GROUP DAILY BENEFITS INSURANCE

GENERAL INSURANCE CONDITIONS (GIC) UNDER THE INSURANCE CONTRACT ACT (ICA).

Edition 2012

BECAUSE HEALTH IS EVERYTHING SWICA

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Client information

Your daily sickness benefits insurance at a glance

Dear Client
This document governs the provisions of daily sickness benefits insurance by SWICA. The introduction offers an overview of the most important aspects of the insurance. This client information is not legally binding; the following General Insurance Conditions apply.

Who is the insurance carrier?
SWICA Healthcare Insurance Ltd., Römerstrasse 38, 8401 Winterthur.

Who is insured?
The insurance covers the persons and groups defined in the policy.
The insurance does not cover individuals who have reached the age of 70.

What is insured?
The insurance covers illnesses that result in incapacity for work of at least 25 % (Art. 13). Health disorders resulting from pregnancy or birth are considered to be the same as an illness.
The recurrence of an illness is defined as a relapse. Such a case is regarded as a new illness only if the insured person was again fully fit for work at his contractual working hours without interruption for at least 365 days at the time of incapacity for work resulting from the relapse (Art. 15).

What is not insured?
- Illnesses that already existed when the person joined the insured company or the insurance contract began and that result in incapacity for work. The provisions of the agreement among daily sickness benefits insurers on the free movement of persons are reserved;
- Accidents;
- Occupational illnesses and accidentlike physical impairments that are covered under the UVG;
- Illnesses resulting from warlike incidents or acts of terror;
- Health impairments resulting from ionizing radiation.

What benefits does the daily sickness benefits insurance include?
- Daily benefits starting from incapacity for work of at least 25 % (Art. 13);
- Childbirth benefits supplementary to statutory maternity allowance (Art. 19)

The individual benefits are listed in the policy.

What conditions must be met in order to become eligible for benefits?
- Incapacity for work must be confirmed by a doctor (Art. 13, para. 1);
- Incapacity for work must be at least 25 % (Art. 13, para. 2);
- The waiting period must have expired (Art. 14, para. 1).

How are the benefits calculated?
Daily benefits are calculated based on the most recent AHV salary (including family supplements in the form of child, education, or household support granted under local rules or as part of standard industry practice) paid by the insured company before the illness set in (Art. 18).
The annual salary for a person shown by name in the policy applies.
The salary is annualized and then divided by 365.
The insured earnings per person and per year are limited to CHF 250 000. Provisions laid out in the policy that differ from these are reserved.
Third-party benefits, such as IV benefits, are included in the calculation.

For how long are daily benefits paid?
The benefit period is defined in the policy. When the person reaches AHV retirement age, daily benefits will be paid for a maximum of 180 days for all current and future benefit cases together. All entitlement to benefits ends when the person reaches the age of 70 (Art. 16, para. 3).

What applies in the case of persons who change over to individual insurance?
Individuals who leave the insured company can change to individual insurance within 90 days without undergoing a medical exam (Art. 12).
Insured persons are not entitled to change to individual insurance if they
- join another daily sickness benefits insurance plan;
- have exhausted the agreed benefit period of this insurance;
- have a fixed-term employment contract of three months or less;
- are occasionally employed as auxiliary staff;
- live outside of Switzerland or the Principality of Liechtenstein;
- draw a retirement pension or have reached statutory AHV retirement age;
- have an agreed annual salary;
- are no longer insured because they have violated their disclosure obligations (contract termination or exclusion);
- have attempted to commit or committed insurance fraud.

How is the premium calculated?
The premium is based on the premium rates defined in the policy and on the insured payroll amount.
If an advance premium has been agreed, SWICA will calculate the definite premium at the end of the year. Any difference that may arise is then either repaid or billed. This procedure does not apply in the case of flatrate premiums. SWICA adjusts the advance premium accordingly for the following year.
SWICA can request a change in premiums as of the following insurance year (adjustment to trends in benefits or if the basic rate for premiums changes). In this case, it must inform the policyholder no later than 30 days before the new premium is due. The policyholder then has the right to terminate the contract.

What are the policyholder's obligations?
The policyholder must
- pay the premiums on time and notify the effective salaries needed for calculating the definite premium (Art. 29 and 30);
- inform its insured persons about the scope of cover granted under the various policies;
- inform its insured persons about their obligations in the event of an illness (Art. 21 – 23);
- inform its insured persons of the possibility to transfer to individual insurance when leaving the company (Art. 12);
- notify SWICA of any illness on time (Art. 20);
- grant SWICA the right to inspect salary information on request and authorize it to view the AHV declaration (Art. 29).

What are the insured person's obligations in a benefit case?

The insured person must

- inform the employer immediately in the event of an illness;
- arrange for professional medical care;
- follow the instructions of the doctors;
- agree to undergo an examination by doctors who have been instructed by SWICA;
- notify the unemployment or disability insurance office of any anticipated claim on time;
- release the attending physician and any doctors who administered care previously of their duty to maintain confidentiality towards SWICA;
- provide SWICA on request with additional information (e.g. medical records, expert opinions, salary statements) and information about benefits paid by third parties and enable SWICA to access official documents (e.g. police records) and documents of third parties (e.g. AHV, employers, other insurers).

How long is the contract term?

The contract term is defined in the policy. At the end of the term, the contract automatically extends for an additional year unless one of the contracting parties receives notice of termination no later than three months before the term ends.

The policyholder can also terminate the contract during a claim involving an insured illness – without affecting the claim in question.

How does the policyholder share in a favourable claims history?

If insurance with surplus participation was purchased, the policyholder will receive a portion of any surplus that may be due from the contract on completion of three full insurance years.

The following formula is used to calculate the surplus:

(annual premiums × premium portion − claims expenditure) × surplus portion.

The premium portion and the surplus portion are shown in the policy.

What data is used and how?

SWICA obtains information about the following in connection with negotiating and managing the contract:

- Client data (name, address, date of birth, gender, bank details, etc.), stored in electronic customer files;
- Application data (answers to questions in the application, health data, medical reports, data from the previous insurer regarding the claims history);
- Contract data (term, insured benefits, payrolls, etc.), stored in contract administration systems and physical policy files;
- Payment data (dates on which premiums are paid, outstanding amounts, reminders, credit balances, etc.), stored in debt collection databases;
- Data on benefits (medical/accident reports on insured persons, investigation reports, invoices, etc.), stored in physical claims files and electronic applications.

This information is needed in order to verify and assess the risk, manage the contract, and process benefit cases correctly. After settling a benefit case, SWICA keeps the claims data for at least 10 years; it keeps all other data for 10 years from the date when the contract ends.

The data can be forwarded to third parties involved in the contract, such as other participating insurers, the authorities, lawyers and external experts. Data can also be forwarded for the purpose of uncovering or preventing insurance fraud. SWICA can request and forward relevant information from the authorities, private and social insurance carriers, doctors and hospitals if authorized to do so by the applicant or insured person.

The companies of SWICA Healthcare Organization grant each other access to client data (in order to identify clients) and contract data (except application and claims data) in order to simplify administrative procedures and for marketing purposes.

Important!

For more information please refer to the quotation, application, policy and the General Insurance Conditions (GIC).

In order to enhance readability, only the masculine form is used throughout this text. It naturally always refers to female persons as well.

General Insurance Conditions for group daily benefits insurance under the Insurance Contract Act (ICA)

I Basic principles

The insurance carrier is SWICA Healthcare Insurance Ltd., Römerstrasse 38, 8401 Winterthur, hereinafter referred to as "SWICA".
The relevant service centre is shown in the policy. For general questions, please call us free of charge on 0800 80 90 80 or send us an email to swica@swica.ch.

Art. 1 Basic contract information
This contract is based on the following:
a) The policy;
b) The General Insurance Conditions, any Special Insurance Conditions, and addenda;
c) The Federal Insurance Contract Act (ICA) for circumstances that are not subject to a) and b) of the provisions referred to;
d) All written contractual agreements between SWICA and the policyholder or the insured person that kept on file.

II Validity of the insurance

Art. 2 Basic principle
1 The contract can include the following types of insurance:
   a) Daily sickness benefits for company owners and family members working for the company, as well as for employees;
   b) Daily accident benefits for company owners and family members working for the company;
   c) Childbirth benefits for company owners and family members working for the company, as well as for employees.
2 The insured persons and the insured benefits are defined in the policy.

Art. 3 Policyholder, insured person, insured companies
1 The term "policyholder" refers to the natural person or legal entity that has entered into the insurance contract.
2 The term "insured person" refers to the insured individual (e.g. company owner, employee).
3 The insured companies are defined in the policy. The insurance covers all locations and branch offices of the policyholder in Switzerland, unless the policy contains provisions to the contrary.

Art. 4 Beginning, term, and end of the insurance contract
1 The beginning and end of the insurance contract are defined in the policy.
2 SWICA can refuse the application in writing until it has issued the policy or a definitive cover note. If it rejects the application, insurance cover ends three days after the policyholder is notified, in which case the prorated premium is due.
3 At the end of the term, the contract is renewed automatically for one year at a time. Both contracting parties can terminate the contract with effect from the end of the term. The termination period is three months. Notice of termination must be given by registered letter. If the contract has been signed for a term of less than one year, it will end without notice of termination on the date specified in the policy.
4 Further reasons for ending the contract include:
   a) The policyholder discontinues its business;
   b) The registered office is moved abroad;
   c) Bankruptcy proceedings are instituted against the policyholder (unless the premium continues to be paid by a third party – e.g. the liquidator).

Art. 5 Termination in the event of illness
1 The policyholder can terminate the contract after any illness for which SWICA pays benefits. The policyholder must send the notice of termination to SWICA by registered letter no later than 14 days after it became or could have become aware of the payment. The contract ends when SWICA receives the notice of termination.
2 In a case involving illness, SWICA waives its right to terminate the contract, unless insurance fraud has been attempted or committed.

Art. 6 Territorial validity
1 Policyholders that have their registered office in Switzerland are covered worldwide. In the case of persons who have been sent on an assignment outside Switzerland or the Principality of Liechtenstein, the insurance ends 24 months after their stay abroad begins. The insurance can be extended on request, provided the persons continue to have mandatory accident cover in Switzerland (UVG) or the Principality of Liechtenstein (OUFL).
2 For insured persons who have become ill, provisions under Art. 14, paras. 5 and 6 apply as well.

Art. 7 Definitions
1 **Illness** refers to any impairment of an individual's physical, mental, or psychological health that is not the result of an accident, requires medical examination or treatment, or results in incapacity for work (Art. 3 of the Federal Act on the General Part of Social Security Law, ATSG).
2 **Incapacity for work** is the full or partial inability to exercise the current profession and do work that can be reasonably expected due to impairment of physical, mental, or psychological health. After 3 months of incapacity for work, the person must also consider switching to a reasonable activity in another profession or remit.
3 **Occupational disability** is the full or partial inability to pursue gainful employment in the relevant stable labour market because of impaired physical, mental, or psychological health and after the completion of reasonable treatment and measures for integrating the individual into the workforce. When deciding whether or not a case falls under occupational disability, only the consequences of the person's health impairments are to be considered. In addition, occupational disability means that a recovery can be ruled out on the basis of an objective opinion (Art. 7 ATSG).
4 The provisions of the UVG define the terms **medical staff** and **treatment centres.**
5 **AHVG** Federal Law on Old Age and Survivors' Insurance (SR 831.10)
ATSG Federal Law on the General Part of the Social Security Law (SR 830.1)
GIC General Insurance Conditions
AVIG Federal Law on Obligatory Unemployment Insurance and Compensation in Cases of Insolvency (SR 837.0)
BVG Federal Law on Occupational Retirement, Survivors' and Disability Pension Plans (SR 831.40)
IVG Federal Law on Disability Insurance (SR 831.20)
MVG Federal Law on Military Insurance (SR 833.10)
OR Federal Act on the Amendment of the Swiss Civil Code (Part Five: The Code of Obligations) (SR 220)
UVG Federal Accident Insurance Act (SR 832.20)
ICA Federal Insurance Contract Act (SR 221.299.1)

III Insured benefits

Art. 8 Contents

SWICA grants insurance cover against the consequences of illness and childbirth within the scope of the agreed benefits.

Art. 9 Exclusions and reductions

1 The insurance does not cover:
   a) An illness that existed on joining the company or at the start of the insurance and that leads to incapacity for work within the scope of the incapacitated or occupationally disabled person's contractual employment, unless SWICA is obliged to continue providing cover based on agreements on the free movement of persons that exist between the insurers;
   b) Illnesses that are compensated from a statutory accident insurance policy (UVG);
   c) Accidents, unless daily accident benefits are insured;
   d) The effects from ionizing radiation and damage from nuclear energy. However, the insurance does cover health impairments resulting from medically prescribed radiotherapy in connection with an insured illness.
   e) Illnesses resulting from warlike incidents or acts of terror. However, if the insured individual is overtaken by such events while abroad, insurance cover remains in effect until 14 days after the first incident.
2 If health impairments can be traced only partially to an insured illness, benefits are reduced commensurately with the separate causes with the help of medical opinions.
3 Absence from work because of out-patient medical tests or treatment does not constitute grounds for entitlement to daily benefits.
4 SWICA waives its right to reduce benefits in the case of illnesses caused through gross negligence.

Art. 10 Insured persons

1 The insurance covers persons or groups of persons who are listed in the policy, are employed by the insured company, and have not yet reached the age of 70. The insurance does not cover employees who have been seconded by a third-party provider.
2 The insurance also covers the following persons:
   – Family members working for the company but not included on the payroll (e.g. spouse, children, parents);
   – The company owner's domestic staff.

Art. 11 Beginning and end of insurance cover

1 Insurance cover for individual insured persons begins on the day when the employment contract with the insured company begins, at the earliest on the start date defined in the contract. The insurance enters into force only after the fully or partially incapacitated insured person is again fully fit for work in accordance with his regular working hours. Persons with reduced working or earning capacity are insured only within the scope of their working or earning capacity.
2 Persons who are listed by name and have an agreed annual salary must undergo a medical exam. SWICA confirms the beginning and scope of insurance cover in writing.
3 Insurance cover for the insured person ends when the
   a) person leaves the insured company;
   b) insurance contract ends;
   c) person reaches the age of 70;
   d) person's assignment outside Switzerland or the Principality of Liechtenstein exceeds 24 months. Extended insurance cover (in accordance with Art. 6) ceases when the applicable mandatory accident cover in Switzerland (UVG) or the Principality of Liechtenstein (OUFL) ends;
   e) maximum benefit period has been exhausted;
   f) obligation to pay benefits has been suspended because the policyholder is in arrears with its payments.

Art. 12 Right to change to individual insurance

1 Insured persons living in Switzerland or the Principality of Liechtenstein who withdraw from the group of insured persons or whose insurance contract ends have the right to change to individual insurance. The right to change applies if a written request is submitted within 90 days.
2 The policyholder must inform the withdrawing insured person in writing about the right to transfer and the 90-day deadline. This notice must be issued in writing at the latest when the person leaves the insured company.
3 Individual insurance starts on the day after the person leaves the group of insured persons or the insurance contract ends.
4 Insurance benefits are adjusted to the new circumstances when the person transfers. The most recent salary serves as basis for calculating the insured salary for the individual insurance. The amount to be insured may not exceed the amount that would result from unemployment compensation. At the request of the insured person, the waiting period can be reduced (to a minimum of 30 days) or extended. The current conditions and rates of the individual insurance apply. The person's age and health at the time of enrolment in the group insurance plan are decisive for continuing the insurance. Any provisos (exclusions) are carried over.
5 The right to change to individual insurance does not apply
   a) if the person changes jobs and transfers to the new employer's daily sickness benefits insurance, provided that the new employer is obliged to continue such cover because of agreements on the free movement of persons;
   b) if this contract is terminated and then continued with another insurer for the same group of persons or parts thereof;
   c) to persons with an employment contract of three months or less and to occasionally employed auxiliary staff;
   d) to self-employed persons and/or their family members who work with them but who are not paid in cash and do not pay AHV contributions;
   e) to persons who start drawing an AHV retirement pension or who have reached statutory AHV retirement age;
   f) if the agreed benefit period under group insurance has been exhausted;
   g) in cases involving a fixed-term cover note where no insurance contract has been formed;
   h) in the event of termination or exclusion resulting from a breach of disclosure obligations;
   i) in the case of attempted or actual insurance fraud.
6 If an insured person is incapacitated for work when he leaves the insured company, all benefits are debited from the group insurance plan. The same applies if an insured person, within 180 days of changing to individual insurance, suffers a relapse of an illness that had required treatment while the group insurance contract was in force.

Art. 13 Entitlement to daily benefits

1 If a doctor confirms that the insured person is incapacitated for work, SWICA will, in the case of full incapacity for work, pay daily benefits as defined in the contract up to the amount in documented earnings.
2 In the case of partial incapacity for work of at least 25 %, daily benefits will be adjusted to the level of incapacity.
3 If the insured person is unemployed as defined in Art. 10 AVIG, SWICA will pay benefits as follows up to the amount in lost unemployment compensation:
   a) Half the daily benefits in the case of incapacity for work of more than 25 %;
   b) Full daily benefits in the case of incapacity for work of more than 50 %.

4 SWICA does not pay daily sickness benefits
   a) if the insured person receives benefits from a federal or cantonal maternity insurer or from a private daily maternity benefits insurance plan;
   b) after every birth after the sixth month of pregnancy, for the period in which the woman is by law not permitted to work.
5 For foreigners working abroad who hold neither a permanent residence permit nor an annually renewable residence permit for Switzerland, entitlement to benefits ends at the latest when the employer's statutory obligation to continue salary payments ends. This does not apply to hospital stays and stays abroad at the employer's request. Cross-border commuters need no longer return daily but must stay at their residence abroad only once a week.
6 An incapacitated insured person who goes abroad without SWICA's approval is not be entitled to benefits while abroad.

Art. 14 Waiting period and start of benefits

1 If the insured person becomes incapacitated and remains so after the agreed waiting period ends, SWICA will pay the agreed daily benefits up to the amount in documented lost earnings for the remaining period of incapacity.
2 The waiting period starts on the first day on which the person is at least 25 % incapacitated based on a medical opinion, at the earliest 3 days before the first medical treatment. Days of incapacity for work of least 25 % count as full days when calculating the waiting period.

Art. 15 Relapse

1 The recurrence of an illness is defined as a relapse. Such a case is regarded as a new case of illness if the insured person was fully fit for work without interruption in accordance with contractual working hours for at least 365 days prior to becoming incapacitated from the relapse.
2 Days of incapacity for work of at least 25 % resulting from earlier periods of incapacity count as follows in the event of a relapse:
   a) In the case of pre-existing insurance cover, the days are added to the benefit period and waiting period.
   b) In the absence of insurance cover, the days are added only to the benefit period.
3 Relapses that occur after group insurance cover has ceased are covered only within the limits of daily benefits paid from SWICA's individual daily benefits insurance.

Art. 16 Benefit period

1 Daily benefits are paid at most for the period defined in the contract. The waiting period is added to the benefit period.
2 If an insured person who is already ill contracts an additional illness, the days of benefit entitlement for the first illness are applied to the benefit period.
3 If the insured person is incapacitated when he reaches statutory AHV retirement age, entitlement to benefits ends unless he can prove that the employment relationship would have continued if he had been fit for work. Once the person has reached statutory AHV retirement age, daily benefits are paid for a maximum of 180 days for all current and future insured events together, at the most until the person reaches the age of 70.
4 Days of incapacity for work of at least 25 % count as full days when calculating the benefit period.
5 After insurance cover ends, SWICA pays daily benefits for illnesses that begin during the contract term until the insured person is able to work again at 75 % of regular capacity at least, but not past the end of the agreed benefit period.
6 If a new illness sets in after the agreed benefit period has expired, the insured person is covered for the new illness only if he has regained full or partial capacity for work after the previous illness and only within the scope of the additional illness-related incapacity for work.
7 If entitlement to benefits as defined in para. 1 ceases and a relapse as defined in Art. 15, para. 1 sets in, SWICA will pay daily benefits at most for the period for which the employer is obliged to continue salary payments in accordance with Art. 324a SCO.

Art. 17 Third-party benefits

1 If the insured person receives benefits from a state or company-owned provider or from a liable third-party, SWICA will supplement the amount up to the insured daily benefits limit after the waiting period ends. Days for which partial benefits are paid because of reductions resulting from third-party benefit payments count as full days when calculating the benefit period and the waiting period. These provisions also apply for the same type of insurance institutions with head office in the Principality of Liechtenstein and other foreign countries.
2 SWICA's obligation to pay a family allowance does not apply in the period in which the insured person is entitled to a family allowance under cantonal or federal law.
3 SWICA pays daily benefits voluntarily in advance in place of a liable third party in order to cover lost earnings only if the insured person or the eligible claimant assigns his benefits to SWICA in writing.
4 If entitlement to daily benefits or a pension from a state or company-owned insurer has not yet been determined, SWICA can pay the insured daily benefits voluntarily in advance. In this case SWICA will reclaim from the insured person any excess benefits that were paid from the date on which entitlement to daily benefits or a pension began. SWICA therefore makes advance payments only on the express condition that the amount is set off against benefits paid by the federal disability insurance (IV) or against refunds from daily benefits or pension amounts paid by other state or company-owned insurers. The amount to be refunded or offset must equal the amount in disability benefits (IV) or daily benefits or pensions that other state or company-owned insurers committed to paying for the same period and can be transferred without the need to obtain additional authorization from the insured person. The insured person must assign to SWICA his benefits from other insurance carriers in the amount of the advance payments he received from SWICA.
5 If several licensed insurers provide cover for a case involving loss of earnings, the insured amount in lost earnings under this contract is covered only in the ratio of guaranteed benefits that are paid jointly by all participating insurers. This provision does not apply to insured persons with an agreed annual salary.
6 SWICA's obligation to pay benefits ceases if the insured person agrees a settlement with a third party without first obtaining SWICA's approval.
7 SWICA is under no obligation to pay benefits if the insured person fails to bring a claim against a third party in due time or neglects to file the claim altogether.
8 The insured person must inform SWICA immediately about the nature and scope of all benefits provided by third parties.

Art. 18 Calculation of benefits

1 The percentage of daily benefits is calculated based on the most recent AHV salary, including any family allowance granted in the form of child, education, or household supplements that are customary for a particular location or industry, received before the illness-related incapacity for work began. The right to make adjustments in cases where this salary no longer reflects current circumstances (estimated lost earnings) is reserved. This salary is annualized and divided by 365. For persons not subject to AHV provisions, any AHV norms, including family supplements in the form of child, education, or household allowances that are customary for a particular location or industry, apply as well. Any salary increases during the period of incapacity for work are not included. Individually agreed salary adjustments and changes in the employ-

ment situation are taken into account in the daily benefits calculation, provided that they were agreed in writing before the person became incapacitated.

2 If a person's earnings fluctuate strongly (e.g. a person employed by the hour or on commission, a temp, or an irregular auxiliary), daily benefits are calculated as follows: The AHV salary, including any family allowance granted in the form of child, education, or household supplements that are customary for a particular location or industry, received in the 12 months before the illness-related incapacity for work began is annualized and divided by 365.

3 Earnings from activities other than those performed for the insured company are disregarded.

4 If an annual salary was agreed in advance, this salary applies. The agreed annual salary does not fall under fixed-sum insurance but under indemnity insurance. SWICA does not require proof of the actual lost earnings up to the agreed annual earnings. Lost earnings that exceed the agreed annual earnings are not insured. If occupational disability continues after the benefit period ends, the agreed annual salary is reduced by the corresponding percentage.

5 If no annual earnings were agreed for persons currently in school or training, the person's current earnings, the earnings that are standard for the industry on completion of the program, or the salary specified in a signed employment contract apply.

6 The maximum earnings per person are limited to CHF 250 000 per year or to the 365th part thereof per day, unless other arrangements have been agreed.

7 The calculated daily benefit amount is paid for every calendar day.

Art. 19 Childbirth benefits

1 If stated in the policy, SWICA will pay the agreed childbirth benefit as a supplement to the statutory maternity allowance per birth for the agreed calendar days. The agreed waiting period is added to the benefit period.

2 If childbirth benefits insurance was purchased for the insured person less than 270 days before the birth, the benefits are paid for 21 calendar days (less the agreed waiting period).

IV Procedural obligations

Art. 20 Deadline for notification of an illness

1 Anyone wishing to receive daily benefits must apply no later than five days after the end of the waiting period. However, if a waiting period of more than 30 days has been agreed, the application must be filed at the latest after 30 days of incapacity for work.

2 If notification of illness is received after this date, the date when notification is received is the first day of incapacity for work.

3 If the illness lasts for more than a month, SWICA will require a monthly medical certificate confirming the level and duration of the incapacity for work. In this case, SWICA will pay daily benefits on a monthly basis.

Art. 21 Obligations of the policyholder or eligible claimant

1 The insured person must do his utmost to assist in managing the illness and its consequences. In accordance with the obligation to mitigate loss, the insured person must refrain from any activity that is incompatible with the incapacity for work or the drawing of daily benefits and that endangers or delays the recovery. The doctors who treat or have treated the insured person must be released from their professional secrecy obligations towards SWICA.

2 The policyholder must inform every insured person of his obligations in the event of illness.

Art. 22 Consultation by a registered doctor

1 In the event of illness, the insured person must contact a registered doctor and ensure that he receives professional care. Furthermore, the insured person must follow the orders of the doctor and nursing staff. When undergoing a medical examination or an assessment the insured person is obliged to use doctors who have been instructed by SWICA.

2 SWICA has the right to visit patients and request additional information. This includes receipts and information, medical certificates, reports, salary statements, and official documents.

Art. 23 Obligation to mitigate loss

1 Benefits can be reduced or refused temporarily or permanently if the insured person withdraws from or refuses to undergo reasonable treatment or to participate in integration measures that are likely to bring about a significant improvement in his capacity for work or that lead to a new form of gainful employment, or if he fails to contribute to such measures to a reasonable extent of his own accord.

2 An incapacitated insured person who cannot be reintegrated into his original job in the company must look for work in another field within 3 months and register with the disability and unemployment insurance.

3 If the remaining capacity for work is unused, daily benefits are calculated by factoring in the insured person's obligation to mitigate loss.

4 If the incapacitated insured person fails to register with the unemployment or disability insurance, SWICA can discontinue or reduce its daily benefits payments. Benefits are calculated by factoring in the payments that can be assumed to be made by these insurers.

Art. 24 Consequences of disregarding a procedural obligation

If the obligations set out in Art. 20 – 23 are breached, SWICA can reduce or refuse to pay benefits.

Art. 25 Tax at source

1 If benefits are paid to the policyholder to forward to the insured person, the policyholder must calculate and pay the tax at source in accordance with the law.

2 If the tax authorities nevertheless institute proceedings against SWICA, SWICA has a right of recourse against the policyholder.

Art. 26 Reclaimed and offset benefits

When prompted to do so in writing, the policyholder or insured person must repay any daily benefits that SWICA may have paid by mistake. SWICA has a right of offset but the policyholder/insured person does not.

Art. 27 Pledging and assignment

Claims against SWICA may be neither assigned nor pledged. Assignments or pledges of such claims cannot be brought against SWICA.

V Premiums

Art. 28 Premium calculation

The AHV salary of up to CHF 250 000 per person and year serves as basis for calculating the premium, unless other arrangements have been agreed. AHV norms also apply to salaries paid to persons who are not subject to AHV provisions. If annual salaries have been agreed, these apply.

Art. 29 Premium statement

1 If advance premiums are agreed, the policyholder must provide SWICA with the required information within a month of receiving the declaration form. SWICA then calculates the definitive premiums based on this information.

2 If the policyholder fails to provide the information on time, SWICA will determine the premium based on an estimate. The policyholder has the right to object to the estimate within 30 days of receiving the statement. In the absence of any such objection, the estimated premium is deemed to have been accepted.
3 SWICA can inspect all material documents (e.g. payroll records, receipts, AHV statements) of the company and, in particular, request a copy of the AHV declaration in order to verify the information on the declaration form. SWICA also has the right to inspect documents directly at the AHV office.
4 The definitive premium from the preceding year is deemed to be the advance premium of the following insurance year.

Art. 30 Premium payment

1 In the absence of an agreement to the contrary, the premium is set per insurance year and must be paid in advance by the due date. In the case of instalments, the full premium for the year remains due. Unless agreed otherwise, January 1 is the principal date when the premium is due, and the insurance year is the same as the calendar year.
2 If the premium is not paid on time, SWICA must remind the policyholder in writing to pay the premium within 14 days from the reminder date and explain the consequences of default. If the reminder is ignored, SWICA's obligation to pay benefits for a case ceases (suspension of cover) from the end date of the reminder period until the outstanding premiums, plus interest and fees, have been paid in full. No entitlement to benefits applies to new cases of illness that occur while cover is suspended, even if all the outstanding premiums are paid.
3 If the contract is cancelled before the insurance year ends, SWICA will refund the partial premium for the remaining part of the insurance period. SWICA refrains from collecting instalments that fall due on a later date. The provisions on premium statement as defined in Art. 29 apply.
4 The premium for the current insurance period is due in full if the policyholder terminates the contract in connection with a benefit case within one year from the date on which it was signed.

Art. 31 Premium adjustments

1 SWICA can adjust the premium rates to the end of the insurance year in line with benefit trends.
2 If the premium rate changes, SWICA can demand that the contract be adjusted effective from the following insurance year.
3 SWICA must inform the policyholder of the new premium rates and premiums at least 30 days before the end of the insurance year.
4 The policyholder then has the right to terminate the entire contract or only the portion affected by the change with effect from the end of the current insurance year. In this case, the entire contract or parts thereof terminate at the end of the insurance year. SWICA must receive notice of termination in writing on the last day of the insurance year at the latest.
5 The changes to the contract are deemed to have been approved unless the policyholder terminates the contract in good time.

VI Surplus participation

Art. 32 Basic principle

1 The policyholder receives a prorated share of the surplus from his contract, provided this has been agreed in the policy. The policyholder is entitled to participate in the surplus after three full consecutive insurance years in which this provision applies.
2 If the portion relevant for determining the surplus changes during the billing period, the bonus is weighted commensurately.
3 Entitlement to surplus participation ceases if the contract is cancelled before the end of the statement period.

Art. 33 Calculation of surplus participation

1 The cost of administering benefits is deducted from the share of the paid premiums specified in the policy. The policyholder receives the agreed portion of any surplus that has been achieved. Losses are not carried forward to the next billing period.
2 The statement is issued no later than 6 months after the end of the calculation period, provided that the relevant premiums have been paid.
3 If the insurance contract is terminated with effect from the end of the calculation period and benefit cases are still pending, the statement is postponed until the cases have been settled. All benefits paid after the termination date are included in the surplus calculation.
4 If accident claims are filed after the account statement has been finalized or payments have been made that fall under the closed billing period, a new account statement regarding surplus participation will be issued. SWICA can claim back any surplus shares that have already been paid.

VII Supplementary provisions for accident insurance

Art. 34 Contents

1 SWICA also pays the agreed daily benefits in the case of an accident, provided this provision is included in the policy. Supplementing Art. 8, SWICA's supplementary accident insurance also covers the consequences of accidents, accidentlike injuries, and occupational illnesses.
2 The insurance covers occupational accidents, accidentlike injuries, occupational illnesses, and non-occupational accidents that occur during the contract term of this supplementary insurance. The definitions of terms used for statutory accident insurance (UVG) apply.
3 Entitlement to insured benefits does not apply in the case of accidents
   a) that the insured person causes intentionally;
   b) resulting from earthquakes in Switzerland or the Principality of Liechtenstein;
   c) resulting from warlike incidents or acts of terror.
   However, if the insured person is overtaken by such events while abroad, insurance cover remains in place until 14 days after the first incident. If the insured person becomes a victim of aircraft hijacking, SWICA pays the full benefits, even if the aircraft is hijacked in a country that is engaged in armed conflict. SWICA does not pay benefits if the insured person is the victim of an aircraft hijacking that takes place more than 48 hours after a war breaks out.
   d) when serving in a foreign army;
   e) when participating in warlike acts, acts of terrorism, or gang-related crimes;
   f) when committing or attempting to commit a crime or misdemeanour. This also includes accidents caused by driving motor vehicles while under the influence of alcohol or drugs;
   g) when participating in civil unrest;
   h) when participating in fights and brawls, unless the fighting parties injure the insured person as a non-participant or while he is assisting a defenceless person;
   i) when participating in motor vehicle races or rallies, including training runs;
   k) as the consequence of the effects of ionizing radiation and damage from nuclear energy. However, the insurance covers impaired health as the consequence of medically ordered radiotherapy in connection with an insured accident or an insuredocupational illness.
4 In all other cases, the provisions of this GIC and the contract apply by extension.

VIII Final provisions

Art. 35 Notifications

1 All notifications to SWICA must be addressed to SWICA Healthcare Insurance Ltd., Römerstrasse 38, 8401 Winterthur, or to the service centre shown on the policy.
2 Notifications by SWICA to the policyholder are legally binding if sent to the most recent address we have on file.

Art. 36 Place of jurisdiction

The policyholder's or the insured person's legal venue is the regular place of jurisdiction and place of residence in Switzerland or the Principality of Liechtenstein.

Art. 37 Authoritative version

If any questions of interpretation arise, the German original of the General Insurance Conditions is to be regarded as the authoritative text.

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SWICA Healthcare Organisation
Because health is everything
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