KLG

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Supplementary Insurance Conditions (ZVB)
SALARIA Daily Allowance Insurance

Contents

1 Introduction

SALARIA daily allowance insurance covers proven loss of income (indemnity insurance) caused by incapacity for work due to illness or, where contractually agreed, accident up to the amount of the insured daily allowance.

The General Insurance Conditions for Supplementary Health Insurance (AVB) serve as the basis for these Supplementary Insurance Conditions (ZVB).

2 Insured benefits

The insured benefits are defined in the policy.

3 Definitions

3.1 Incapacity for work is the full or partial inability to perform an acceptable form of employment in a person's existing job or area of activity due to impairment to physical, mental or psychological health. After 6 months, an acceptable form of employment in another profession or area of activity shall also be taken into consideration.

3.2 Indemnity insurance is an insurance under which, in the event of a claim, only the loss that has actually occurred and can be specifically proven is compensated within the scope of the insured sum agreed.

3.3 A claim arises as a result of incapacity for work due to illness or accident. Any further incapacity for work during a claim does not constitute a new claim within the meaning of Section 8.3.

4 Expiry, amendment and termination of the insurance

4.1 In addition to Section 9.3 AVB, the insurance automatically ends
- Upon the policyholder reaching the regular AHV retirement age (subject to Section 4.2).
- In amendment of Section 9.3 d) AVB when a place of residence or habitual residence is transferred abroad and there are no longer any insured earnings from Switzerland.
- Once the maximum duration of benefits is reached.

4.2 Insured persons who are still employed and fully able to work after reaching the official AHV retirement age can apply to retain their existing insurance cover until completing their 70th year of age. The daily allowance insurance shall expire no later than this point in time. Once AHV retirement age is reached, longer waiting periods shall be reduced to 30 days and the duration of benefits limited to 180 days within 5 years for one or more cases of incapacity for work.

4.3 Unemployed persons within the meaning of Art. 10 of the Federal Unemployment Insurance Act (AVIG) can, regardless of their state of health, convert their existing daily allowance insurance at the previous amount into insurance cover with a 30-day waiting period. All requests must be submitted within 3 months of their becoming unemployed.

4.4 By way of derogation from the termination provisions according to Section 10 AVB, the insured person may, in the situations presented below, terminate or amend the insurance in writing effective to the end of a month:
- Loss of insured earnings
- Where overinsurance is likely to be permanent (e.g. inclusion in another group daily allowance insurance policy, lower income or partial disability pension).

5 Benefit conditions

5.1 The daily allowance will be paid out proportionally to the degree of the incapacity for work, based on a certified incapacity for work of at least 25%. For unemployed persons within the meaning of Art. 10 AVIG (Federal Unemployment Insurance Act), the provisions of Art. 100 para. 2 VVG (Federal Insurance Contract Act) shall apply.

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5.2 The insured person must provide proof of loss of income (indemnity insurance). Should the proven loss of income be lower than the insured daily allowance, the insured benefits shall be reduced accordingly in order to avoid the insured person profiting from the insurance. No entitlement to benefits exists in the case of failure to provide proof of loss of income.

5.3 Loss of income includes proven income lost immediately prior to becoming currently incapacitated for work up to the maximal amount of insured daily allowance:
- The basis for calculating the daily allowance for employees of a company is the last effective AHV salary received prior to the start of the period of incapacity for work. If income is irregular, the average salary since the start of employment, at the most for the last 12 months, will be used as the basis.
- For unemployed persons, entitlement to daily unemployment benefits qualifies as loss of income.
- For self-employed persons, loss of income is identified through inspecting relevant business documentation (e.g. income statement).

5.4 Salary adjustments due to a change in the employment level or general salary increases will only be taken into account if they were agreed in writing prior to the onset of incapacity for work. Mandatory salary increases due to provisions of collective bargaining agreements (GAV) are taken into account.

5.5 The daily allowance amount is calculated by converting the insured salary to a full year and dividing the insured annual salary amount by 365.

6 Obligations and the duty to mitigate losses in the event of a claim

In addition to Section 18.1 AVB, the following provisions apply:

6.1 The insured person must do everything to promote the recovery of their ability to work and refrain from anything that jeopardises the healing process.

6.2 Irrespective of the agreed waiting period, claims for daily allowance must be submitted to Helsana no later than 30 days after the beginning of the incapacity for work by way of notification of illness and submission of the doctor's certification of incapacity for work in order to be valid.

In the case of a delay in notification and where the delay affects the benefits due, entitlement to insured benefits commences on receipt of the notification at the earliest. However, the duration of benefits already commences on the first day of certified incapacity for work. The maximum duration of benefits will be reduced by the number of days between the first day of the certified incapacity for work and the date of the late notification submitted by the insured person.

6.3 A medical certificate is valid until the next medical consultation, but for no longer than 1 month. If the claim lasts longer than 1 month, a medical certificate on the degree and duration of the incapacity for work must be submitted to Helsana on a monthly basis. Certificates of incapacity for work without a personal medical consultation are accepted for a maximum of 5 days.

6.4 If the insured person fully or partially regains the capacity to work, Helsana must be immediately notified of the start and the degree of the capacity to work.

6.5 The insured person is also obliged to undergo additional medical examinations or evaluations deemed necessary by Helsana. These examinations will be paid for by Helsana.

6.6 The insured person must provide Helsana with all information required to clarify the entitlement to benefits and to determine the amount of benefits. In particular, the insured person may be required to submit additional supporting documents and information and to obtain medical reports and medical certificates for the attention of Helsana that are necessary for the assessment of the duty to provide benefits. Medical certificates and reports submitted to Helsana that are not written in German, French, Italian or English and not accompanied by a certified translation in one of these languages will be translated at the expense of the insured person. Helsana is also entitled to carry out personal visits to insured persons.

6.7 If, in the case of self-employed persons or partnerships, it is necessary to examine business operations in order to clarify the claim, the policyholder must allow Helsana or a third party commissioned by Helsana to inspect their accounts and associated accounting records.

6.8 In the event of a claim, the insured person must notify the other insurance policies affected, in particular the Federal disability insurance, after 6 months at the latest. Once notification is completed, it cannot be withdrawn and benefits may not be waived.

6.9 Insured persons who are likely to be fully or partially incapable of working in their usual profession on a permanent basis are obliged to utilise any residual ability to work in an acceptable form of employment, even if this entails a change of profession. Helsana may request the insured person to change their profession and pay transitional daily allowance. A request for a change of job in the insured person's current occupation with another employer does not constitute a change of profession and does not entail any entitlement to transitional daily benefits.

7 Breach of obligations and the duty to mitigate losses

In addition to Section 19 AVB, the following provisions apply:

7.1 If the insured person fails to comply with the statutory or contractual obligations and the duty to mitigate losses in accordance with Section 6 above, or if they fail to comply with the deadline specified in the reminder letter, the insurance benefits will be temporarily or permanently reduced or refused. Days with reduced or no entitlement to benefits will be counted towards the duration of benefits.

7.2 The consequences pursuant to Section 7.1 also apply if an insured person withdraws from, refuses to cooperate with, or does not make a reasonable effort of their own volition to try an acceptable form of treatment or reintegration into working life that is likely to generate a considerable improvement in the person's ability to work.

7.3 If an insured person fails to attend an examination ordered by Helsana without being excused for a valid reason, Helsana may charge the costs incurred directly to the insured person or offset them against a daily allowance claim due.

8 Waiting period and duration of benefits

8.1 The obligation to provide benefits begins after expiry of the waiting period agreed in the policy. The waiting period begins on the 1st day that the incapacity for work is confirmed by a doctor, but at the earliest 3 days before the start of medical treatment.

8.2 The agreed waiting period will only be calculated once within a 365-day period. If the incapacity for work in a claim lasts longer than 365 days, no new waiting period will be calculated.

8.3 Helsana shall provide the daily allowance per claim for no longer than the duration of benefits specified in the policy. Waiting periods are included in the duration of benefits. Any further incapacity for work during a claim does not constitute a new claim.

8.4 Days of partial incapacity for work or days with reduced benefits are counted as full days towards the duration of benefits.

8.5 Recurrence of an illness or the consequences of an accident are treated as a new claim with regard to the duration of benefits and the waiting period if the insured person was not unable to work for at least 365 consecutive days before the relapse. If the relapse takes place within 365 days, the pre-existing waiting period is waived and daily benefits already paid out are taken into account when calculating the maximum duration of benefits.

8.6 The insured person may not prevent expiry of their entitlement to daily allowance insurance by waiving receipt of benefits.

8.7 If the insurance is cancelled, the entitlement to benefits continues to apply to the ongoing claim in accordance with the provisions set out in the contract (subsequent benefit).

9 Third-party benefits

9.1 Third-party benefits include, but are not limited to, benefits from social and private insurers (including daily allowance insurers under KVG), pension funds of any kind (compulsory or non-compulsory) and liable third parties. This excludes benefits from fixed-sum, capital and pension insurance policies concluded as part of a freely selectable pension plan.

9.2 If multiple private insurers are obliged to provide benefits and the total insured daily allowance exceeds the level of proven loss of income in accordance with Section 5.2, Helsana will reduce the daily allowance proportionally.

9.3 In the event of an overlap with benefits from social insurances, voluntary daily allowance insurances under KVG and insurances in accordance with BVG, the daily allowance benefits shall be paid subsequently. As a result, Helsana's duty to provide benefits is restricted to the difference between the third-party benefits and the insured benefit in accordance with Section 5.3.

9.4 When providing benefits in accordance with disability insurance, Helsana requests reimbursement directly from the Federal Disability Insurance as from the date on which the daily allowance or pension starts.

10 Maternity

10.1 Daily allowance benefits are not insured for maternity within the meaning of AVB 7.2.

10.2 The obligation to provide benefits in the event of illness or accident shall be suspended for eight weeks after the birth. If the insured person refrains from employment for a longer period at her own wish, the obligation to provide benefits will be suspended until she resumes employment.

11 Claims abroad

11.1 If, during a period of incapacity for work, the insured person travels to another country temporarily for treatment, medical care, childbirth, going on holiday or other reasons without the consent of Helsana, no benefits will be paid out until they return to Switzerland. The number of days spent abroad shall in all cases be taken into account for the period of benefits.

11.2 In order to maintain the entitlement to benefits during a claim, the insured person must submit a justified application to Helsana in writing at least 5 days in advance of going abroad.

11.3 If an incapacity for work occurs while abroad, daily allowances can only be claimed during the period of hospitalisation.

12 Special aspects of transferring from a Helsana group daily benefits insurance

12.1 In addition to Section 21 AVB, no insurance cover is provided for incapacity for work that existed when the present insurance was taken out.

12.2 In the event of a relapse (cf. Section 8.5), the period of benefits relating to the group daily allowance insurance is taken into account.

12.3 There is no entitlement to benefits in the case of incapacity for work due to an illness or the consequences of an accident for which the maximum period of benefits allowed by the group daily allowance insurance has been reached.