The Helsana Group comprises Helsana Insurance Company Ltd, Helsana Supplementary Insurance Ltd, Helsana Accidents Ltd and Progrès Insurance Company Ltd.

Helsana

2014 version

General Insurance Conditions (AVB) for the Helsana Business Salary Group Daily Benefit Insurance in accordance with the VVG

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Translation: Only the original German text approved by the Swiss Supervisory Authority is binding.

Helsana Supplementary Insurances Ltd provides the insurance benefits in its capacity as party to the insurance contract in relation to the insured persons and is referred to as "insurer".

Basis

1 Subject of insurance

The Group Daily Benefit Insurance of Helsana Supplementary Insurances Ltd, Zurich, hereinafter referred to as the insurer, provides insurance protection against the economic consequences of inability to work due to illness and, if contractually agreed, of accidents. Maternity benefits can also be insured.

2 Basis of the contract

The following form the basis of the contract:

2.1 the policy and any endorsements thereto;

2.2 the statements made by the policyholder and/or insured person in the proposal form and any health declarations;

2.3 the present General Insurance Conditions (AVB);

2.4 any Supplementary Insurance Conditions (ZVB);

2.5 the Federal Law governing Insurance Contracts (VVG, Insurance Contract Act);

2.6 any special arrangements or agreements, if they have been confirmed by the insurer in the policy as Special Insurance Conditions (BVB).

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3 Definitions

3.1 Illness is any impairment of physical, mental or psychological health which is not caused by an accident and which requires medical examination or treatment, or which results in an inability to work.

3.2 An accident is the sudden, unintentional and damaging effect of an unusual external factor on the human body, resulting in impairment to physical, mental or psychological health. The occupational diseases and bodily injuries similar to those from accidents listed in the directive concerning Compulsory Accident Insurance (UVV) are considered equal to accidents.

3.3 Maternity includes pregnancy and birth, and the subsequent recovery time required by the new mother.

3.4 Inability to work is the full or partial inability to perform reasonable work in a person's existing job or area of activity due to impairment of physical, mental or psychological health. Over the longer term, reasonable work in another job or area of activity may also be considered.

3.5 Incapacity for gainful work is the total or partial loss of earning possibilities in a balanced labour market which is caused by the impairment of physical, mental or psychological health and which continues after reasonable treatment and integration.

When assessing whether the insured person is unable to work, only the consequences of any health impairment are taken into account. An insured person is only deemed to be unable to work if, from an objective point of view, this incapacity cannot be overcome.

3.6 Invalidity is a total or partial incapacity for work which is likely to be permanent or to continue for a lengthy period.

3.7 Property/casualty insurance is insurance under which, in the event of a claim, only the costs that were actually incurred and can be specifically proven are reimbursed as part of the insured earned income

3.8 Doctors are deemed to be all doctors, dentists or chiropractors licensed to practice in Switzerland and the Principality of Liechtenstein who are in possession of a Swiss or an equivalent foreign diploma, or in other countries, holders of the equivalent certificate of proficiency entitling them to practice the profession.

Insured group of persons

4 Insured companies

The insured company consists of those principal/secondary companies, branches and subsidiaries listed in the policy.

5 Insured persons

5.1 The insurance covers the persons or groups of persons listed in the contract.

5.2 Employees are insured
- if an employment relationship exists between them and the policyholder,
- if they are subject to Swiss AHV, or would be subject to it on reaching the relevant age, or
- if they have not yet reached the qualifying age for AHV.

Employees who are capable of work on attaining the qualifying age for AHV and are still employed without interruption at the insured company, and if they have not yet reached the age of 71.

5.3 Self-employed persons, company owners and members of their families who are not on the company's payroll are only insured if they are mentioned by name in the policy and have not yet reached the age of 71.

5.4 The following persons are only insured on the basis of a special contractual agreement:
a) temporary personnel with limited-term work contracts of up to 3 months;
b) part-time staff, working less than 8 hours per week;
c) persons paid on an hourly rate basis, who do not regularly work at least 8 hours per week in the company;
d) home-workers.

5.5 The following persons are not covered by the insurance:
a) staff lent to the policyholder/insured company by third-party companies;
b) persons who work for the insured company on the basis of an agency contract;
c) persons who have reached the qualifying age for AHV when they take up work/when the insurance commences;
d) members of management and executive bodies who are not simultaneously working as an employee at the insured company;
e) staff who are employed in Switzerland but who are not subject to the Swiss social insurance schemes by virtue of the Agreement on the Free Movement of Persons with the European Union (EU) or the EFTA Convention.

6 Insured earned income

6.1 For employees, the percentage of the effective AHV salary stated in the policy is insured. The maximum insured annual salary is stated in the policy.

The basis for calculating daily benefits is the last salary received before the event giving rise to the claim.

If income is irregular, the average salary since the start of employment, but for the last 12 months at most, will be used as the basis.

Salary adjustments resulting from a change in the degree of employment or general salary increases are only taken into account if these have been agreed in writing in a contract prior to to the insured person becoming unable to work.

Mandatory salary increases due to provisions of collective labour agreements (GAV) are taken into account.

If members of management or executive bodies simultaneously work as employees at the insured company, the pay included in the AHV salary in the form of board of directors' fees, bonuses, fixed remuneration and attendance fees is also insured.

6.2 For self-employed persons, company owners and their family members who are not on the company payroll, the earned income stated in the policy is the maximum amount insured.

6.3 If no fixed-term insurance cover is agreed in the policy, the insurance is deemed to be property/casualty insurance. In the case of property/casualty insurance, the insured person must provide evidence of the loss of income. Any entitlement to benefits exists only to the extent of the loss of income that can be proven.

7 Geographical area of validity

7.1 The insurance cover is valid worldwide.

7.2 For periods spent outside Switzerland in countries which are not part of the European Union (EU) or the European Free Trade Area (EFTA), benefits will only be paid if a hospital stay is medically necessary and only for as long as the insured person is unable to return to Switzerland.

7.3 The requirements set out under Section 7.2 do not apply to employees that have been sent abroad. This is subject to the provisions of Section 5.2.

Start and end of insurance

8 Start of insurance

8.1 The insurance begins on the date stated in the policy or in the insurer's written confirmation of the application for insurance.

8.2 If no written cancellation of the contract is received by the due date, the contract is tacitly renewed for a further year on reaching the expiry date stated in the policy, and after each subsequent year of insurance.

8.3 For self-employed persons, company owners and members of their families who are not on the company payroll, inclusion in the insurance must be applied for individually.

8.4 Insurance for new employees commences on the date when they start work. Persons who are partially or wholly unable to work at the start of the employment contract or at the start of the insurance because of illness, accident or infirmity are not covered by the insurance until they are fully able to work as per the terms of their employment contract. No health test is required for inclusion in the insurance policy at the level of cover agreed, and there are no exclusions for recurring or pre-existent health problems (full cover).

8.5 Partially disabled or handicapped employees who, due to the impairment of their health, are only in a position to work part-time in the insured company, must be fully able to fulfil their part-time employment contract on the day they start work or when the insurance commences. A temporary or permanent worsening of the complaint which led to the partial disability is not insured. In the case of a temporary or permanent worsening of the complaint which led to the partial disability, benefits will only be paid for a period of 90 days.

8.6 If insured persons have a right to more favourable conditions on the basis of free movement agreements, these conditions shall apply.

9 End of insurance cover

9.1 Insurance cover ceases for all insured persons on termination of the group contract.

9.2 The group insurance contract ends
a) when notice of cancellation is given;
b) when bankruptcy proceedings are commenced against the policyholder;
c) if the company headquarters are moved outside Switzerland;
d) if the company is closed down; or;
e) when a change of ownership occurs.

9.3 Insurance cover ceases for the individual insured person:
a) when he/she leaves the insured group of persons or ceases to work for the policyholder;
b) when he/she reaches the qualifying age for AHV or, for persons who continued to be covered by the insurance as stipulated in Section 5.2 and 5.3, on reaching the age of 71;
c) as soon as continued insurance cover is guaranteed by another insurer on the basis of free movement agreements;
d) on the death of the insured person; or
e) the insured person takes up residence abroad. This restriction does not apply for employees who remain subject to the Swiss social insurance legislation.

9.4 For insured persons who are unable to work or incapacitated for gainful work at the end of the insurance, the entitlement to benefits continues to be guaranteed for the case in progress within the limits of contractual provisions (sustained benefit). On restoration of full ability to work, the entitlement to subsequent benefit shall lapse.

9.5 Sustained benefits pursuant to Section 9.4 are not applicable:
a) if the contract is continued with another insurer who must guarantee the continuation of daily benefit payments on the basis of agreements on free movement;
b) if the employment contract is terminated during the trial period;
c) if the employment was for a limited term; or
d) in the event of a relapse in accordance with Section 17.2.

10 Cancellation

10.1 The contract may be cancelled by the policyholder or the insurer at the earliest on reaching the expiry date stated in the policy, and thereafter at the end of each year of insurance. Notice of cancellation must be given in writing and must be in the possession of the insurer or the policyholder at least three months in advance. The insurance year commences on the main premium due date stated in the policy.

10.2 The policyholder has the right to cancel the contract whenever the insurer makes a compensation payment in relation to a claim. Notice of cancellation must be given in writing and must reach the insurer no later than 14 days after the last payment in relation to a claim on the part of the insurer. The contract shall cease when the insurer receives the notice of cancellation. The insurer waives this right to cancellation,

10.3 This waiver of cancellation on the part of the insurer does not apply in the event of insurance fraud (whether attempted or committed), documents being forged or if any of the disclosure obligations were breached at the time of the contract being concluded.

11 Changeover to individual insurance

11.1 Persons leaving the insured group of persons have the right to change over within 3 months to the insurer's individual daily benefit insurance pursuant to the VVG, without any renewed examination of their state of health. The insured persons have the same right if the group insurance contract ceases to exist.

11.2 When terminating the employment contract, the policyholder must inform the insured persons who are leaving the group of insured persons covered by the group insurance in writing of their right to change over to the individual insurance, and of the time limit of 3 months. The same obligation is also applicable if the group contract is terminated.

11.3 If the insured person is receiving a sustained benefit pursuant to Section 9.4, the time limit starts after the obligation to pay benefits ends. In this case, notification is handled by the insurer.

11.4 Persons who change over are entitled to the same insurance cover as provided by their existing insured benefits. However, the amount of daily benefit is restricted to the maximum insurable daily benefit under the individual insurance. The new contract is governed by the provisions and tariffs of the individual insurance. For unemployed persons as defined in article 10 of the Federal Unemployment Insurance Law (AVIG), the provisions of article 100, paragraph 2, VVG shall also apply.

11.5 In case of relapses for which settlement is made under the terms of the individual insurance, the previous period during which benefits were drawn under the group contract shall be credited.

11.6 The right to free movement/changeover is not available to insured persons who:

a) who live abroad unless they remain subject to Swiss social insurance legislation due to intergovernmental agreements;
b) are employed on the basis of a limited-term employment contract. For unemployed persons as defined in article 10 of the Federal Unemployment Insurance Law (AVIG), the provisions of article 100, paragraph 2, VVG shall apply;
c) have their employment relationship terminated during the probationary period. For unemployed persons within the meaning of Art. 10 AVIG (Federal Unemployment Insurance Act), the provisions of Art. 100 para. 2 VVG (Federal Act on Insurance Contracts) shall apply.
d) have reached the official AHV retirement age or have taken early retirement;
e) have exhausted their benefits under the group contract and are no longer able to work;
f) change jobs and join the group daily sickness benefit insurance of a new employer; or
g) have their group contract terminated and continued with another insurer, insofar as the new insurer is obliged to continue the insurance cover on the basis of an agreement regarding free movement.

Benefits

12 Eligibility for benefits

12.1 The daily benefits will be paid out in proportion to the degree of the insured person's inability to work, provided that there is a certified inability to work of at least 25%. If the insured person is unable to work for a sustained period of time and his/her income falls by at least 25%, the daily benefits will be adjusted in line with the fall in income.

12.2 For self-employed persons, company owners and members of their families who are not on the company payroll, the certified inability to work must be at least 50%.

12.3 Partially disabled persons or employees who, due to the impairment of their health, are only in a position to work part-time in the insured company, are considered as fully capable of work if they are fully able to work within the meaning of these conditions. Their inability to work is measured by the degree of inability to continue performing their present job.

12.4 Loss of working hours due to out-patient examinations or treatment cannot be claimed under the daily benefit insurance.

12.5 Lost working hours due to health treatment are only insured if the treatment has been deemed medically necessary and a request for such treatment is received by the insurer no later than 14 days before treatment is started.

12.6 No benefits will be paid out if the insured person goes abroad for treatment, care or childbirth without the insurer's approval.

13 Notice and obligations in the event of a claim

13.1 For insurance policies with waiting periods of between 0 and 10 days, the insurer must be notified of any inability to work by the policyholder no later than 15 days after commencement of the inability to work. For waiting periods of more than 10 days, the notification must reach the insurer within 35 days of the commencement of the inability to work.

A doctor's certification of inability to work must be supplied within a further 3 days of the notification of sickness.

If notification is not given until later, any entitlement to the insured benefits will commence at the earliest as from receipt of this notification. However, the duration of the benefits begins on the first day the insured person is unable to work.

13.2 The insured person must provide proof of loss of income. If the person is unable to prove loss of income, there is no entitlement to benefits.

13.3 If, in clarifying the entitlement, it is necessary to check the performance of the policyholder's business, the latter shall allow the insurer to inspect his/her business records and any associated documentation.

13.4 The insured persons must do everything in their power to promote their recovery and refrain from doing anything which would delay recovery. In particular, insured persons must avoid doing anything that could prevent their recovery or delay their return to work.

13.5 Within 5 days or becoming unable to work, the insured person must consult a doctor, who will ensure appropriate treatment is provided. The insured person must follow the instructions of the doctor and care staff providing the treatment. The insured person is also obliged to undergo medical examinations deemed necessary by the insurer, at the latter's expense.

13.6 The insurer is entitled to make visits to patients and request additional documentation and information, in particular medical certificates and reports. Medical certificates that are not in German, French, Italian or English and to which a certified translation is not appended shall be translated at the expense of the insured person. In particular, insured persons must release doctors who are treating them, or who have treated them in the past, from their duty to maintain confidentiality vis-à-vis the insurer.

13.7 After the end of the inability to work, confirmation must be sent to the insurer immediately stating the degree and duration of the inability to work. If the illness lasts longer than one month, a certificate stating the degree and duration of the inability to work must be sent to the insurer on a monthly basis.

13.8 Insured persons who are likely to remain fully or partially unable to work in their usual job are obliged to make use of any remaining ability to work, even if this means a change of job. The insurer shall request the insured person to change jobs, and shall advise them of the consequences as stated in Section 14.

13.9 The insured person is obliged to assist in the execution of this insurance. The insured person must make all details available to the insurer that are required to clarify the entitlement to benefits and to determine the amount of benefits. In particular, the insured person must provide the insurer with all the medical reports and doctor's certificates that are necessary to determine its liability to provide benefits.

13.10 The insurer makes benefits conditional upon notification of the case to any other insurance companies involved. Entitlement to benefits shall be interrupted if the insured person fails to comply with the request to make such notification. The entitlement shall resume once the notification has been made. The duration of the interruption shall be credited against the total benefit period. However, the insured person shall lose their entitlement to benefits if they fail to assert a claim on these insurance companies when they are able to do so, or if they withdraw such a claim.

14 Breach of obligations

14.1 The insurance benefits will be temporarily or permanently reduced or, in serious cases, refused if the insured person breaches the required obligations or duties in accordance with Section 13 above in a manner that is not deemed to be excusable behaviour under the circumstances.

14.2 If the insured person withdraws from or rejects an examination ordered by the insurer, reasonable treatment that promises a significant improvement in the insured person's ability to work or their resumption of a gainful activity offering the prospect of a new employment opportunity, or if the insured person does not make reasonable efforts of his/her own to ensure his/her recovery, the benefits may be temporarily or permanently reduced or refused.

14.3 These legal disadvantages shall not apply if the insured person can reasonably prove that he/she is not at fault.

15 Start of benefits

15.1 The obligation to pay benefits begins after expiry of the waiting period agreed in the policy. The waiting period begins on the first day of the inability to work as established by the doctor, but at the earliest 5 days before the start of medical treatment.

15.2 If the employer grants unpaid leave to an insured person, the insurance cover shall continue to exist as long as the employment contract continues to run, but for no longer than a period of 7 months after the end of the entitlement to a salary. During the envisaged period of leave, there is no entitlement to insurance benefits and no premium is due. If the insured person falls ill during the unpaid leave, the insurer shall credit the days from the start of the inability to work until the originally intended resumption of gainful employment against the waiting period and the benefit period. The obligations stated in Section 13 AVB shall apply, in particular as regards the notification of sickness and certification of the inability to work.

16 Waiting period

The agreed waiting period is defined in the policy and is calculated for each claim. Days with partial inability to work are counted as full days.

17 Duration of benefits

17.1 The insurer pays out daily benefits for each claim during the benefit period defined in the policy, minus the agreed waiting period. Days with partial inability to work are counted as full days.

17.2 Recurrence of an illness or the results of an accident are treated as a new claim with regard to the benefit period and the waiting period if the insured person was not unable to work or was receiving medical treatment because of this illness or the results of this accident for at least 365 consecutive days before the recurrence.

If the recurrence takes place within 365 days, the waiting period that has already been completed is waived, and benefits already paid out are credited when calculating the maximum benefit period.

17.3 After the maximum benefit period for a claim has expired, the insured person is no longer entitled to benefits for this claim. Any residual ability to work remains insured.

For persons listed in the policy, the previously insured earned income is reduced according to the degree of residual ability to work.

17.4 For insured persons who are already drawing an AHV retirement pension when the claim commences, but at the latest on attaining the qualifying age for AHV, a benefit period totalling 180 calendar days is valid instead of the benefit period stated in the policy.

17.5 The insured person cannot prevent the benefit period from expiring by waiving his/her right to benefits before the end of his/her inability to work.

18 Interruption of benefits

18.1 If, during the period where the insured person is unable to work, he/she is remanded in custody, or is subject to a sentence or order, no daily benefits shall be due for such period. The days for which no compensation payment is made shall be credited against the benefit period as whole days. This also applies to interruptions to the entitlement to insurance benefits as a result of any breaches of obligations and periods when benefits are suspended due to premiums not being paid or time spent abroad.

18.2 If an insured person wishes to go abroad during the period where he/she is unable to work, the insurer must be informed in advance. After analysing the circumstances, the insurer may then withdraw insurance benefits for a limited period of time.

18.3 If an insured person who is unable to work goes abroad without informing the insurer in advance, he/she shall lose his/her entitlement to insurance benefits for the duration of the stay abroad.

19 Maternity

The obligation to pay benefits in case of sickness and accidents is suspended for 8 weeks after the birth of a child. If the insured person remains away from work until the 16th week after the birth at her own wish, the obligation to pay benefits is suspended until this point. This is subject to the insurance cover for maternity benefits in accordance with Section 20.

20 Maternity benefits

20.1 If maternity benefits have been agreed, the benefits paid by the insurer are defined in the policy. Self-employed persons, company owners and members of their families who are not on the company payroll are not insured.

20.2 The entitlement to benefit commences on payment of maternity benefits pursuant to EOG (Federal Law on Income Compensation). The benefit period cannot be interrupted and simultaneous entitlement to daily sickness allowance is excluded. In addition, the eligibility requirements for claims pursuant to the EOG shall apply. Section 23.1 shall apply in respect of overcompensation.

20.3 If the insured person has been insured for maternity benefits for less than 270 consecutive days before the birth, then the insurer will pay no benefits. This provision is subject to any free movement regulations.

21 Calculation of daily benefit

The daily benefit amount is calculated by converting the insured salary to an annual salary, and dividing the insured annual salary by 365.

22 Profit from insurance

22.1 An entitlement to daily benefit payments only exists insofar as no profit accrues to the insured person from the insurance.

22.2 Profit from the insurance is deemed to mean benefits which exceed the full cover for the insured person's loss of income. This excludes benefits from fixed-sum, capital-sum and annuity insurances concluded under discretionary (non-tax-privileged) retirement savings schemes.

23 Overcompensation

23.1 Any combination with benefits provided by social insurance institutions must not lead to overcompensation of the insured person.

The overcompensation limit is the amount of the insured benefits stated in Sections 6.1 or 6.2. Daily benefits are provided subsequently to the benefits from social insurance institutions and insurances under the BVG.

Accordingly, the insurer's obligation to provide benefits is limited to the difference between the benefits provided by social insurance institutions – including voluntary daily benefit insurances pursuant to the KVG (Federal Health Insurance Act) – and insurances pursuant to the BVG, and the above-mentioned overcompensation limit.

23.2 The insurer shall request repayment of benefits paid out in respect of disability insurance directly from the Federal Disability Insurance as from the pension/daily benefits commencement date. The amount of the refund requested will correspond to the amount of overcompensation as per Section 23.1.

23.3 Days with reduced benefits are counted as full days with respect to the duration of benefits. This also applies to days on which the benefits under the disability insurance are greater than those under the daily sickness benefit insurance.

24 Payment of benefits

24.1 The insured benefits are due at the latest 4 weeks after the date on which the insurer receives all documents necessary for the determination of its liability to pay benefits. For lengthy periods of inability to work, the insurer may make part payments of the accumulated daily benefits if this is requested, but not more often than once a month.

24.2 Unless otherwise agreed, the benefit payments are made to the policyholder, without prejudice to the right of a beneficiary to claim as defined under art. 87 of the VVG.

24.3 The policyholder shall receive the full amounts of benefits that are subject to tax at source. The policyholder is responsible for calculating and paying the correct amount of tax at source as required by law.

25 Pledging and assigning of benefits, right of recourse

25.1 Without the consent of the insurer, benefits cannot be pledged or assigned to third persons with legal effect.

25.2 If the policyholders or insured persons make any agreement with liable third parties whereby they partly or wholly waive their claims to insurance benefits or compensation without the insurer's consent, their entitlement to benefits from the insurer becomes null and void.

26 Restrictions on insurance cover

26.1 No insurance benefits will be paid for illnesses, accidents or the results of accidents and illnesses:

a) resulting from hazardous behaviour. Hazardous behaviour is deemed to comprise actions by means of which the insured persons expose themselves to great danger, without taking or being able to take the precautions which would limit the risk to a reasonable degree. Rescue operations to save other persons are insured, even if they can be regarded as hazardous behaviour;
b) resulting from exposure to ionising radiation or injuries due to nuclear energy, with the exception of damage due to medical treatment in relation to an insured claim;
c) resulting from operations that are not medically necessary (e.g. cosmetic surgery);
d) resulting from incidents of war
da) in Switzerland;
db) abroad, unless the insured person falls ill or has an accident within 14 days of the first occurrence of such events in the country in which he/she is staying and the outbreak of warlike events in that country took him/her by surprise;

26.2 Furthermore, no insurance benefits shall be paid for accidents or the results of accidents resulting from exceptionally dangerous actions. In particular, such actions include:

a) participation in riots and upheavals;
b) foreign military service;
c) participation in warlike acts, acts of terrorism, deliberate offences and crimes or attempts to carry out same;
d) participation in brawls and fights, unless the insured persons were injured by the fighters as uninvolved parties or in an attempt to help a defenceless person;
e) dangers into which insured persons put themselves by severe provocation of others;

26.3 The insurer shall waive its right to reduce insurance benefits in the event of gross negligence. However, there is no entitlement to benefits with respect to reductions in benefits by other insurers.

Premiums

27 Bases for premium calculation

27.1 Notwithstanding any other contractual agreement, the income earned at the insured company which is subject to AHV is used for premium calculations, taking account of the maximum insured annual salary per person.

Salaries or portions of salaries on which no AHV contributions are levied due to the age of the insured person are also treated as income on which premiums are to be paid, provided the person in question is insured.

27.2 For self-employed persons, company owners, and their family members who are not on the company payroll, the earned income stated in the policy is used as the basis for calculating premiums.

28 Payment of premiums

28.1 The policyholder shall pay the premium for the whole period of insurance in advance. In case of payment by instalments, the insurer may levy a supplement.

28.2 For employees, the advance premium is based on the probable salary and is adjusted at the beginning of the following year in line with the final salary statement.

28.3 Employees who are unable to work are freed from the obligation to pay premiums to the extent of the benefits provided under the group contract. This does not apply to self-employed persons, company owners or members of their families who are not on the company payroll.

29 Total payroll declaration

29.1 At the end of each year, the insurer requests the policyholder to provide a definitive total salary statement. For this purpose, the insurer sends the policyholder a payroll declaration form to be filled out completely and truthfully and returned to the insurer within 30 days. The insurer then draws up the final settlement of account for the preceding year.

29.2 If the policyholder does not fulfil its obligation to provide this statement, then the premiums will be determined by estimation. If it later becomes apparent that these premiums were too low, then the policyholder shall owe the insurer not only the difference but also 5% interest on arrears.

29.3 The insurer or third parties acting on his/her behalf have the right to inspect the payroll accounting of the policyholder at any time or to request copies of his AHV accounting statements.

30 Refund of premiums

30.1 If the premium has been paid in advance for a set period of insurance and the contract is cancelled for legally or contractually stipulated reasons before the end of this period, then the insurer will reimburse the premium corresponding to the unexpired part of the insurance year.

30.2 The premium for the current insurance period is nevertheless owed in full if the contract was in force for less than one year at the time of cancellation and the contract was cancelled by the policyholder.

30.3 An insurance period commences on the main premium due date stated in the policy and lasts for one year.

31 Late payment

If the policyholder does not fulfil its obligation to pay, it shall receive a written reminder to make payment within 14 days of the date of the reminder, together with notification of the consequences should it continue to default on its payments.

If the reminder does not meet with the desired success, the obligation to pay benefits will be suspended on expiry of the period mentioned in the reminder. If the insurer does not make legal claim to the outstanding premiums plus additional costs within two months of the expiry date of the reminder, then the contract is deemed to have expired.

32 Insurance with surplus sharing

32.1 If the insurance has been concluded with surplus sharing, the policyholder receives a contractually agreed share of the surplus accrued from its contract after three years of insurance.

32.2 The surplus is determined by taking the total amount of final premiums paid for the respective accounting period and deducting any benefits paid out over this period.

32.3 Any loss accrued will not be carried forward to the next accounting period.

32.4 If claims are notified subsequent to the completion of the account settlement statement or if further payments are made which fall within the completed accounting period, the insurer may draw up a new account settlement statement for the surplus sharing and claim repayment of surplus shares paid in excess.

32.5 The right to surplus sharing expires when the contract is cancelled if this takes place before the end of an accounting period.

33 Offsetting of benefits and refund obligation

33.1 The policyholder and the insured persons have no right to offset outstanding premiums against any entitlement to benefits.

33.2 Any benefits drawn without entitlement by the policyholder or the insured person must be refunded to the insurer.

34 Alterations to premium tariff

The insurer shall notify the policyholder of the alteration in writing no later than 30 days before the end of the year. If the policyholder is not in agreement with the new arrangements, it may cancel the parts of the contract affected by the alteration or the whole contract effective as at the end of the year of insurance. If the insurer does not receive written notice of cancellation within 30 days of receipt of the notice of alteration, this shall be deemed as consent on the part of the policyholder.

35 Alteration to premium rate

35.1 At the end of the contract, the insurer may adjust the premiums on the basis of claims experience. The observation period is deemed to comprise the current insurance year and two to four of the preceding insurance years. If the total of benefits paid (including reserves for unsettled claims) exceeds the risk premiums received, the insurer may adjust the premium rates in accordance with the tariff provisions.

35.2 For self-employed persons, company owners and members of their families who are not on the company payroll and if, in addition, no employees are insured, the premium rates may be adjusted to the tariff for the relevant age group of the insured persons.

35.3 The insurer shall notify the policyholder of the new premium rates no later than 60 days prior to the main premium due date. If the policyholder does not agree to the change in premium, he/she may cancel the contract at the end of the current insurance year. Notice of termination must be given in writing and must reach the insurer no later than on the last day of the insurance year. If the policyholder fails to give notice of cancellation, this shall be deemed as agreement to maintain the contract in its existing scope with the new premium rate.

Final provisions

36 Notifications and duty of information

36.1 To the policyholder:
All notifications to the policyholder or his/her appointed representative will be sent to the last Swiss address known to the insurer.

36.2 To the insured persons:
All notifications to the insured persons shall be handled via the policyholder, who is obliged to inform all the insured persons about the essential contents of the contract, as well as any amendments/terminations to it. The insurer shall provide the policyholder with the documentation required for information purposes.

36.3 To the insurer:
All notifications must be addressed directly to the insurer to the address specified in the policy, and they must be in German, French, Italian or English. A certified translation must be appended to documents in other languages.

36.4 If a policyholder changes its business domicile, its point of contact/representative, or the nature of its activities, or if the ownership structure of the company changes, or if it takes over other companies or operations, the insurer must be notified immediately in writing.

37 Data protection

37.1 Helsana Supplementary Insurances Ltd and the other companies in the Helsana Group process the personal information of insured persons for the purposes of contractual processing and in order to provide personalised patient advice and care, but also in order to continually improve the quality of products and services they offer to potential, existing and former policyholders. The insurer can also commission other parties to process such information.

The data is evaluated using mathematical and statistical methods to form needs-oriented customer groups in order to optimally address the varying individual needs of insured persons, and to enable Helsana Supplementary Insurances Ltd, the companies in the Helsana Group and partner companies (specifically those listed on the insurer's website) to provide cost-effective products and services of interest to potential, existing and former policyholders.

Helsana Supplementary Insurances Ltd and the other companies belonging to the Helsana Group are therefore expressly authorised to inspect any health insurance files that may exist in relation to basic and/or supplementary insurance policies and to process them for the purposes mentioned exclusively in the area of supplementary insurance.

37.2 The members of the Helsana Group are Helsana Insurance Company Ltd, Helsana Supplementary Insurances Ltd, Helsana Accidents Ltd, Progrès Insurance Company Ltd, Helsana Investment Ltd and Procare Providence Ltd.

37.3 The current partner companies of Helsana Supplementary Insurances Ltd are listed on the insurer's website.

37.4 Helsana Supplementary Insurances Ltd and the Helsana Group are subject to particularly strict data protection guidelines. Therefore, no personal data is transmitted to third parties outside of the Helsana Group. Exceptions only occur in cases where the disclosure of data is expressly stipulated or permitted by a legal provision.

37.5 Personal data is only processed and stored in a database or in paper form for as long as required by legal and contractual provisions. Personal data is subsequently deleted.

38 Place of jurisdiction

Any disputes arising from the insurance contract must be dealt with in a court of law with jurisdiction for the Swiss domicile of the policyholder or the beneficiary.