General terms and conditions of insurance (GTC) under the Federal Insurance Contract Act (ICA)

2022 edition

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General terms and conditions of insurance

1 Insurance fundamentals

1.1 Purpose
By way of addition to the KVG (Federal Health Insurance Act) health insurance, additional insurance and further types of insurance are provided pursuant to these general terms and conditions of insurance.

1.2 Insurance providers
The insurance providers are the insurance companies listed in the individual insurance departments (henceforth referred to as the insurers).

1.3 Insured person
The insured person is the person specified in the insurance policy. The policy holder is the contracting party receiving insurance cover for himself and/or for other people by concluding the insurance contract. Where reference is made to the insured person in these general terms and conditions of insurance (GTC) and associated special terms and conditions (STC), this should also be understood as reference to the policyholder.

1.4 Insurance cover
The insurance covers the financial consequences of illness, accident and maternity for the period for which the insurance is concluded.

Accident cover may be excluded where this is stipulated in the provisions of individual insurance departments.

1.5 General terms and conditions of insurance (GTC)
The GTC regulate the insurance relationship unless special provisions are stipulated in the individual agreement. The GTC apply to all the insurance departments listed below. Details of benefits are set out in the special terms and conditions on the individual insurance departments. Where the individual insurance departments differ from the general terms and conditions of insurance, the special terms and conditions of the individual insurance department take priority.

1.6 Conditions governing group insurance
The GTC also apply to group insurance for treatment costs. The individual group agreement may contain different conditions, in particular in respect of affiliations, scope of benefits, premium fixing, duration of insurance, termination and the division of rights and obligations between the policyholder and the insured person. The provisions of the group agreement take priority over the general insurance conditions. The insured person is entitled to inspect the terms of the group agreement relating to the insurance relationship.

1.7 Conditions for the framework contracts
The GTC also apply to the framework contracts for treatment costs. In the individual framework contract, deviating conditions can be agreed between the framework contract partner and the insurer. These agreements concern, for example, administrative simplifications or a framework contract discount. The framework contract partner and the insurer may amend or cancel the framework contract discount. The insured person will be notified of a framework agreement discount adjustment 30 days in advance. The insured person is then entitled to withdraw from the insurance department concerned within 30 days of notification by the insurer, with effect from the date on which the framework agreement discount adjustment comes into effect.

The insured person concludes the insurance contract directly with the insurer. The conditions in the framework contract shall take precedence over the General Terms and Conditions of Insurance. The insured person shall be made aware of any conditions that apply to him/her before the contract is concluded. The terms of these General Terms and Conditions of Insurance shall apply unless other provisions are made in the framework contract. The insured person is entitled to obtain information from the insurer regarding conditions in the framework contract that relate to the insurance relationship.

1.8 Federal Insurance Contract Act (ICA)
Save where otherwise stipulated in the contractual provisions, the provisions of the Federal Insurance Contract Act of 2 April 1908 shall apply. This regulation also applies to insurance contracts concluded before 1 January 2022.

2 Insurance departments

2.1 Insurance possibilities
The insurance departments pursuant to these GTC are the following indemnity or lump-sum insurance plans.

Indemnity insurance: In the event of entitlement to the benefit, the insurer will pay the insured person the due benefit costs, taking into account any excesses, limits and/or other contractually agreed maximum amounts.
- plus
- premium
- general supplement
- private supplement
- hospita general, semi-private, private, private accident, global, flex, comfort,
- private patient supplement for inpatient treatment
- salto
- mondial
- dental
- compensa
- tourist
- protect

Lump-sum insurance plans: In the event of entitlement to the benefit, the insurer will pay the insured person the agreed sum regardless of whether the insured person has suffered damages.
- capita accident
- capita illness

Individual insurance departments are managed with mondial variants.

2.2 Changes in insurance departments
Insurance departments may be adjusted to changing needs, supplemented or redistributed by the insurer, while safe-guarding existing rights.

2.3 Selected insurance departments
The insurance policy specifies the insurance departments chosen. Special provisions or agreements which differ from the general insurance conditions are also specified in the insurance policy.

3 Insured persons

3.1 Individual insurance
Insured persons are listed in the insurance policy.

3.2 Group insurance
Classes of persons covered by or eligible for insurance cover are specified in the group contract. The persons or groups of persons listed in the insurance policy are insured.

4 Start and duration of the insurance

4.1 Procedure for arranging insurance
4.1.1 Application
The insurance application is submitted in writing using the preprinted insurer form. The questions on the form must be answered truthfully and in full. Persons not competent to act on their own behalf can only be insured by their legal representative.

4.1.2 Obligation to provide information
If inaccurate or incomplete information is provided, the insurer may terminate the policy within four weeks of the date on which it becomes aware of the fact. Cancellation of the policy entails the lapse of the insurer's obligation to pay benefits for past insured events insofar as the inaccurate or incomplete information is relevant. If the benefit has already been paid, the insurer is entitled to a refund.

In submitting the application, the applicant authorizes the insurer to obtain from medical practitioners and other insurers the information needed to conclude the insurance and clarify its subsequent obligation to pay benefits.

The insurer may require a medical certificate or order a medical examination at its own expense. The insured person must make sure that he/she is able to provide the necessary information about the insured person.

4.1.3 Refusal or exclusion of benefits
The insurer may refuse applications or exclude individual benefits from the insurance cover.

4.1.4 Documentation
When the policy is concluded the insured person receives
- the policy document,
- the special terms and conditions,
- the general terms and conditions of insurance.

4.1.5 Binding period
Any person who applies to the insurer for insurance is held to that application for 14 days if they have not specified a shorter period for the application's acceptance. If the insurer requires a medical examination, the person submitting the application is held to the application for four weeks.

4.1.6 Right of cancellation – definition
The insured person may cancel his application to conclude the contract or the declaration regarding its acceptance in writing. The cancellation period is 14 days and starts on the day on which the insurance person applied for or accepted the contract. The insured person will have met the deadline provided that he has informed the insurer of his wish to withdraw or posted his declaration of withdrawal by the final day of the cancellation period. The right of cancellation in the case of agreements with a term of less than one month is excluded. Insofar as injured third parties are able to assert claims against the insurer in good faith despite a cancellation, the premium is payable by the insured person and the insurer cannot contest the claim of the injured third party on the grounds of invalidity of the contract.

4.1.7 Right of cancellation – effect
A cancellation renders the insured person's application to conclude a contract or declaration of acceptance invalid from the outset. The parties must refund any benefits already received. The insured person does not owe the insurer any additional compensation. Where deemed appropriate, the insured person must reimburse the insurer, in part or in full, for the costs of any special investigations carried out by the insurer in good faith in connection with the conclusion of the contract.

4.2 Start of insurance
Insurance begins on the date specified in the policy document.

4.3 Duration of insurance
4.3.1 Insurance term
The insurance runs in each case for one calendar year from 1 January to 31 December.

4.3.2 Longer insurance period
If insurance is taken out for a period of at least three full calendar years, a discount may be granted.

4.3.3 Time of conclusion of the insurance
The insurance may be taken out at any time during the calendar year. The premium will then be calculated on a pro rata basis.

4.3.4 Extension of insurance
At the end of each year the insurance contract is tacitly extended by a further year unless the insured person has given the required notice of termination.

Any changes made by the insurer take effect at the beginning of the new policy term.

4.4 Change of insurance
4.4.1 Changes by the insured person
Applications to amend the insurance contract with increased cover or for which a health declaration is required are treated as applications for a new insurance contract.

If the insurance cover is reduced, the provisions on notice of termination shall apply.

4.4.2 Changes by the insurer
If, after conclusion of the insurance, far-reaching changes occur in the background conditions affecting the provision of insurance against the financial consequences of illness, maternity and accident, such as an increase in the number of medical personnel or new categories of medical personnel, extension of the range of medical services, introduction of new cost-intensive forms of therapy or medication and similar developments or amendments to the legislation on social insurance, the insurer is authorized to adjust the insurance provisions accordingly.

The insured person is notified of these new contractual conditions 30 days before they come into force at the beginning of the new policy term. The policyholder is then entitled to withdraw from the insurance departments concerned within 30 days of notification and with effect from the date of the contract change. If no notice of termination is given by the insured person, he/she shall be deemed to have consented to the new contractual conditions.

4.5 Suspension of insurance

4.5.1 Condition

Cancellation of the insurance may be requested for all or some of the insurance departments, provided that evidence of other insurance cover is supplied. The procedure for the conclusion of a new policy (application, obligation to provide information, possibility of rejection, documentation, right of cancellation) also applies to the agreement on suspension. A reduced premium is charged during the suspension period.

4.5.2 Duration and scope of suspension

Suspension begins after the application has been made, but not before the beginning of the month in which the reason for suspension occurred. Suspension must be requested for at least three months and may be concluded for a period of up to six years. A subsequent extension of the suspension may be requested. If the insurer cannot agree to such extension, the contract lapses. A contact address in Switzerland must be given for persons resident abroad. When the reason for suspension ceases to exist, the insurance cover is revived in full if this is requested within 30 days. If the insurance cover is not reactivated within this period, the insurance lapses without further formalities.

5 Termination of insurance

5.1 Termination by the insured person

5.1.1 Ordinary termination

Written notice of termination of the policy or of an insurance department may be given by 30 September of any year to take effect on 31 December. The right to stipulate different notice provisions for individual insurance departments is reserved.

5.1.2 Termination in the event of a claim

After every event for which the insurer has paid benefits, the insured person may give written notice of withdrawal from the relevant part of the contract, i.e. from the relevant insurance department, within 14 days of disbursement or of his becoming aware that the insurer was going to pay benefits. The premium is payable until the contract is terminated.

5.1.3 Right of transfer on termination of the group contract

Insured persons whose cover lapses when a group contract is terminated are entitled to switch to an individual insurance contract with the same level of insurance. Any switch to a higher level of insurance cover shall necessitate making a new health declaration. This right of transfer must be exercised within 30 days of the end of the collective agreement.

No right of transfer exists if the insured person has signed a new group agreement for the same persons with a different insurer.

5.2 No termination by the insurer

The insurer does not terminate the contract on expiry of the contract or in the event of a claim. The right to terminate the contract due to attempted or actual insurance fraud is reserved.

5.3 Other grounds for termination

a) on the death of the insured person,
b) on removal abroad (except for cross-border commuters, employees posted abroad or if a **mondial** policy is taken out),
c) on reaching the age limit stipulated for insurance cover,
d) on the exhaustion of the rights to draw all the benefits in an insurance department,
e) if the contract is not extended after reaching the maximum policy term (max. 36 months, extension by an additional 36 months possible) for **mondial** or in the event of a suspension,
f) if the insured person is subject to the statutory insurance requirement in Switzerland or in the country of residence in the course of the insurance relationship or exemption from this requirement expires, **mondial** shall expire as at the date that the statutory insurance requirement once again applies, however no earlier than the end of the month in which the insurer receives a corresponding notification.

6 Benefits

6.1 Definitions

6.1.1 Sickness

Sickness means any impairment of physical, mental or psychological health which is not the consequence of an accident and which necessitates a medical examination or treatment or results in incapacity.

6.1.2 Accident

Accident means the sudden, unintentional harmful effect of an exceptional external factor on the human body, resulting in an impairment of physical, mental or psychological health or death. If they are not unambiguously attributable to an illness or degeneration, the following types of physical injury are always equated with accidents even without any unusual external influence, this list being exhaustive:
a) broken bones,
b) dislocated joints,
c) torn meniscus,
d) torn muscles,
e) strained muscles,
f) torn tendons,
g) ligament lesions,
h) eardrum injuries.

Damage to objects inserted following an illness to replace a body part or a body function that was not caused by an accident do not constitute physical injury within the meaning of the above paragraph.

Occupational illnesses acknowledged as accidents under the Swiss Federal Law on Accident Insurance (UVG) are also classified as accidents.

6.1.3 Maternity

Benefits in connection with pregnancy and childbirth are the same as those for illness if at the time of the birth the mother has been covered by the insurer for at least 270 days, or in the event of equivalent previous insurance by another insurer if the insurer confirms that the insurance application was submitted at least 270 days before the birth.

6.2 Scope of benefits

6.2.1 Geographical scope

The insurance applies in principle to benefits provided in Switzerland and to emergency treatment worldwide. The provisions on geographical validity set out in the insurance provisions of the individual insurance departments take precedence.

For cross-border commuters, insurance protection also covers benefits provided at their place of residence.

6.2.2 Temporal scope

An entitlement to benefits exists for the duration of the insurance. No entitlement to benefits exists for costs incurred after the termination of the insurance. Determining factors are the treatment date or the time when the insured benefit is claimed. Obligations to periodically provide benefits within the meaning of Art. 35c ICA remain reserved.

6.3 Insured benefits

6.3.1 Benefit coverage

Insured benefits are those provided under the cover specified in the policy and the provisions for individual insurance departments.

6.3.2 Economical treatment

Treatment is covered if it is economical, effective, expedient and medically necessary. In other words, the costs of medical treatment are met if it is confined to actions which are in the interests of the insured person and conducive to the purpose of the treatment.

In order to ensure that its insured persons receive optimum treatment, the insurer may agree associated measures with approved service providers with the object of providing the most effective, expedient and economical treatment for the insured person through improved cooperation and coordination between itself and service providers. The insurer may instruct a health consultant to take these measures.

If bills are manifestly excessive, the insurer may reduce the benefits accordingly or make payment conditional on the assignment of a claim for a reduction.

6.3.3 Treatment by recognized medical personnel

Treatment by medical personnel or medical institutions is insured if they are recognized under the KVG. Benefits provided by other persons or institutions are insured in cases where provision for this is made in the individual insurance departments.

6.4 Limitation of benefits

6.4.1 Pre-existing illnesses and accidents

The insurer may decline to cover illnesses and consequences of accidents that exist or had previously existed at the time when the policy is concluded. Alternatively it may reject the application in its entirety. For complementary insurance with reservations, the benefits that were already covered in the former insurance department are subject to no restrictions in the new insurance department or class.

The insured person is notified in writing of the limitation of cover.

6.4.2 Exclusion of benefits

a) in respect of illnesses and consequences of accidents already in existence when the policy was concluded that were excluded from cover by the insurer,
b) in respect of illnesses and consequences of accidents already in existence when the application was submitted that were disclosed either partially or not at all,
c) during a waiting period,
d) if a treatment does not serve to remedy a health problem or its consequences, except for measures to prevent the threatened occurrence or deterioration of a health problem if the patient was already ill,
e) for treatment by a service provider not recognized by the insurer,
f) for dental treatment for which the relevant insurance department does not expressly provide cover,
g) while cover is suspended,
h) in the event of late payment, from the expiry of the reminder period until all liabilities have been met in full,
i) if the insured person is involved in acts of war, unrest and similar events and during foreign military service,
j) in the case of illness or accident as a consequence of warlike events which began more than 14 days previously,
k) in the case of illness or accident as a consequence of active involvement in criminal actions, fights and other acts of violence,
l) for the consequences of earthquakes and other natural disasters,
m) for the health consequences of major industrial incidents or accidents involving nuclear power,
n) for organ transplants for which the Swiss Association for the Community Tasks of Health Insurers (SVK), Solothurn, has agreed flat-rate charges, regardless of where the transplant is conducted,
o) for statutory and agreed cost shares applying to compulsory health care insurance,
p) for epidemic diseases.

All other benefit exclusions and limitations are specified in the provisions relating to the individual insurance departments.

6.4.3 Limitation of benefits

Benefits can be reduced:

a) if statutory reporting obligations or obligations stipulated in the ICA are breached in the event of a claim,
b) if an illness or accident was the result of gross negligence, particularly the abuse of alcohol, drugs or other substances,
c) in the event of health damage attributable to a hazardous action, i.e. if the insured person exposes himself to an especially serious risk without taking or being able to take precautionary measures to reduce the risk to a reasonable level. This does not include actions taken to rescue persons. The term hazardous action within the meaning of this provision includes, in particular, participation in motor vehicle races or training for them, or in hazardous sports unless these are organized, operated and supervised by qualified professionals. The insurer keeps a list of all sports considered to be hazardous. This list is not exhaustive and can be viewed by the insured persons at any time,
d) if the health damage was caused deliberately, including as a consequence of attempted suicide or self-harm,
e) if the documentation needed to process the insurance claim is not forthcoming within four weeks despite a written reminder.

However, benefits will not be limited if

a) the insured person was not at fault for the circumstances described above or
b) the insured person proves that the breach of contract had no impact on the occurrence of the event, nor on the scope of the services due on the part of the insurer.

7 Obligations in the event of sickness or accident

7.1 Notification obligation

Insured persons must submit their benefit claims to the insurer within the time limits specified in the provisions for individual

insurance departments. The occurrence of an accident must be reported within a maximum of ten days.

The report must be truthful. Where benefits are claimed, the insurer must be supplied with full information together with the necessary medical and administrative particulars.

Only detailed, legible original bills will be accepted.

7.2 Damage limitation

The insured person must do everything possible to reduce the damage, in particular taking every action conducive to recovery and refraining from any action that might delay it. The insured person shall assist the activity of the health consultant in the framework of associated measures taken by the insurer and shall give him any information required.

7.3 Obligation to provide information

Where the insurer is concerned, the insured person releases medical practitioners and other medical personnel, together with insurers, from their confidentiality obligation. The insurer may seek such information as is necessary.

On request, the insured person must agree to an examination by a second doctor or by the insurer's medical consultant. The insurer will bear the costs.

The insured person must inform the insurer about all benefits provided by third parties in the event of illness, accident and invalidity. On request, invoices issued by third parties must be submitted to the insurer.

In the case of persons not competent to cut on their own behalf, the insured person must ensure that the obligation to provide information is met.

8 Premiums and payments

8.1 Fixing the premiums

8.1.1 General

Premiums for each insurance department are set out in rate tables.

8.1.2 Amount of premiums

The amount of premiums is determined by reference to risk, for example, by reference to the insured's age (or age groups), place of residence, or the proportion of the risk to be borne by the insured person himself or his insurer.

Premium changes as a result of switching to another risk group are made automatically. The insurer reserves the right to introduce new maximum age ranges in response to changing demographics. The age ranges are shown at the end of the Special Terms and Conditions for the respective insurance department.

A reduced premium is charged for suspended insurance.

8.1.3 Family discount

Premium discounts may be granted for families, in particular for children up to 18 years of age, in cases where a policy is concluded for a period of at least three full calendar years or if a couple arranges identical cover.

A children's discount is subject to the following conditions:

- where the insurance term is at least three years: One parent must have at least the same insurance cover with the insurer as the child and they must live together in the same household (family policy).
- for premium exemptions for the third child and subsequent children: The two oldest siblings, aged up to 25 and living together in the same household (family policy), must have at least the same insurance cover with the insurer.

8.2 Adjustment of premium scales and cost sharing

Premium scales and cost sharing may be adjusted in the light of costs and the pattern of claims. The family discount is excluded from the adjustment.

Insured persons are given 30 days' advance notice of premium adjustments. The policyholder is entitled, within 30 days of notification by the insurer, to withdraw from the relevant insurance department with effect from the date on which the premium adjustment is due to take effect. Premium adjustments due to an automatic switch to a higher or new maximum age range give rise to an extraordinary right of termination on the same terms.

If no notice of termination is given, the policyholder is deemed to have consented to the premium adjustment.

8.3 Premium payment

8.3.1 Due date

Premiums are payable in advance in accordance with the due dates and days of grace specified in the premium demand. Premiums must be paid without interruption, i.e. in the event of accident, illness, pregnancy and maternity, incapacity or when the entitlement to benefits is suspended.

If the insurance begins or ends during a calendar month, the premium is payable for the whole month.

8.3.2 Payment arrears

If the obligation to pay a premium or a cost share is not met by the insured person within a further period of 30 days, a written reminder is issued to settle the outstanding premiums or cost shares within 14 days. The reminder notifies the insured person of the consequences of failing to make payment.

The costs of reminders and any additional enforcement costs incurred in connection with outstanding payments are charged to the insured person.

If no payment is made despite the reminder, the obligation to provide benefits for treatment or loss of income shall be suspended from the expiry of the grace period until the outstanding premiums, plus interest and administrative costs, have been settled in full.

For illnesses, accidents and their consequences which occur while the obligation to provide benefits is suspended, no insurance cover is in force even if the outstanding sums are subsequently paid.

The insurer may withdraw from the contract at any time after the expiry of the reminder period. If the outstanding premium is not collected with due legal effect within two months of the expiry of the reminder period, the contract lapses.

8.4 Profit share

8.4.1 Principle

If the insured adult person presents a favourable risk profile, he or she may benefit from any excess, i.e. the insurer's net profit.

8.4.2 Condition

A condition for a possible profit share is that the insured per-

son must not have drawn any benefits from the insurer for at least one calendar year. This applies to all insurance departments, including compulsory health care insurance or daily allowance insurance pursuant to the KVG.

8.4.3 Disbursement
Any profit share is paid in the form of a single nonrecurring payment, at least one year after the calendar year in which no benefits have been drawn. It can only be paid to persons who are insured with the insurer at the time of the disbursement.

8.5 No-claims discount (NCD)
8.5.1 Principle
In the variant with a no-claims discount, a premium discount is granted if no claims are made.

8.6 Other payment provisions
8.6.1 Offsetting
The insurer may offset any benefits against claims on the insured person or policyholder. The insured person and the policyholder have no right of offset vis-à-vis the insurer.

8.6.2 Pledging and assignment
Claims against the insurer cannot be pledged or assigned without its consent.

8.6.3 Disbursement of benefits
Service providers' fees, subject to any agreement to the contrary between them and the insurer, are payable by the insured person. The insurer disburses benefits to the insured person by credit transfer to his bank or post office account. Account details must be supplied to the insurer in good time. If beneficiaries request a different disbursement method, the insurer may make a charge in respect of the additional costs incurred.

If other agreements and charge scales exist between the insurer and service providers, the insurer makes direct payments to them. In the event of direct payment to the benefit providers by the insurer, the insured person is required to reimburse the insurer with the agreed cost participation within 30 days of billing.

Fee agreements between the invoice issuer and insured persons are not binding on the insurer. A benefit entitlement exists only within the framework of the charge scale acknowledged by the insurer for the corresponding service provider. Benefits paid without justification are reclaimed by the insurer.

8.6.4 Time barring
The insured person's entitlement to benefits from the insurer expires within five years after the occurrence of the circumstance that gave rise to the insurer's liability to pay benefits.

For contracts concluded after 1 January 2022, a limitation period of five years applies with respect to the liabilities of the insured person. For contracts concluded before 1 January 2022, a limitation period of two years applies with respect to the liabilities of the insured person.

9 Third-party benefits

9.1 Subsidiarity
9.1.1 General
If a third party is liable for a reported case of illness or accident by law or through its own fault, the insurer is not liable to provide benefits or is at most liable to pay the amount not otherwise covered.

There is no obligation to provide benefits under the present terms and conditions of insurance to the extent that claims exist against third parties.

9.1.2 Public benefits
There is no obligation to provide benefits under these terms and conditions of insurance to the extent that claims to benefits or reductions exist against cantonal and local authorities.

9.1.3 Multiple insurance
If multiple insurance policies apply, each insurer shall be liable for the damages at a ratio matching that of their sum insured as a proportion of the total sum insured. This also applies if the other insurers only have a secondary obligation to pay benefits.

9.1.4 Waiver of benefits
Where insured parties waive benefits from third parties in whole or in part without the consent of the insurer, the obligation to provide benefits under these terms and conditions of insurance shall lapse. Capitalization of a benefit claim is also treated as a waiver.

9.2 Social insurance
No benefits covered by social insurance schemes (KV, UV, IV, MV, AHV, AIV, etc.) will be paid. Benefit claims must be registered with the insured person's social security scheme.

9.3 Advance payment of benefits and redress
Advance payments may be made in relation to third parties other than the social insurance schemes. A requirement is that the insured person must have made reasonable efforts to enforce his claims without success and is willing to assign his claims against third parties to the insurer in the amount of the benefits provided.

9.4 Overinsurance
The insured person must not gain any profit on the benefits provided under these general terms and conditions of insurance when the benefits paid by third parties are taken into account. In the event of overinsurance, the benefits are reduced accordingly.

10 Customer card

Persons insured with the insurer receive a personal customer card from the insurer. This serves to identify them to service providers.

Otherwise the general conditions of insurance relating to compulsory health insurance and the associated special terms and conditions apply.

11 Data protection

Data about insured persons is processed in accordance with applicable data protection law, particularly in accordance with the applicable provisions of the Federal Data Protection Act (DSG). In the course of this, Sympany Versicherungen AG treats the category of data requiring special protection, e.g. health data, in accordance with the aforementioned Federal Data Protection Act.

If data processing is entrusted to a third party, the insurer shall ensure that data are processed only as they would be by itself.

The insurer only obtains and processes data (e.g. personal particulars, information about the state of health, verification of the details given in the application, cash collection, claim processing) required for the insurance contract to be processed pursuant to the ICA. The insurer treats the information obtained as completely confidential.

The insurer forwards data to third parties only if the disclosure is directly related to the implementation of the contract. This applies in particular when data is disclosed to an insurance provider if, in an insurance department, provision is made for collaboration with an insurance provider other than Sympany Versicherungen AG. In other cases, the insurer provides information only with the consent of the insured person.

The insurer shall store the data carefully and take appropriate technical and organizational measures to prevent unauthorized access to the data.

Detailed information on data protection can be found online at www.sympany.ch/data-protection

If Sympany Versicherungen AG works with another insurance provider in an insurance department, further particulars can be found in the insurance provider's own privacy policy.

12 Notices

The insurer must be notified in writing of changes in the personal circumstances of insured persons that are material to the insurance, such as a change of domicile, within 30 days. If the insured person fails to meet his obligation to report a change in his personal circumstances relevant to premium calculation, any difference in the premium is due retroactively. A contact address in Switzerland must be supplied for persons resident abroad.

All written communications must be sent in written form or another form which allows for evidence of the communication to be supplied in text form. If the communication is sent in another form which allows for evidence of the communication to be supplied in text form, it must be possible for the insurer to identify the insured person.

All communications must be sent to the insurer by the insured person. The channels of communication available for this purpose, through which the insured person can contact the insurer, will be – where permitted by law and jurisdiction – indicated by the insurer and can be viewed at www.sympany.ch/messages

Written notices from the insurer are sent with legal validity to insured persons at their last known address or at the contact address in Switzerland, or by means of the policyholder's journal.

13 Jurisdiction

In the event of disputes arising from policies under these general terms and conditions and any special provisions, the complainant may refer the matter to the courts at his Swiss place of residence or at the place of business of the insurer.

14 Technicalities

The German version of these GTC as well as the STC is the original version. The French, Italian, and English versions are translations. In case of any discrepancies regarding their content, the German version is authoritative.

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