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

Helsana

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General Insurance Conditions (AVB) for Helsana Business Salary Group Daily Benefits Insurance pursuant to the KVG

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

Basis

1 Subject of insurance

The Group Daily Benefit Insurance of Helsana Insurance Company Ltd, hereinafter referred to as the insurer, provides insurance protection against the economic consequences of incapacity to work as a result of illness, maternity and, if contractually agreed, accidents.

2 Basis of the contract

Insofar as mandatory provisions under the Federal Law on General Provisions concerning Legislation on Social Insurances (ATSG), the Federal Law on Health Insurance (KVG) and other federal laws are not applicable, the following contractual bases shall apply:

2.1 the policy and any supplements thereto;

2.2 the statements made by the policyholder or the insured person in the insurance application and in any health declarations;

2.3 the current General Insurance Conditions (AVB);

2.4 any Supplementary Insurance Conditions (ZVB);

2.5 any special arrangements and/or agreements, if confirmed as Special Insurance Conditions (BVB) by the insurer in the policy.

3 Definitions

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

3.2 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. Occupational illnesses and bodily injuries similar to those caused by accidents

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as specified in the Ordinance concerning Compulsory Accident Insurance (UVV) shall be considered as accidents.

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

3.4 Incapacity 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 is also taken into consideration.

3.5 Occupational disability is the full or partial loss of the ability to earn any income in a stable employment situation due to impairment of physical, mental or psychological health and which continues after appropriate treatment and rehabilitation.

3.6 Disability is a total or partial occupational disability which is likely to be permanent or of a longer duration.

3.7 For the purposes of this contract, the term "medical practitioner" refers to all licensed doctors, dentists and chiropractors in Switzerland or the Principality of Liechtenstein who are in possession of a Swiss or an equivalent foreign diploma which is the equivalent certificate of proficiency in other countries.

Insured group of persons

4 Insured companies

Insured companies are defined as those companies, subsidiaries and branches listed individually 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 insured company,
- if they are subject to the Swiss AHV or would be subject to it at the corresponding age and
- if they have not yet reached age 65.

5.3 Self-employed persons, company owners and members of their families who are not specified in the payroll accounting, are only insured if mentioned by name in the policy.

5.4 The following persons are only insured under special contractual agreement:
a) short-term employees with limited-term work contracts of up to 3 months;
b) part-time employees, working less than 8 hours per week;
c) employees working on an hourly rate basis, who do not regularly work a fixed number of at least 8 hours per week in the company;
d) home-workers;
e) employees who are employed in Switzerland, but who are not subject to Swiss social insurance under the agreement with the European Union (EU) on the free movement of persons or the EFTA Convention.

5.5 The following persons are not covered by the insurance:
a) personnel on loan to the policyholder or insured company from other companies;
b) persons working for the insured company under an agency contract.

6 Insurable income

6.1 For employees, the insurance covers the percentage of the effective AHV salary with its various components as defined in the policy, unless otherwise agreed in the contract. The basis for calculating the daily benefits is the last salary received before the start of the insured event. If income is irregular, the average salary since the start of employment, at most over the last 12 months, will be used as the basis. Salary increases awarded while daily benefits are being drawn will not be taken into account unless the increase is mandatory under the terms of a collective employment contract (GAV). The maximum insured annual salary is defined in the policy.

6.2 For self-employed persons, company owners and members of their families who are not specified in the payroll accounting, the income stated in the policy shall be the maximum amount insured. This must correspond to the actual income from the insured company.

6.3 The insured persons are obliged to notify the insurer of cases of overinsurance which are likely to be permanent. In such cases, the insurer is entitled to reduce the existing daily benefits insurance.

7 Area of validity

7.1 The insurance cover is valid worldwide.

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

7.3 The requirements listed under Section 7.2 shall not apply to persons sent by the company to work outside Switzerland
- while they are staying in the country of their place of work outside the EU or EFTA,
- while they are subject to the AHV (AHVG), and
- if the date when they started working abroad was less than two years ago (special permits will be checked in individual cases).

Start and end of insurance

8 Start of insurance

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

8.2 If no cancellation of the contract is received by the specified deadline, the contract is tacitly renewed for a further year on reaching the expiry date defined in the policy and at the end of each subsequent year of insurance.

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

8.4 For new employees the insurance begins on the day they start work for the company. Persons who are partially or wholly unable to work on the date when their employment contract or insurance cover starts due to illness, accident or infirmity are not covered by the insurance until they are fully able for work within the framework of their employment contract. No health examination is required for inclusion in the insurance at the agreed level of cover, and there are no exclusions for recurring or already existing health problems.

8.5 Partially invalid or disabled 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 work at the agreed part-time level of employment on the day they start work or on the day the insurance cover starts.

8.6 If insured persons have a right to more favourable conditions under free movement regulations then these conditions will apply.

9 Exclusions

9.1 When concluding a new policy or increasing the level of insurance cover for persons specified or to be specified by name, acceptance of the application will be dependent on a health examination. In this situation, illnesses and consequences of accidents existing at the time when the insurance is applied for or prior to this time and which are known to lead to relapses may be excluded from the insurance by the insurer at such time as the insurance is concluded by means of an exclusion. This provision shall be subject to Art. 70 paras. 1 and 2 and Art. 71 para. 1 KVG.

9.2 The questions in the health declaration are to be answered completely and truthfully. If the insured person has provided untrue or incomplete details of illnesses or consequences of accidents, a subsequent exclusion may be added.

9.3 Exclusions to be added on the basis of the health declaration are subject to the provisions of Art. 69 KVG.

10 End of insurance cover

10.1 The insurance cover ceases for all insured persons on termination of the group contract.

10.2 The group insurance contract ends:
a) when notice of cancellation is given;
b) in the event of the policyholder commencing bankruptcy proceedings;
c) in the event that the company headquarters are moved abroad;
d) in the event of the company closing down;
e) at the time of change of ownership.

10.3 For persons insured on an individual basis, insurance cover ceases:
a) on leaving the insured group of persons or the company;
b) on reaching or passing age 65;
c) as soon as continued insurance cover is provided by another insurer under free movement regulations;
d) on the death of the insured person.

10.4 For insured persons who are unable to work or are unfit for gainful employment at the end of the insurance, the entitlement to benefits is guaranteed for the current case as per the provisions of the contract (post-expiry benefit). On fully regaining the ability to work the entitlement to post-expiry benefits will cease.

10.5 The post-expiry benefits pursuant to Section 10.4 will not apply if the contract is continued with another insurer who is obliged to provide continued payment of daily benefits under free movement regulations.

11 Cancellation

The contract may be cancelled by the policyholder or the insurer during the first year on reaching the expiry date stated in the policy, and subsequently at the end of any year of insurance. Notice of cancellation must be submitted in writing to the insurer or the policyholder respectively at least three months before the end of the period of insurance. The year of insurance commences on the main premium payment date stated in the policy.

12 Transferral to individual insurance

12.1 Persons leaving the insured group of persons have the right to transfer, within three months, to the insurer's individual daily benefits insurance pursuant to the KVG without having to undergo a new health examination. Employees have the same right if the group insurance contract lapses.

12.2 When dissolving the employment contract, the policyholder must inform the employees leaving the insured group of persons in writing of their right to transfer to the individual insurance and of the time limit of three months. The same duty also applies in the event of the group contract being dissolved.

12.3 The three-month time limit begins on leaving the group insurance, at the latest however on the date of receipt of the written notice concerning the right of transferral. If the insured person is receiving post-expiry benefits pursuant to Section 10.4, the time limit will start from the point when the obligation to provide benefits ceases. In this case, the situation will be clarified by the insurer.

12.4 Persons transferring from the group insurance to individual insurance have the right to insurance cover providing the same benefits as previously. However, the amount of the daily benefit will be limited to the current income from gainful employment or benefits provided under Unemployment Insurance (ALV) and shall not exceed the benefits previously insured. The new contract will be governed by the provisions and tariffs of the individual insurance. Unemployed persons as defined by Art. 10 of the Swiss Federal Law on Unemployment Insurance (AVIG) shall be subject to the terms of Art. 71 and Art. 73 KVG.

12.5 If the insured person is unable to work at the time when the employment contract is terminated by the employer, or if a relapse is suffered after the employment relationship has ended, the benefits provided under the current insurance will continue at the same level.

12.6 Prior benefits received will be taken into account for the benefits entitlement under the individual insurance.

12.7 There is no free movement or right of transferral for insured persons
- a) who live abroad (subject to the provisions in accordance with the regulations on the free movement of persons);
- b) who have no insurable income;
- c) who are aged 65 or over;
- d) if the benefits provided under the group contract have been exhausted.

12.8 There is also no right of transferral
- a) when changing jobs and joining the group daily benefits insurance of a new employer;
- b) when the contract is dissolved and is continued with another insurer, insofar as the new insurer is obliged under free movement regulations to continue the insurance cover.

Benefits

13 Eligibility for benefits

13.1 Daily benefits will be paid out in cases of proven incapacity to work of at least 25% in proportion to the degree of incapacity.

13.2 For self-employed persons, company owners and members of their families who are not listed in the payroll accounting the incapacity must be at least 50%.

13.3 Partially invalid or disabled insured persons are considered to be fully able to work in respect of these provisions if they are fully able to work in accordance with their level of employment. Their incapacity is measured by the degree to which they are unable to continue in their previous job.

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

13.5 Loss of working hours due to health cures are only insured when the health cure is required for medical reasons and a request for such a cure is submitted to the insurer in good time before the cure is started.

13.6 No benefits will be provided if the insured person goes abroad for treatment, care or childbirth without the consent of the insurer.

14 Notice and obligations in the event of a claim

14.1 In the case of policies with waiting periods of between 0 and 10 days, the policyholder must notify the insurer of any incapacity to work no later than 15 days after its commencement. In the case of waiting periods of 11 days or more, the insurer must be notified within 35 days of the onset of the incapacity to work. A octor's certificate of incapacity to work must be supplied within a further three days of notification of illness. If notification is delayed without any acceptable excuse being provided, entitlement to the insured benefits will commence on receipt of the notification at the earliest.

14.2 The insured person must provide proof of loss of income. Otherwise they will not be entitled to benefits.

14.3 The insured persons must do everything in their power to recover and refrain from doing anything which would delay recovery. In particular they must follow the instructions of their medical practitioners.

14.4 Once the incapacity to work is over, written confirmation must be sent to the insurer immediately stating the degree and duration thereof.

14.5 Insured persons who are likely to be fully or partially incapable of working in their usual job on a permanent basis, are obliged to utilise any residual ability to work, even if this entails a change of job. The insurer shall request the insured person to take on another form of employment, and shall notify them of the consequences according to Section 15.

14.6 The insured person must make regular visits to the doctor for treatment or for check-ups. The insured person is also obliged to undergo medical examinations deemed necessary by the insurer. These examinations will be paid for by the insurer. The insurer reserves the right to make visits in order to check that medical instructions are being followed.

14.7 The insured person is obliged to cooperate in the execution of this insurance. In particular, they must provide the insurer with all information required to clarify the entitlement to benefits and to determine the amount of benefits.

14.8 Payment of benefits by the insurer depends on whether the case is reported to the other insurers involved. Entitlement to benefits will be interrupted if the insured person fails to heed the obligation to notify. Entitlement will be reinstated once the obligation to notify has been fulfilled. However, the insured persons will lose their entitlement to benefits if they waive or withdraw claims which they are entitled to submit to these insurers.

15 Breach of obligations

15.1 The insurance benefits will be temporarily or permanently reduced or, in serious cases, withdrawn if the insured person breaches the obligations or duties required under these Insurance Conditions; in particular, if the 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 which is likely to lead to a considerable improvement in the person's ability to work or to their reintegration into working life offering new opportunities for earning an income.

15.2 These legal disadvantages shall not come into force if the breach of obligations or duties can be regarded as excusable under the circumstances.

16 Start of benefits

16.1 The obligation to provide benefits begins after expiry of the waiting period agreed in the policy. The waiting period begins on the first day when the incapacity to work is confirmed by a doctor, but at the earliest three days before commencement of medical treatment.

16.2 If the employer grants the insured person unpaid leave, the insurance cover will continue to be provided for as long as the employment contract remains in force, subject to a maximum of six months from the cessation of entitlement to a salary. Throughout the planned duration of the leave the insured person will not be entitled to insurance benefits and no premiums will be due. If the insured person falls ill while on unpaid leave the insurer will take into account the days between the onset of incapacity and the date on which the insured person originally intended to return to work when calculating the waiting period and the period of benefits. The obligations pursuant to Section 14 AVB shall apply, including in particular those relating to notification of illness and certificates of incapacity to work.

17 Waiting period

17.1 The agreed waiting period is defined in the policy. Days of partial incapacity to work are counted as full days.

17.2 The waiting period is calculated once for each claim, unless otherwise agreed in the contract.

17.3 If the agreed waiting period applies per claim, the waiting period will be waived in the event of relapses within 180 days of the person resuming work.

18 Period of benefits

18.1 The insurer shall provide daily benefits for one or more illnesses occurring during the period of benefits defined in the policy, with the exception of cases in which, subsequent to leaving the group insurance, the insured person does not exercise their right of transferral.

18.2 Waiting periods are taken into account for the period of benefits, unless otherwise agreed in the contract.

18.3 In the event of partial incapacity to work, correspondingly reduced daily benefits will be provided during the period described in Section 18.1. The residual level of ability to work will continue to be covered by the insurance.

18.4 If daily benefits are reduced as a result of overcompensation pursuant to Section 24 of these Insurance Conditions, the period of benefits will be extended in accordance with this reduction.

19 Interruption of benefits

19.1 In the event of an interruption of employment without entitlement to salary while daily benefits are being drawn (e.g. through imprisonment or detention on remand etc.), no daily benefits will be due for this period.

19.2 If an insured person who is unable to work leaves Switzerland temporarily without informing the insurer (e.g. on holiday), the entitlement to insurance benefits will be lost until the person returns to Switzerland.

20 Prohibition of waiver

Insured persons may not prevent the period of benefits from being exhausted by waiving their right to benefits before the end of their incapacity to work.

21 Maternity

21.1 For pregnancy and childbirth, daily benefits will be paid for a period of 16 weeks. To be entitled to this benefit, the insured person must be insured for at least 270 days, without any interruption of more than three months, before the date of giving birth. At least eight of these 16 weeks must be after giving birth.

21.2 The benefits will be provided subsequent to maternity benefits pursuant to the Swiss law on compensation for the loss of income (EOG).

21.3 Entitlement to benefits begins on the date on which the mother gives birth.

21.4 Maternity benefits are not taken into account for the maximum period of benefits.

21.5 If a waiting period has been agreed for maternity, this will be taken into account for the period of maternity benefits.

22 Calculation of daily benefits

The basis for calculating the daily benefit amount is the insured annual salary divided by 365 (366 for leap years).

23 Profit from insurance

23.1 Insured persons shall only be entitled to daily benefits to the extent that they do not accrue any profit from the insurance.

23.2 All benefits which exceed full cover of the insured person's loss of income from their insured occupation at the insured company are deemed to be profit.

24 Overcompensation

24.1 Benefits provided for the same event by more than one social insurance institution must not lead to overcompensation of the insured person. A case of overcompensation will exist where statutory social insurance benefits exceed the projected earnings lost as a result of the insured event. Daily benefits are provided subsequent to benefits from other social insurers and will be reduced by the amount of overcompensation.

24.2 If the insured person has a daily benefits insurance policy for illness or accident with a private insurance company, the insurer shall provide the insured daily benefits only to the extent that this does not lead to overcompensation. Benefits from fixed-sum insurance policies form an exception to this rule.

24.3 If the private insurer reduces or withdraws benefits on the basis of a subsidiarity clause, benefits will be provided by the insurer on a proportionate basis.

25 Payment of benefits

As a rule, benefits are paid to the policyholder. In special cases, daily benefits may be paid to the insured persons, subject to Art. 20 of the ATSG.

26 Temporary residents

After expiry of their employment contract, temporary residents have no further entitlement to daily benefits. If it can be proved that the person would have been issued with another work permit if they had been able to work during the year following commencement of the inability to work, the daily benefits will be provided at the previously applicable rate during the period stated in the work permit.

27 Prohibition of assigning and pledging benefits

Claims for payment against the insurer may not be assigned or pledged.

28 Restrictions in the insurance cover

The insurance benefits will be temporarily or permanently reduced, and in particularly serious cases withdrawn, for illnesses, accidents or the consequences thereof which the insured person has intentionally caused or worsened, or which result from exceptionally dangerous activities or hazardous behaviour. The definitions and restrictions given in the rules on compulsory accident insurance shall be applicable.

Premiums

29 Basis for premium calculation

29.1 Subject to contractual agreement to the contrary, premiums are calculated on the basis of the income subject to AHV earned from working for the insured company, taking into account the maximum insured annual salary per person. Salaries or parts of salaries on which no AHV contributions are charged, owing to the age of the insured person, are also considered to be income.

29.2 For self-employed persons, company owners and members of their families who are not specified in the payroll accounting, premiums will be calculated on the basis of the income stated in the policy.

30 Payment of premiums

30.1 The premiums are owed by the policyholder for the whole period of insurance in advance. The insurer may apply a surcharge to premiums paid in instalments.

30.2 For employees, the deposit premium is calculated on the basis of the expected salaries and is adjusted at the beginning of the following year in light of the final payroll declaration.

30.3 During a period of incapacity to work, the insured person is freed from the obligation to make premium payments, to the extent of the benefits provided under the group contract. However, this does not apply to self-employed persons, company owners or members of their families who are not listed in the payroll accounting.

31 Payroll declaration

31.1 At the end of each year, the insurer asks the policyholder to declare the final salaries. To this end, the insurer provides the policyholder with a payroll declaration form to be filled out completely and truthfully and returned to the insurer within 30 days. The insurer then prepares the final statement for the previous year.

31.2 If policyholders fail to fulfil their obligation by returning the completed payroll declaration form, the premiums will be determined on the basis of an estimate. If it subsequently transpires that these premiums were too low, the policyholder will owe the insurer the difference plus 5% interest on arrears.

31.3 The insurer or third parties acting on their behalf have the right to inspect the payroll accounting of the policyholder or request copies of its AHV statements.

32 Refund of premiums

32.1 If the premium has been paid in advance for a set period of insurance and the contract is cancelled for legal or contractual reasons before the end of this period then the insurer will reimburse the premium in proportion to the unused part of the period.

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

32.3 A period of insurance commences on the main premium payment date stated in the policy and lasts for one year.

33 Default of payment

33.1 After expiry of the premium payment period, a reminder will be sent, setting a subsequent deadline of 14 days. If payment is not made within this subsequent period, 5% interest on arrears will be charged from the first day after the expiry of the deadline. On expiry of the reminder period, the insurer's obligation to provide benefits vis-à-vis the employer will be suspended. It will be reinstated once any outstanding premiums have been paid in full, including interest on arrears and costs of reminders and debt enforcement.

33.2 In the event of late premium payment, the insurer also reserves the right to cancel the group contract without complying with the official notice period.

34 Insurance with surplus sharing

34.1 If the insurance has been agreed with surplus sharing, the policyholder receives a contractually agreed share of the surplus accrued from their contract after three years of insurance (accounting period from 1st January – 31st December).

34.2 The surplus is determined as follows: The following are deducted from the total amount of final premiums paid for the respective accounting periods:

a) the benefits apportionable to the accounting periods;
b) administration costs, provisions and reserves based on the share determined in the contract.

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

34.4 If claims are reported after the statement has been issued or further payments are made which fall within the completed accounting period a new surplus sharing statement will be produced. The insurer will request reimbursement of overpayments of surplus sharing bonuses or will offset such overpayments against outstanding daily benefits payments.

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

35 Offsetting of benefits and refund obligation

35.1 The policyholder and the insured persons are not entitled to offset outstanding premiums against benefit entitlements. The insurer may charge 5% interest on arrears for late payment.

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

36 Alterations to premium tariff

The insurer must inform the policyholder in writing of any alterations 30 days before the end of the year at the latest. If the policyholder is not in agreement with the new tariff they can cancel the parts of the contract affected by the alteration or the whole contract with effect from the end of the year of insurance. If the insurer does not receive notice of cancellation within 30 days of informing the policyholder of the alteration, the policyholder is deemed to have given their agreement.

37 Alterations to premium rate

37.1 At the end of the contract, the insurer may adjust the premiums on the basis of the claims experience. The current year of insurance and the two to four previous years of insurance shall be taken as the observation period. If the total benefits (including reserves for ongoing claims) exceeds the risk premiums collected, the insurer may adjust the premium rates in accordance with tariff provisions.

37.2 The insurer will notify the policyholder of the new premium rates at least 60 days before the main premium payment date. If the policyholder is not in agreement with the change in premium, they may terminate the contract at the end of the current year of insurance. Notice of termination must be submitted in writing to the insurer by the last day of the year of insurance at the latest. If the policyholder fails to terminate the contract, they shall be deemed to have agreed to the continuation of the contract, providing the same terms as before at the new premium rate.

Final provisions

38 Duty of confidentiality

Employees of the insurer who have access to information regarding the insured person's diagnoses, state of health, entitlement to benefits, benefits received, income and financial situation, are obliged to maintain complete confidentiality pursuant to Art. 33 ATSG. In the event of infringements, Art. 92 KVG shall apply.

39 Disputes

39.1 If an insured person is not in agreement with a decision, the insurer shall issue a written statement setting out the reasons for such decision.

39.2 Any objections to this statement may be lodged with the insurer within 30 days of the ruling being sent.

39.3 If no objection is lodged within this period or if any objections made are rejected on a legally binding basis, the ruling shall obtain legal force.

40 Notices

40.1 To the policyholder:
All notices to the policyholder or the contact named by the policyholder will be sent to the last Swiss address known to the insurer.

40.2 To the insured persons:
All notices to the insured persons will be issued by the policyholder. The latter is obliged to inform all insured persons about the key details of the contract.

40.3 To the insurer:
All notices must be addressed directly to the insurer in German, French, Italian or English. Documents in other languages must be accompanied by an authorised translation.

40.4 The policyholder must immediately inform the insurer in writing of any change of business domicile, contact details or type of company or if there is any change in the ownership of the company.

41 Effective date

These General Insurance Conditions (AVB) for Group Daily Benefits Insurance have been approved by the relevant corporate bodies of Helsana Insurance Company Ltd and come into force on 1 January 2007. They replace the corresponding General Insurance Conditions (AVB) for the Helsana Business Salary Group Daily Benefits Insurance pursuant to the KVG, 1 January 2004 Edition.