KLuG

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Customer information according to the Federal Law on Insurance Contracts Accident insurance for death and disability (UTI)

Customer information

The following customer information gives an overview of the identity of the insurance company and the main content of the contract in accordance with Article 3 of the Federal Law on Insurance Contracts. The rights and obligations of the contracting parties result from the insurance application or the insurance cover confirmation, from the General Conditions of Insurance, and the applicable laws, in particular the Federal Law on Insurance Contracts.

Who is the insurance company?

The insurance company on the basis of a group insurance contract is SOLIDA Versicherungen AG, Saumackerstrasse 35, 8048 Zurich (hereinafter SOLIDA). The policyholder is KLuG Krankenversicherung, Gubelstrasse 22, CH-6300 Zug (hereinafter «the health insurer»).

The health insurer's existing customers can register for the insurance coverage by entering into a contractual relationship with the health insurer. In this way, they become insured persons.

It is only through an insured accident that a direct relationship arises between the beneficiary and SOLIDA with an independent right of claim (Art. 95a of the Federal Law on Insurance Contracts).

Which risks are insured and what is the scope of the insurance cover?

Accidental death and disability insurance provides insurance cover in the event of death and disability caused by an accident. It is a pure risk insurance without a savings component. The insurance benefit is owed regardless of whether the insured event has caused economic loss or another insurance company is also paying benefits. The persons listed in the insurance cover confirmation are insured. As the group insurer, SOLIDA provides the benefits insured in accordance with the insurance cover confirmation:

In the event of death, the insured lump-sum death benefit is paid if the insured person dies within five years as a result of an accident and if accident cover existed at the time of the accident. The specifically agreed lump-sum death benefit results from the insurance application or the insurance cover confirmation and is paid after deduction of any disability compensation already paid for the same accident.

In the event of permanent disability, the insured lump-sum disability benefit is paid provided that a medically theoretical disability that is expected to be permanent occurs within five years of the accident and accident cover existed at the time of the accident. The lump sum disability benefit is determined according to the level of disability and the agreed insured sum. The principles applicable to the determination of the level of disability are specified in the General Conditions of Insurance and are based on an abstract assessment method according to the disability schedule. The agreed sum insured results from the insurance application or from the insurance cover confirmation.

If the insured person has reached the age of 65 at the time of the accident, the insurance benefit for permanent disability is paid out in the form of a life annuity.

There are benefit limitations for old age (maximum sums insured, waiver on increase of insurance cover) as well as for children and adolescents.

The specific insured risks and the scope of the insurance cover are given in the insurance application or the insurance cover confirmation, and in the General Conditions of Insurance.

Among other things, insurance cover is not provided for accidents that are

- a result of war, civil war, and/or war-like conditions;
- a result of earthquakes in Switzerland and the Principality of Liechtenstein;
- a result of extraordinary hazards;
- a result of, or occur on the occasion of, the insured person or the beneficiary intentionally committing or attempting to commit, or participating in, a felony or offence;
- caused when the insured person has a blood alcohol content of two parts per million by weight or more;
- a result of hazardous activities;
- a result of suicide or damage to the health of the insured person's own body, which the insured person caused intentionally or in a state of completely or partially diminished responsibility;
- a result of deliberate ingestion of medicines, drugs and chemical products;
- a result of medical or surgical interventions that were not necessitated by an insured accident.

The exact description of the exclusions listed above as well as further limitations of the scope of cover are given in the General Conditions of Insurance.

How much is the premium and when is it to be paid?

The amount of the premium depends on the age as well as the desired cover. If the rates are changed during the term, the contracting partner of the health insurer has the right to terminate the contract.

The obligation to pay the premium begins with the start of the contract. The premiums are to be paid in advance in accordance with the provisions in the insurance cover confirmation.

What other obligations does the insured person have?

Duty to notify: Every insured event that is likely to give rise to a claim for insurance benefits must be notified to SOLIDA immediately.

Duty to cooperate: The insured person or the persons entitled to benefits must do everything that can serve to clarify the accident and its consequences; in particular, they must release the doctors from their professional duty of confidentiality.

In the event of loss of any claim as a result of default, the insured person or the beneficiary is obliged to provide SOLIDA with any requested information about the previous and current health condition as well as about the accident and the course of recovery within 30 days of a written request to this effect.

Further obligations arise from the General Conditions of Insurance as well as from the Federal Law on Insurance Contracts.

When does the contract start?

The contract begins on the date stated in the insurance cover confirmation.

How long does the contract last?

The contract is tacitly extended by one year after the expiry of the minimum contract period of one year, unless it is terminated in due time.

When does the contract end?

The contract ends
- by revocation:
  The contracting partner of the health insurer may revoke its registration within 14 days of the registration in writing or in another form that allows proof by text.
- by termination:
  - After a minimum contract period of one year, the contracting parties may terminate the contract at the end of a calendar year by giving three months' notice. The contracting partner of the health insurer shall send the corresponding notice to the health insurer in writing or in another form that allows proof by text.
  - The contracting partner of the health insurer may also terminate the contract in the event of premium changes. In this case, the notice of termination must reach the health insurer on the last day of the calendar year.
  - The contracting party of the health insurer may further terminate the contract after each accident for which a benefit is to be paid, at the latest 14 days after he or she has become aware of the payment.
  - The health insurer may also terminate the contract if material facts of risk have been concealed or incorrectly disclosed.
- upon the death of the insured person;
- by termination of the group insurance contract between SOLIDA and the health insurer.

The health insurer may also withdraw from the contract
- if its contracting partner is in default with the payment of the premium, has been reminded and the insurer waives the right to claim the premium;
- in the event of insurance fraud.

Further options for contract termination result from the General Conditions of Insurance as well as from the Federal Law on Insurance Contracts.

How do the health insurer and SOLIDA process data?

The company responsible for the processing of personal data in connection with insurance registration, policy maintenance and payment collection is the health insurer.

SOLIDA (SOLIDA Versicherungen AG, Saumackerstrasse 35, 8048 Zurich) acts as the responsible company with regard to the processing of personal data in claims settlement.

Personal data is processed by the above-mentioned responsible companies for purposes arising from the contractual documents or the processing of the contract, in particular for the determination of the premium, for risk clarification, for the processing of insured events and for statistical evaluations. In addition, by signing the contract, the contracting partner of the health insurer consents to the processing of its data for marketing purposes.

To the extent necessary, the health insurer and SOLIDA transfer data for processing to third parties involved in the processing of the contract. Accordingly, they may also forward data to co-insurance or reinsurance companies. Furthermore, the health insurer and SOLIDA may obtain relevant information (health, administrative and criminal law data) from official bodies and other third parties, in particular about the claims history. This applies irrespective of the conclusion of the contract. The contracting partner of the health insurer has the right to request from SOLIDA and the health insurer the information provided for by law concerning the processing of data relating to them. The responsible companies shall retain the personal data within the scope of the statutory retention obligations. Furthermore, they shall retain the relevant personal data beyond the statutory retention period if this is necessary for the enforcement and defence of the legal claims of one of the two responsible companies. The duration of the retention period is based, among other things, on the statutory limitation periods or the period during which claims can be asserted against SOLIDA or the health insurer. Personal data that is no longer required is deleted or made anonymous in accordance with the law.