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

Helsana

Version dated 1 January 2014

# Insurance Conditions (VB)
# SALARIA – Voluntary Daily Allowance Insurance
in accordance with the Federal Health Insurance Act (KVG) of 18 March 1994

**List of Contents**



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

**Introduction**

The legal entity specified in the policy provides the insurance benefits and is referred to as the **"**insurer**"**. All terms used in the text to refer to persons are to be understood as gender-neutral.

**General Provisions**

**1 What is the legal basis of this insurance?**

1.1 The provisions of the Federal Act on the General Part of Social Insurance Law of 6 October 2000 (ATSG), the Federal Health Insurance Act of 18 March 1994 (KVG) and the provisions governing the implementation of these laws shall be applicable for the execution of this insurance.

1.2 These Insurance Conditions (VB) contain provisions which apply supplementarily to the legal provisions mentioned in Section 1.1.

**2 What is covered by the insurance?**

2.1 Daily allowance insurance covers the loss of income due to incapacity to work occurring as a result of illness, accident or maternity. The insurance always includes cover for illness and maternity, with the option of including or omitting cover for accidents.

2.2 Occupational illnesses and bodily injuries similar to those caused by accidents as specified in the Federal Accident Insurance Act (UVG) shall be considered as accidents.

2.3 The insurance options (e.g. amount of daily allowance, waiting periods) are determined by the insurer. The insured benefits are listed in the insurance policy.

**3 Who is covered by the insurance?**

The insurance covers the person specified in the insurance policy.

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**4 What is the procedure for inclusion in the insurance?**

4.1 The application forms for concluding or altering the insurance are to be filled out completely and truthfully.

4.2 The insurer shall be entitled to require persons who have applied for insurance to be examined by a medical examiner at its own expense.

**5 When and how is the insurance terminated or reduced?**

5.1 Subject to a three-month period of notice, the policyholder may terminate or reduce the daily allowance insurance in writing with effect from the end of a month.

5.2 However, the policyholder may terminate the daily allowance insurance in writing with effect from the end of a month provided one of the following conditions is fulfilled:

a) the insured person takes up permanent residence abroad;
b) the daily allowance insurance premiums are increased;
c) the insured person transfers to the compulsory daily allowance insurance provided by the employer;
d) loss of insured earned income.

5.3 On reaching the age of 65, the insurance shall automatically be reduced to CHF 10.

5.4 The daily allowance insurance shall cease automatically if the maximum period of benefit has been exhausted and the insured person is no longer carrying out any form of gainful employment.

5.5 In the event of misuse or if there are important, inexcusable reasons (e.g. if incorrect details are intentionally provided in the application or the illness/accident notification), if premium payment is delayed or premiums are outstanding, an insured person may be excluded from the daily allowance insurance. In such cases there is no entitlement to reinclusion.

**6 Can the premiums change once the insurance has been concluded?**

6.1 The premiums shall be determined on the basis of the insured person's age when the insurance is concluded or the benefits are increased.

6.2 Insured persons who have reached the age of 25 shall be allocated to the age group of insured persons from the age of 26.

6.3 The insurer reserves the right to alter the premium tariff at any time.

**7 What conditions apply with regard to premium payment?**

7.1 If the insurance relationship commences or ceases during the course of a calendar month, the premiums shall be paid for the entire calendar month.

7.2 Premiums shall be charged on a monthly basis, shall be payable in advance and shall be due on the first day of each month. Separate regulations shall apply to insured persons who undertake to pay two or more monthly premiums on a regular basis. Premiums may be paid by means of direct debit from a bank or postal account. A charge shall be payable by the insured person for each revocation of a direct debit.

7.3 If premiums are outstanding, the insured person's attention shall be drawn to this fact by means of a reminder of the consequences of late payment and a deadline shall be set by which the outstanding premiums are to be paid. If payment is not received within this subsequent period, the insurer may institute debt enforcement proceedings to recover the premiums.

7.4 Charges such as reminder charges and collection charges arising as a result of outstanding premium payments and charges imposed for payment in instalments shall be borne by the insured person.

**8 What are the consequences of late premium payment?**

8.1 Benefits may be suspended if payment is not made within the subsequent period specified in Section 7.3.

8.2 The obligation to provide benefits under the insurance shall be reinstated once any outstanding premiums have been paid in full, including interest on arrears and costs of reminders and debt enforcement. There is no entitlement to claim for illnesses, accidents and the consequences thereof occurring during the benefit suspension period. If benefits are already being provided for a claim, the total duration of benefit payment shall be reduced by the length of the benefit suspension period.

**9 What are the conditions for eligibility to benefits?**

9.1 Entitlement to benefits exists in the event that the insured person suffers certified incapacity to work of at least 25% that results in loss of income.

9.2 The obligation to provide benefits shall begin after expiry of the waiting period agreed in the policy. The waiting period shall begin 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.

**10 What duties and obligations apply in the event of illness or accident?**

10.1 The insured person must notify the insurer in writing of any incapacity to work no later than 30 days after its commencement. In the event that a waiting period is less than 30 days, notification must take place no later than five days after expiry of the waiting period.

10.2 A doctor's or chiropractor's certificate of incapacity to work must be supplied within a further three days. If submission of this certificate is delayed, entitlement to the insured daily allowance shall exist from the time when the medical certificate is submitted at the earliest. After the end of the incapacity to work, written confirmation of the degree and duration of the incapacity to work must be sent to the insurer without delay.

10.3 The insured person must provide proof of loss of income.

10.4 The insured person must make regular visits to their doctor for treatment or for check-ups. The insured person shall also be obliged to undergo any medical examinations deemed necessary by the insurer. These examinations shall be paid for by the insurer. The insurer shall be entitled to make sick visits in order to check that doctor's orders are being followed.

10.5 The insured person must follow their doctor's orders, and must do everything in their power to aid their recovery and refrain from doing anything which would delay it.

10.6 The insured person must provide the insurer with all information required to determine the benefits. This includes any rulings from other social insurance institutions.

10.7 The insured person must release the medical practitioners by whom they are being or have been treated from their duty to maintain confidentiality in respect of the insurer, and authorise them to provide all information requested by the insurer in connection with this insurance policy.

10.8 An insured person who is fully or partially incapable of working in their usual job, either temporarily or permanently, shall be obliged to utilise their residual ability to work in a new job in another field of employment. The insurer shall request the insured person to take on another acceptable form of employment, and shall notify them of the legal consequences.

**11 What are the consequences if these duties or obligations are disregarded?**

The insurance benefits shall be temporarily or permanently reduced or, in serious cases, withdrawn if the insured person breaches the required obligations or duties in an inexcusable manner.

**12 What should be noted with regard to payment of benefits?**

12.1 The agreed waiting period shall be added to the period of benefits and shall only be calculated once within any 365-day period.

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

12.3 In the event of partial incapacity to work of at least 25%, the daily allowance shall be paid out proportionally to the degree of incapacity to work.

12.4 If benefits are provided for the same event by more than one insurer, the total benefits may not exceed the proven loss of income. If this is the case, the benefits under this policy shall be provided subsequent to other insurers' benefits, i.e. they shall be reduced by the amount of the excess indemnity. This shall exclude benefits from fixed-sum insurance policies which are paid irrespective of the actual loss of income.

12.5 If a private insurer reduces or withdraws benefits on the basis of a subsidiarity clause, benefits shall be provided proportionally under this policy.

12.6 Women who give up gainful employment more than eight weeks before confinement shall not be entitled to benefits, except where they have given up gainful employment due to illness or an insured accident.

12.7 Payments to the insured person shall be transferred free of charge to their postal or bank account. If the insured person requires payment via money order (ASR), the appropriate charges shall be invoiced in full to the insured person.

**13 What particular rules apply to stays abroad?**

13.1 No benefits shall be provided if the insured person goes abroad for treatment, care or childbirth. This does not affect the right to treatment covered by compulsory health insurance.

13.2 If an insured person who is unable to work wishes to go abroad, they must inform the insurer in advance. The insurer may, depending on the circumstances, suspend the insurance payments for a limited duration.

13.3 An insured person who becomes unable to work while abroad only has a right to benefits during a medically required hospital stay if it is not possible to return to Switzerland. This restriction does not apply within the member states of the European Union (EU) or the European Free Trade Association (EFTA).

13.4 The right to claim resulting from the agreements on the free movement of persons concluded with the European Union (EU) and the European Free Trade Association (EFTA) remain unaffected.

**14 Under what circumstances is the insurance cover subject to restrictions?**

14.1 The insurance benefits shall 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,
- which result from exceptionally dangerous activities (e.g. military service abroad or participation in armed conflicts, acts of terrorism, fights, criminal actions or civil torts) or
- which result from hazardous behaviour.

14.2 Loss of working hours due to outpatient examinations or treatment cannot be claimed under the daily allowance insurance.

14.3 Loss of working hours due to spa stays shall only be insured when the spa stay is medically indicated and a request for such a spa stay is received by the insurer in good time before the spa stay begins.

**15 What is the procedure in the event of a dispute?**

If an insured person is not in agreement with a decision made by the insurer, they may request a written ruling. This ruling includes an explanation about rights of appeal.

**16 What conditions apply to notifications and payments?**

16.1 Notifications sent to the insurer must be directed to the address stated in the policy.

16.2 Policyholders shall receive notifications and payments from the insurer at their most recent reported address in Switzerland.

16.3 Additional information and binding notifications, for example, in relation to amendments to these Insurance Conditions, are published on the insurer's homepage, in the customer magazine and issued with the annual policy enclosures.

**17 When do these Insurance Conditions come into force?**

These Insurance Conditions come into force on 1 January 2014. They replace the General Insurance Conditions, version dated 1 January 2005.