doing so, the insurer will make sure that the data will be processed only in the manner in which it would process them itself. In other cases, the insurer will only provide information with the insured person's consent.

12.4 Data storage

The insurer will store the data diligently and will protect them from unauthorised individuals by applying appropriate technical and organisational measures.

13. Notifications

Notifications from the insurer are made with legal validity in writing to the insured person or the policyholder.

The insurer must be informed in writing of any changes that are important for the insurance scheme, in particular changes in relation to the composition of the insured group of persons, the collective bargaining agreement (CBA) or the Regulation of occupational pensions (BVG) provisions.

Where these GIC require notification in writing, it is sufficient to provide notification in another form that also provides evidence in text form.

14. Place of jurisdiction

In the event of any disputes arising out of the insurance contract, the claimant may choose to have their case heard before the court at the insured person's place of residence in Switzerland or the insured person's place of work in Switzerland or the insurer's registered office.

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