General conditions of insurance (GCI)

Sympany Insurance Ltd.

2008 Edition

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1. General provisions

1.1. Purpose

The purpose of loss of earnings insurance for companies is to provide cover in case of loss of earnings which is due to the incapacity to work as a result of sickness. The cover of loss of earnings as a result of accident and birth (birth benefit) can also be included.

1.2. Insurer

The insurer is Sympany Insurance Ltd., Basel (hereinafter referred to as Sympany).

1.3. Basis of contract

The basis of the contract is formed by
- the insurance application, including any possible health declarations
- the insurance policy
- the Special Provisions listed in the insurance policy
- these present General conditions of insurance (GCI)
- the federal law on insurance contracts (VVG) dated 2 April 1908.

1.4. Insurance policy

The insurance policy sets out the insurance cover agreed to. Special provisions or agreements which deviate from or complement the general conditions of insurance are also noted in the insurance policy.

1.5. Insurance contract act

Insofar as there are no deviating regulations in the insurance contract or the GCI, the provisions of the federal law on insurance contracts dated 2 April 1908 (VVG) apply.

1.6. Gender

Sympany subscribes to gender equality. Any use of masculine forms in these GCI also includes female persons.

2. Group of insured persons

2.1. Policyholder

The policyholder is the company and associated business divisions specified in the insurance policy, or the natural person that concludes the contract.

2.2. Insured persons

2.2.1. Employees
The insurance covers all natural persons or groups of persons that are specified in the insurance policy,
- that are subject to AHV, and
- that have not yet completed their 70th year, or on attaining AHV age were already employed by the policyholder and fully able to work

Cross-border commuters are insured under the same conditions.

2.2.2. Insurance based on special agreements
Special agreements are required to insure the following:
a) short-term temporary help (i.e. temporary help with a contract limited to a maximum of three months),
b) part-time employees and hourly-rate employees who are not insured against the consequences of non work-related accidents pursuant to UVG,
c) home workers,
d) persons with their residence abroad who are neither cross-border commuters nor expatriates nor short-stay employees.

2.2.3. Company owners and family members
The following are also insured provided they are named in the policy with details of their fixed payroll total:
a) the company owner,
b) his spouse, children or parents who actively work in the company but do not appear in the payroll accounting.

2.2.4. Non-insured persons
Excluded from the insurance are
a) employees on loan to the policyholder from third-party companies,
b) persons who work for the insured company on a contract basis.

3. Geographical validity

3.1. General

The insurance is valid worldwide with the exceptions below.

3.2. Expatriates

For expatriates the insurance will be valid for 24 months from the date of posting abroad. On request, insurance cover can be extended, as long as UVG cover is also in place.

3.3. Travelling abroad in the event of sickness

If a sick and insured person who has a right to benefits travels abroad, no benefits may be claimed for the duration of the stay abroad without the prior approval of Sympany.
This restriction does not apply to cross-border commuters when staying in Switzerland.

4. Insurance options

4.1. Full cover

4.1.1. Principle
Full cover is coordinated with BVG and has as its purpose an unconditional insurance for loss of earnings until the start of the BVG pension.

4.1.2. Prior sicknesses and accidents
In case of full cover, benefits are also provided for sicknesses and the consequences of accidents which were already in existence at the start of the insurance cover.

4.2. Cover with health declaration

4.2.1. Principle
Cover with health declaration has as its purpose an insurance of loss of earnings due to sickness and the consequences of accidents which arise after the start of the insurance cover.

4.2.2. Prior sicknesses and accidents
For sicknesses and the consequences of accidents which were in existence at the start of the insurance cover, insured benefits are provided according to scaled cover for the duration of the benefits.
Company owners and their family members do not have a right to benefits according to scaled cover.
Sympany will inform the insured person of the cover restriction in writing. The restriction comes into effect at the start of the insurance cover.

4.2.3. Registration
The policyholder must notify Sympany of every new employee in the company in writing.

4.2.4. Health declaration
In order to check prior sicknesses and the consequences of accidents, a health examination will be carried out for a new company employee which is based on a declaration of the insured person using the form provided by Sympany.

4.2.5. Duty to disclose
The insured person is obliged to declare to Sympany all sicknesses and consequences of accidents which are or were in existence at the start of the insurance cover. Sympany may require a medical certificate or an examination by a medical examiner. Sympany can determine the doctor and will bear the costs.

4.2.6. Policyholder's obligation
The policyholder must ensure that Sympany receives all required details about the insured person. He is obliged to inform the insured persons, on their entry into the insurance cover, of any possible benefit restrictions due to prior sicknesses and the consequences of accidents.

4.3. Scaled cover

4.3.1. Principle
Scaled cover has as its purpose an unconditional provision of daily benefits, adjusted to the employer's statutory obligation to continue paying salaries pursuant to the Swiss Code of Obligations.

4.3.2. Prior sicknesses and accidents
With scaled cover, benefits are also provided for sicknesses and the consequences of accidents which were already in existence at the start of the insurance cover.

5. Commencement, duration and termination of insurance contract

5.1. Commencement of insurance contract

Insurance cover commences on the day agreed in the insurance policy. The insurance contract may be concluded at any time during the calendar year.

5.2. Duration of insurance contract

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

5.2.2. Extension of insurance contract
At the end of the agreed contract term, the contract is automatically renewed for a further year, provided the contract has not been cancelled in due time.

5.3. Termination of insurance contract

5.3.1. Cancellation
The insurance contract can be cancelled in writing by both parties to the contract to the end of the calendar year, subject to a period of notice of three months. The earliest possible cancellation date is the expiry date specified in the insurance policy.

5.3.2. Lapse of insurance contract
The insurance contract lapses with immediate effect
a) if the policyholder ceases his business activities,
b) if the registered office is relocated abroad,
c) if bankruptcy proceedings are instituted against the policyholder.

5.3.3. Dissolution by Sympany
Sympany is not bound to this contract and can cancel it:
a) if premiums are in arrears pursuant to the provisions regarding payment default,
b) if, at the time of concluding the insurance contract, the policyholder incorrectly stated or concealed material facts which he knew or had to know, or if the policyholder states facts that are false or conceals facts during the course of the insurance contract which would exclude or reduce Sympany's duty to pay benefits.

5.3.4. Waiver of right to cancel in the event of a claim
Sympany expressly waives its statutory right to cancel the contract in the event of a claim. It reserves the right to cancel the contract with effect from the expiry date of the contract.

6. Commencement, duration and termination of insurance cover

6.1. Commencement of insurance cover

Insurance cover begins on the day of starting work at the policyholder's company.

For persons who are not fully able to work at the start of insurance cover or on the day of starting work, the insurance cover only begins when they are fully able to work.

Partially disabled or handicapped employees who, as a result of the impairment of their health, perform only part-time duties in the insured company, must be fully able to carry out the duties for the agreed part-time employment on the day of starting work.
If insured persons have a right to more favourable conditions based on freedom of movement agreements, these conditions will take precedence.

6.2. End of insurance cover

For the insured person, insurance cover ends
a) on termination of the employment relationship with the policyholder,
b) on retirement,
c) in the event of continued employment after attaining AHV age, on completion of his 70th year of life,
d) on final exhaustion of his right to benefits,
e) in the event of a period of absence from work without any salary entitlement. Insurance cover does not lapse during periods of absence from work due to sickness, accident or service in the Swiss Army, civil service or civil defence; insurance cover for sickness that occurs during an unpaid leave of up to 210 calendar days can be included; the existence of a special agreement insurance pursuant to UVG is the prerequisite for insurance cover for sicknesses that occur from the 31st day of the period of absence from work,
f) in the event of death,
g) on termination of the insurance contract,
h) during the suspension of the duty to pay benefits as a result of a payment default on the part of the policyholder.

6.3. Transfer to individual insurance

6.3.1. Right to transfer
Each insured person residing in Switzerland may transfer to individual insurance
– upon withdrawal from the group of insured persons of the group insurance
– upon the end of receiving benefits, or
– upon the end of the insurance contract
The right to transfer must be asserted in writing within three months of the orientation on the right to transfer.

Individual insurance commences one day after withdrawal from the insured group of persons, after the end of receiving benefits or after the end of the insurance contract.

The conditions and tariffs for individual insurance which are valid at the time of transfer will apply.

This remains subject to the provisions for additional cover.

6.3.2. Employer's duty to inform
The policyholder is obliged to notify the withdrawing insured person, in writing and in good time, of the right to transfer and the period for transferring to individual insurance.

If the policyholder does not carry out this duty to inform, he is responsible for the compensation of any resulting damage.

6.3.3. Scope of continued insurance
On principle, continued insurance will retain the scope of the existing insurance cover, to the extent that it corresponds with the new earnings level.
Persons who are not in gainful employment can obtain insurance up to the level of a single AHV maximum pension.
Unemployed persons pursuant to the federal law on obligatory unemployment insurance may convert their insurance into an insurance with a waiting period of 30 days, subject to a corresponding premium adjustment and irrespective of their health status.

The amount of the insured daily benefit will be lowered to the level of the unemployment compensation at the beginning of unemployment.

6.3.4. Taking benefits already received into account
Benefits already received
– from this group insurance
– from previous insurers
will be taken into account regarding the duration of individual insurance benefits.

6.3.5. Exclusion of right to transfer
There is no right to transfer
a) in the event of a change of employer and transfer to that employer's loss of earnings insurance,
b) in the event that the policyholder has concluded a new insurance contract for this group of persons with another insurer who must warrant the continuation of insurance cover based on the Free Movement of Persons Agreement,
c) as long as benefits are provided in line with additional cover,
d) when the insured person retires, at the latest on attainment of the AHV retirement age,
e) for insured persons with their residence abroad,
f) during the period of provisional cover.

7. Scope of insurance

7.1. Amount of insured daily benefit

The amount of the daily benefit is agreed between the policyholder and Sympany.

7.2. Basis of assessment

7.2.1. Principle
The daily benefit is calculated as one 365th of the average and insured loss of earnings in one year. The daily benefit thus determined is paid for each calendar day.

7.2.2. Employees
The earnings lost as a result of the insured event form the basis of assessment for employees. Such earnings lost refer to the last AHV-liable salary drawn from the policyholder prior to becoming incapacitated for work, including salary items legally due but not yet paid.

For persons not subject to AHV, the agreed gross salary as per AHV norms will apply instead of the AHV salary.

Income received from other activities will not be taken into account. If earnings are subject to major fluctuations (e.g. commissions, profit sharing, irregular temporary work, etc.), then the daily benefit will be calculated by dividing by 365 the earnings achieved in the last 12 months prior to becoming incapacitated for work. If the period of time prior to becoming incapacitated for work amounts to less than 12 months, then the daily benefit will be calculated on a pro rata basis.

7.2.3. Persons with fixed payroll total
The fixed payroll total agreed to in advance forms the basis of assessment for the persons named in the insurance policy.

7.2.4. Managing Director
Managing Directors who are considered employees based on legal stipulations may make an application to insure a fixed payroll total.

7.2.5. Increase of insurance cover
A health declaration is required for the increase of an agreed fixed payroll total. Any possible benefit restrictions or rejection of the application will only be applied to the insurance increase.

7.3. Maximum cover

The amount of the insurable earnings per person and year is limited to CHF 250,000.

8. Benefits

8.1. Requirements for benefits

8.1.1. Sickness
Sickness is defined as an impairment of physical or mental health which is not the result of an accident and which requires medical examination or treatment and results in incapacity to work.

8.1.2. Accident
Accident is defined as a sudden, non-intentional injury to the human body by an extraordinary external factor, which results in an impairment of physical or mental health. The following, conclusive list of injuries to the body are considered equivalent to accidents even without any extraordinary external factors being involved, insofar as they are not clearly the result of sickness or degeneration.
a) bone fractures
b) dislocation of joints
c) meniscus tears
d) muscle tears
e) pulled muscles
f) tendon tears
g) ligament lesions
h) ear drum injuries

Also considered equivalent to accidents are occupational illnesses which are recognised as such pursuant to UVG. No body injury in line with the above paragraph is represented by non accident-related damage to objects which were used as a result of a sickness and substituted for a body part or body function.

8.1.3. Right to maternity benefits
The right to a birth benefit originates with the right to maternity benefits according to the federal law on income compensation (EOG).

8.1.4. Incapacity to work
Incapacity to work is given when the insured person is wholly or partially unable to carry out his work duties or another reasonable form of gainful employment due to sickness, accident or birth. Partial incapacity to work is given in cases of an incapacity to work of at least 25 per cent.

8.1.5. Medical certificate
A medical certificate attesting to the insured person’s incapacity to work is compulsory for payment of daily benefits. Backdating of medical certificates and sickness or accident reports is allowed up to a maximum of three days.

8.2. Scope of benefits

8.2.1. General
Benefits are calculated according to the agreed scope of insurance and these present conditions of insurance. The sum of the daily benefits paid may not exceed the earnings lost due to the insured person’s incapacity to work resulting from the insured event, or the agreed fixed payroll total.

8.2.2. Partial incapacity to work
In the event of partial incapacity to work, benefits are paid according to the degree of incapacitation.

8.2.3. Additional cover
Persons who are wholly or partially incapacitated for work at the time of termination of their employment relationship, have a right to benefits until the end of the sickness that forms the basis for the additional cover, at the longest, however, until the expiry of the agreed duration of benefits.

Relapses do not provide a claim for further benefits.

This additional cover lapses
- in the event of another insurer’s right to free movement of persons in case of a contract transfer
- in the event of a change of employer and transfer to the loss of earnings insurance of the new employer
- on termination of the insurance contract
- when the insured person retires, at the latest on attainment of the AHV retirement age
- when foreign employees relocate their residence abroad, excluding the duration of a hospital stay abroad; cross-border commuters are not considered as foreign employees
- for short-stay employees during the shoulder season

If additional cover lapses, the provisions for transfer to individual insurance apply.

8.2.4. Accident
If accident risk is also insured, benefits are calculated according to the scope of insurance agreed in the insurance policy. If the inclusion of accidents is in addition to the obligatory accident insurance pursuant to UVG, daily benefits will only be provided to the extent to which the UVG insurer is liable.

8.2.5. Suspension of benefits during maternity periods
During the right to maternity benefits pursuant to EOG or to birth benefits as per this insurance, the duty to provide benefits in the event of sickness or accident is suspended.

8.2.6. Birth benefit
Birth benefits supplement maternity benefits pursuant to EOG.
For the duration of maternity benefits, but at the longest for 98 days, the difference between maternity benefits and the insured birth benefit will be paid.
Birth benefits will be paid at the level of the insured daily benefit for an additional 14 days. Birth benefits will not be paid if the employment relationship between the insured person and the policyholder ends before childbirth.

8.3. Commencement of benefits

Benefits commence after expiry of the agreed waiting period.

The waiting period commences on the day on which the incapacity to work begins as per the medical certificate, at the earliest, however, three days before the first medical treatment. Barring any agreement to the contrary, the waiting periods for each case of sickness or accident will be calculated anew.

8.4. Duration of benefits

8.4.1. Principle
The duration of benefits is specified in the insurance policy and – with the exception of scaled cover – is determined for each insurance case. Days of partial incapacity to work are deemed as full days for the determination of the duration of benefits.

8.4.2. Taking waiting period into account
The agreed waiting period will be taken into account regarding the duration of benefits. Days with an incapacity to work of at least 25 per cent are considered to be waiting days.

8.4.3. New insurance case
Renewed occurrence of sickness or of the consequences of an accident (relapse) are treated as a new insurance case, if the insured person was capable of work for an unbroken period of 12 months since the last occurrence of the same sickness or the same consequences of the accident. The level of employment at the beginning of the insured event will be regarded as decisive.

8.4.4. Scaled cover
With scaled cover, the duration of benefits is in line with the duration of the employment relationship in the insured company, in accordance with the employer's obligation to continue paying salaries. The following scale is used as a basis:

Duration of employment relationship	Duration of benefits
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

If short-stay employees return to the insured company each year, the employment duration will be taken into account, in terms of the total months worked in the company.

8.4.5. Duration of benefits in the event of birth
The maximum duration of benefits in the event of birth is 112 days. Birth benefits, which amount to the difference between the maternity benefit and the insured birth benefit, end when work is resumed. Birth benefits for the additional 14 days will be paid at the insured level, provided there is a right to maternity benefits pursuant to EOG on the day of childbirth. Birth benefits are paid without taking a waiting period into account. Daily benefits in the event of birth are not taken into account regarding the maximum duration of benefits.

8.4.6. AHV age
Insured persons who continue to work regularly for the policyholder after attaining AHV age have a right to the insured daily benefit for a total of 180 days, at the longest, however, until they have completed their 70th year of life. The same provision also applies to the company owner and his family members (spouse, children, parents) who work in the business but do not appear in the payroll accounting.

8.4.7. Taking benefits into account in the event of contract transfer
Benefits already received from previous insurers will be taken into account regarding the duration of benefits in the event of a contract transfer or contract renewal.

8.5. Restrictions to benefits

8.5.1. Exclusion of benefits
There is no right to insurance benefits:
a) for the consequences of accidents and occupational illnesses which must be covered by a different insurer,
b) if the certificate of incapacity to work has been issued by a doctor or chiropractor not recognised by Sympany,
c) if participating in acts of war, unrest or similar activities, and if performing military service abroad,
d) for sicknesses and accidents resulting from active participation in criminal activities, brawls and other acts of violence,
e) if the degree of the insured person's incapacity to work is less than 25 per cent,
f) if, despite reminders, no payment has been made by the policyholder by the end of the reminder period,
g) after termination of the insurance contract,
h) during a period of unpaid leave,
i) if the insured person deliberately draws benefits or attempts to draw benefits not due to him,
j) if the injury to health has been intentionally caused,
k) for injuries caused by nuclear energy,
l) if the insured person temporarily leaves Switzerland during a period of incapacity to work without Sympany's approval, until his return to Switzerland.

8.5.2. Limitations to benefits
Benefits may be reduced:
a) if the sickness or the consequences of an accident are only a part of the cause of becoming incapacitated for work,
b) for injuries to health which are the result of a hazard, i.e. if the insured person exposes himself to a particularly strong hazard without taking or being able to take precautions that would reduce the risk to a reasonable level; rescue activities in aid of persons are excepted; in terms of this provision, a hazard is considered in particular the participation in races or training with motor vehicles,
c) if the insured person repeatedly fails to comply with Sympany's instructions or his doctor's requirements, and demonstrates significant opposition to said instructions and requirements,
d) if the documentation required to substantiate the insurance claim is not provided within four weeks, despite reminders in writing.

Minimum benefits (duration of benefits according to scaled cover) will be paid:
e) for insured temporary staff,
f) during a stay abroad that is not job-related. The full insured benefits will be paid for the duration of a hospital stay abroad,
g) for sicknesses and accidents that are the result of war events which broke out more than 14 days before becoming incapacitated for work,
h) for the consequences of earthquakes and other natural disasters,
i) for epidemic illnesses.

8.5.3. Duty to refund payments
Benefits drawn in error or wrongfully must be returned by the policyholder to Sympany.

9. Duty to assist in case of sickness and accident

9.1. Duties in the event of a claim

The policyholder must notify Sympany within five days of every instance of incapacity to work which could give rise to a claim for daily benefits, indicating whether it applies to an accident or a sickness.

In case of agreed waiting periods of more than 21 days, the instance of incapacity to work must be reported to Sympany in writing, by way of a sickness report, at the latest 30 days after the start of incapacitation.

The medical certificate must be sent to Sympany at the latest ten days after becoming incapacitated for work, and along with the sickness report in case of waiting periods of more than 21 days.

In the event of failure to do so without sufficient justification, Sympany will only provide benefits from the time of receipt of the report. Sympany must be informed immediately if there is a reduction in the degree of incapacity to work.

The notification must be truthful. If benefits are claimed, the insured person or the policyholder, respectively, must make all information available to Sympany, including the requisite medical and administrative particulars.

9.2. Damage mitigation

The insured person must do everything that will contribute to reducing the claim, in particular all that will promote convalescence. He must refrain from doing anything that will delay this. In particular, the instructions given by medical personnel must be heeded.

An insured person who is expected to be either fully or partially incapacitated for work in his chosen profession is obliged to take advantage of any remaining capacity to work.
On request from Sympany or the policyholder, the insured person must
- allow himself to be examined by a second doctor or by Sympany's medical examiner; the costs will be borne by Sympany
- consult a doctor on the first day of incapacity to work

9.3. Duty to disclose

In the event of an accident, the insured person or the policyholder, respectively, provides Sympany with all required information as to how the accident happened and about any third parties involved in the accident.

The insured person absolves the doctors involved with his treatment and other medical personnel from their duty of confidentiality with respect to Sympany. Sympany can, if necessary, obtain information from other insurers.

The insured person and the policyholder will provide Sympany, of their own accord, with information regarding all third-party benefits in the event of sickness, accident and disability. On request, third-party accounts are to be submitted to Sympany.

The policyholder is required to implement the duty to disclose with respect to the insured person.

Sympany may verify the incapacity to work in each case as well as the loss of earnings not covered and, if necessary, institute its own suitable control measures.

9.4. Breach of duty to assist

The insurance benefits will be temporarily or permanently reduced or declined in very serious cases, if the insured person or the policyholder, respectively, breaches the duties arising from these GCI in an inexcusable manner.

9.5. Withholding tax

If the daily benefits are paid to the policyholder for onward payment to the insured person, the policyholder is responsible for the lawful accounting and payment of the withholding tax.

10. Premiums and payments

10.1. Calculation of premium

The calculation of the premium is based on the AHV-liable gross payroll total of the insured company. Only the maximum agreed cover per person and year can be taken into account.

Gross salaries of persons not liable for AHV are also decisive for the calculation of the premium.
If a fixed payroll total was agreed in advance for a person named in the insurance policy, it is considered the basis for calculations.

The insurance premium rate of the insured payroll total is specified in the insurance policy.

10.2. Payment of premium

10.2.1. Invoicing and due date
Sympany issues an advance invoice to the policyholder on a quarterly, semi-annual or annual basis.

The premiums are due in advance by the policyholder and payable by the due date as stipulated in the insurance policy.

The amount of the advance invoice is based on the definitive payroll total of the previous calendar year.

10.2.2. Final account
Sympany will send the policyholder a declaration form after the end of the calendar year. The policyholder must return the declaration of the payroll total with the requisite documents (AHV declaration, lists of insured persons, payroll records, etc.) within one month to Sympany. Sympany will calculate the final premium amounts based on this information and will present a final account. There will be no additional payment or refund if the difference is less than CHF 10.

If the policyholder fails to comply with his duty to report the payroll total, or if there are no figures available for the previous year, Sympany may use estimated figures to determine the definitive final account as well as the future advance premium amounts.

10.2.3. Inspection of payroll accounting
Sympany has the right to inspect the policyholder's payroll accounting.

10.2.4. Refund of premiums
If the premium has been paid in advance for a specific contract term and if the insurance contract is dissolved for statutory or contractual reasons before the expiry of the agreed contract term, Sympany will refund the premium for the remaining contract period, and will no longer invoice any premiums falling due later.

The premium for the ongoing insurance period is due in its entirety if the policyholder cancels the contract in the event of a claim and the contract has been in force for less than one year at the time of the cancellation.

10.2.5. Payment default
If the policyholder's premium payment obligation is not fulfilled within an additional period of 30 days, Sympany will issue a written request that the outstanding premiums be paid within a period of 14 days. The request for payment will draw the attention of the policyholder to the consequences of non-payment.

If, despite issuing the request for payment, no payment is made within this reminder period, the duty to pay benefits will be suspended from the end of the reminder period until the payment of the full amount of the outstanding premiums including all interest and administrative costs. For loss of earnings incurred during the suspension of the duty to pay benefits, there will be no right to benefits even once the arrears have been paid.

If the outstanding advance premium or final account is not forcibly collected within a period of two months after the end of the reminder period, then the insurance contract will lapse.

10.3. Waiver of premium in the event of a claim

As long as the employment relationship at the insured company exists, or benefits are being provided within the scope of additional cover, the duty to pay premiums no longer applies, to the extent of the benefits provided on the basis of this contract.

Insured persons with a fixed payroll total who are listed in the insurance policy are excepted from this provision.

10.4. Premium adjustments

A change in premium as a result of claims experience can be carried out if the benefits (inclusive of reserves) provided within the observation period exceed 75 per cent of the premiums paid. The current and at least two previous calendar years are considered as the observation period.

The policyholder will be notified of premium adjustments at the latest 30 days before the end of the calendar year. The policyholder has the right to cancel the insurance contract within 30 days of the notification, to the time of its effectiveness. If there is no cancellation, this is considered as an approval of the premium adjustment.

10.5. Profit participation

Profit participation may be agreed to.

If profit participation is agreed to, the policyholder will participate in any profit made after three full insurance years in each case (= accounting period).

The profit will be determined by subtracting the insurance benefits paid from the decisive premium share collected in the accounting period. The decisive premium share and the profit participation system are mentioned in the insurance policy.

An account will be issued as soon as the premiums related to the accounting period have been paid and the corresponding claims have been completed. Losses will not be carried forward to the next accounting period.

If any further cases of sickness or consequences of an accident are reported after issuing the final account, or if further payments are made which relate to the closed accounting period, then a new calculation of the profit participation will be made. Sympany can request the refunding of profit participation amounts already paid out.

The right to profit participation lapses if the insurance contract is dissolved before the end of the accounting period.

10.6. Provision of benefits

10.6.1. Payment of daily benefits in the event of sickness and accident
Daily benefits will be paid after regaining the capacity to work based on a medical certificate. If the period of incapacity to work lasts for more than one month, daily benefits will be paid out monthly in arrears. Daily benefits are paid to the policyholder for onward payment to the insured persons, as long as they are employed by the policyholder.

10.6.2. Payment of birth benefit
The birth benefit will be paid to the policyholder for onward payment to the insured person after childbirth, based on verification of benefits pursuant to EOG.

10.6.3. Settlement
Sympany can settle benefit payments due against receivables from the policyholder.

10.6.4. Pledging and assignment
Amounts owing to Sympany cannot be pledged nor assigned without the consent of Sympany.

10.6.5. Limitation
The policyholder's right to benefits from Sympany is limited to two years after the occurrence of the event which formed the basis of Sympany's duty to pay benefits.

11. Third parties

11.1. Subsidiarity

11.1.1. General
If a third party is liable for a reported case of sickness or accident for legal reasons or default, then Sympany will subsequently supplement the benefits up to the amount of the insured daily benefit.

Within the scope of an insured person's rights to benefits from third parties, there is no duty to pay benefits according to these GCI.

11.1.2. Multiple insurance
If several insurers are liable, a calculation will be made to determine how much each insurer would have to pay if it was the sole insurer. This is also the case if the other insurers' liability is only subsidiary. The indemnity according to these GCI is limited to that portion of the total insured sum which corresponds to this cover.

11.1.3. Social insurances
If social insurances are liable, the insured daily benefits will be reduced by the amount of the social insurance benefits. Such benefit claims must be lodged with the respective social insurance.

The insured person assigns to Sympany any titles to additional payments from social insurances (KV, UV, IV, MV, AHV, AVI, EO, BV, family supplements for agriculture, etc.).

11.1.4. Waiver of benefit
If insured persons wholly or partially waive benefits from third parties, without the consent of Sympany, the duty to pay benefits according to these GCI will no longer apply. This waiver includes the realisation of a right to benefits.

11.2. Advance benefits and recourse

Sympany can provide advance benefits with respect to third parties, except for social insurances. The prerequisite for this is that the insured person has, within reasonable limits, unsuccessfully endeavoured to assert his claims against a third party, and assigns these claims to Sympany within the scope of the benefits provided.

11.3. Excessive compensation

11.3.1. Employees
The insured persons or the policyholder, respectively, may not make a profit from the benefits according to these GCI, taking into account benefits from third parties. In the event of over-insurance, benefits will be reduced accordingly. Refunding of any excess payments made will be requested. Days with partial benefits due to reductions as a result of claims for benefits from third parties are counted as full days for the calculation of the duration of benefits and the waiting period.

11.3.2. Insured persons with fixed payroll total
The scope of benefits corresponds to the agreed daily benefit. The provisions regarding over-insurance do not apply. On the other hand, no benefit claims are acknowledged which are the responsibility of social insurances (KV, UV, IV, MV, AHV, AVI, EO, BV, family supplements for agriculture, etc.).

11.3.3. Daily benefit insurances with other insurers
The policyholder must immediately notify Sympany of any existing or newly concluded daily benefit insurances with other insurers.

12. Notifications

Notifications by Sympany are legally valid when provided in writing to the insured person or the policyholder. Changes which are of major significance to the insurance, in particular with regard to the composition of the group of insured persons, to the collective labour agreement or to the BVG regulations, have to be notified to Sympany in writing within 30 days.

13. Jurisdiction

For litigation arising out of the insurance contract, the plaintiff may elect to have recourse to the court at the Swiss domicile, at the Swiss place of employment or at the registered office of Sympany.

This text is a translation. In the case of discrepancies the German version shall prevail.

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