CONCORDIA
your health, our priority

2023 Edition

TIKU/DIMA/DIMI Term Life Insurance

Flexible Pension Provision (Pillar 3b)
Customer information regarding the General Insurance Terms and Conditions of TIKU/DIMA/DIMI Term Life Insurance

This document defines the insurance provider and provides an overview of the essential content of the insurance contract in accordance with Art. 3 of the Swiss federal law on insurance contracts (VVG/LCA). It also contains the full General Insurance Terms and Conditions.

Term life insurance without a savings component

TIKU/DIMA/DIMI provides cover for death and disability resulting from an illness or accident.

- In the event of death, the insured capital sum upon death is paid out.
- In the event of permanent disability, the insured capital sum upon disability is paid out. In the event of a disability of 25 percent or more, it is paid out proportionally. In the event of a disability of at least 70 percent, the insured person receives the whole capital sum upon disability.
- If the insured person is over 20 years of age, accident insurance may be excluded.
- The insurance has no savings component and no surrender value.

The capital sums upon death and disability are benefits of fixed sum insurance.

Choice of insurance sums

The insurance sums for death and disability may be chosen freely in increments of CHF 10,000. The minimum sum that may be selected is CHF 50,000 in the event of disability and CHF 10,000 in the event of death.

TIKU/DIMA/DIMI for children

For children up to the age of 12, the maximum insurance sum in the event of death is CHF 20,000. If the child dies before it is 2½ years old, a maximum of CHF 2,500 is paid out. From the age of 12, the insurance sums for adults apply.

Premium and payment

The total premium is calculated on the basis of the premium for death and the premium for disability. The amount of these premiums depends on the insured capital as well as the age and gender of the insured person. Risk increases with age; the premiums are adjusted accordingly. From the year in which the insured person reaches the age of 56, the benefit is reduced annually by 20 percent, but in return the premium is not adjusted for increasing risk.

The insurance provider may adjust the premium tariff during the term of the contract.

The pro rata premium for the first calendar year is due upon conclusion of the contract. Subsequently, the premium is payable at the beginning of each calendar year in advance. More frequent payments are possible for a small surcharge.

Start and end of insurance

The application form must be completed truthfully and in full. If a question has been answered incorrectly or something has been concealed, CONCORDIA may cancel the insurance and refuse to provide benefits. If the facts stated in the application form change afterwards, they must be reported before the start of insurance. This applies in particular to illnesses and accidents that occur after submitting the application form.

The insurance begins on the date listed in the policy. In ordinary circumstances, it ends either on 31 December of the year in which the insured person reaches the age of 59, or with the death of the insured person. After a minimum contract duration of one year, TIKU/DIMA/DIMI may be cancelled with effect from the end of the current calendar year.

You can cancel your application for or acceptance of the contract in writing. The cooling-off period is 14 days from the date on which you apply for or accept the contract.

If you are in arrears with the payment of the premium for the first year and do not pay in spite of reminders, CONCORDIA may dissolve the contract.

Furthermore, the insurance ends if the insured person establishes their place of residence abroad or stays abroad for more than 12 months and CONCORDIA has not given written consent to continue the insurance.

Further circumstances in which the contract may be terminated and the period during which the insurance cover applies are set out in the General Insurance Terms and Conditions and the Swiss federal law on insurance contracts (VVG/LCA).

Limitations on benefits

If death or disability has been caused deliberately or by gross negligence, or if death or disability occurs as the result of a reckless venture, CONCORDIA may reduce the insurance benefits or refuse them altogether. Further exclusions and limitations regarding the insurance cover are contained in the General Insurance Terms and Conditions, any applicable Special Terms and Conditions and the VVG/LCA.

For what purpose does CONCORDIA process data?

- **Conclusion and processing of the insurance contract (incl. issuing a quote):** The data are processed for the purpose of creating a quote as well as concluding and processing the insurance contract. In particular, this includes the following purposes: Processing requests; benefit processing; compliance with legal, regulatory and internal provisions; commission settlement; data maintenance; statistical analysis; review of applications and underwriting as well as clarification of a breach of duty to notify (VVG/LCA); customer information; customer correspondence; debt collection and disbursement; customer advisory; insurance card; clarification of insurance requirement; discount review; combating insurance fraud. The data can be stored physically or electronically.

- **Security:** The data are processed to guarantee information security. In particular, this can include the following purposes: Monitoring and documenting the systems and networks of CONCORDIA, ensuring operations, fault management, testing, back-up management.

- **Marketing:** The data are used for the marketing purposes of CONCORDIA. In particular, the affected persons can be contacted once a year by letter and by phone from employees of CONCORDIA Insurances Ltd or through a partner centre. Other marketing activities may include: Determining customer satisfaction and customer needs, market research and provision of tailored services. Consent for the future can be withdrawn at any time. The legality of data processing that is conducted between the time of consent and the withdrawal of consent is not affected by this.

Does CONCORDIA exchange data with third parties?

Under certain circumstances, data can be obtained through third parties (e.g. hospitals, medical experts, other insurers, authorities). The data in these cases relate to insured persons (e.g. name, address, contact data, insurance products) or their health (e.g. invoices, medical reports, statements of benefits).

Within the scope of legal and contractual obligations, data can be disclosed to recipients. Depending on the individual case, this relates to the following categories of recipients: Service providers that support CONCORDIA in fulfilling processing purposes (e.g. IT service providers, printing companies, partner centres), authorities, other insurers, reinsurers, external experts, third parties involved in legal disputes as well as other companies of the CONCORDIA Group.

The data may be transferred to the representative office of CONCORDIA in Liechtenstein. The Federal Council has established that the law in Liechtenstein provides adequate protection in accordance with Art. 16 para. 2 of the Federal act on data protection (DSG/LPD/FADP).

Who is responsible for data processing?

CONCORDIA Insurances Ltd, Bundesplatz 15, 6002 Lucerne, is responsible for data processing. Insured persons have the right to request the information stipulated by law from CONCORDIA on the data processed about them. The company data protection officer can be contacted at the following: CONCORDIA, Data Protection, Bundesplatz 15, 6002 Lucerne, info@concordia.ch or +41 41 228 01 11.

You can find comprehensive information on this in the privacy policy at www.concordia.ch/dataprotection.

Written form requirement

Other means of documentation in the form of text are deemed to be equivalent to the conventional written form. Exceptions to this principle are listed in the General Insurance Terms and Conditions.

The following are normally deemed to be equivalent to the written form:

- Text received through CONCORDIA's customer portal;
- Text received through the electronic contact form on CONCORDIA's website (www.concordia.ch) after prior verification of identity. CONCORDIA is not obliged to provide such a contact form;
- Text in signed and scanned pdf documents received by CONCORDIA via e-mail at info@concordia.ch or at the e-mail address listed in the policy;
- Text in e-mails with a qualified electronic signature received by CONCORDIA at info@concordia.ch or at the e-mail address listed in the policy.

Insurance provider

The insurance provider is CONCORDIA Insurances Ltd, whose registered office is located at Bundesplatz 15, 6002 Lucerne. CONCORDIA is a public limited company (Aktiengesellschaft/ société anonyme/società anonima) of the CONCORDIA Group.

Additional information on the rights and duties of the contract partners – in particular insurance cover, exclusion from benefits, the insurance sum, premiums and data protection – can be found in the insurance application form, the policy, the General Insurance Terms and Conditions, the Special Terms and Conditions if applicable and the VVG/LCA.

CONCORDIA
your health, our priority

2022 Edition

TIKU/DIMA/DIMI Term Life Insurance

Flexible Pension Provision (Pillar 3b)
General Insurance Terms and Conditions

1. Object of Insurance

1.1 Insured Risks

TIKU/DIMA/DIMI Term Life Insurance (TIKU in German, DIMA in French and DIMI in Italian) provides cover against the financial consequences of death or disability resulting from an illness or accident, doing so within the framework of flexible pension provision (Pillar 3b).

TIKU/DIMA/DIMI is a pure risk insurance. Because its premiums contain no savings component, it has no surrender value and provides no benefit in case of survival, except in the event of disability.

The capital sums upon death and disability are benefits of fixed sum insurance.

The insurance is valid worldwide; however, outside of Switzerland and the Principality of Liechtenstein, it is valid only during trips and stays of up to 12 months unless otherwise agreed in writing with the insurance provider.

1.2 Insured Capital Sum

1.2.1 For each insured person, a capital sum upon death, a capital sum upon disability, or both may be insured.

1.2.2 The amount of capital insured per risk is specified in the insurance policy. It amounts to at least CHF 10,000 in the event of death and at least CHF 50,000 in the event of disability. Until the insured person reaches the age of 12, a maximum of CHF 20,000 may be insured in the event of death.

1.2.3 Up until the end of the calendar year in which the insured person reaches the age of 20, the insured capital in case of illness and in case of accident is the same amount for each. From the start of the insured person's prevailing age of 21, the amount of capital insured in case of accident may be the same as, or lower than, the amount of capital insured in case of illness.

1.2.4 The insured capital remains constant until the end of the calendar year in which the insured person reaches the age of 55. Once the insured person reaches the prevailing age of 56, the insured capital decreases annually by 20 percent of the capital sum that was insured at the age of 55.

1.2.5 If a part of the capital sum upon disability is paid out, the other part remains insured. Any reinstatement or increase of the original amount of insured capital is excluded.

1.3 Illness

An illness is defined as any medically ascertainable involuntary physical or mental health disorder necessitating medical treatment, which cannot be attributed to an accident.

1.4 Accident

An accident is defined as the sudden, involuntary damaging effect of an unusual external factor on the human body resulting in a medically and objectively ascertainable impairment of physical, mental or psychological health, or resulting in death. The following are also considered to be accidents:

- damage to health caused by involuntarily breathing in gases or fumes and by inadvertently ingesting poisonous or corrosive substances;
- dislocating, straining and tearing muscles and tendons as a result of sudden exertions;
- frostbite, heatstroke, sunstroke and damage to health caused by ultraviolet rays, excluding sunburn;
- involuntary drowning.

If the accident risk is not insured, no entitlement to benefits arises if death or disability is caused by an accident or by an accident-like bodily injury. In the event that there is a concurrence of various causes, benefits are provided in proportion to the part not resulting from the accident.

1.5 Earning Incapacity

Earning incapacity exists when, as the result of an illness or accident:

- the gainfully employed insured person is completely or partially incapable of practising their profession or another reasonable gainful activity. Another gainful activity is deemed reasonable if it is commensurate with the abilities and professional status of the insured person, even if the knowledge needed for the activity requires retraining.
- the insured person who is not gainfully employed or is undergoing training is completely or partially unable to carry out the activities they previously carried out.

1.6 Disability

A disability is the permanent earning incapacity that is expected to last until the end of the insured person's life. It is recognised by the insurer as such:

- if a notable improvement in the earning capacity cannot be expected from the continuation of medical treatment and the earning incapacity will be lifelong in spite of rehabilitation measures, and
- if the earning incapacity has existed over a period of at least 12 months. If the disability has been ascertained before the 12 months have expired, the insurance provider may recognise it earlier.

1.7 Determination by the Insurance Provider

The insurance provider determines the earning incapacity or disability as well as the onset, degree

and duration of these based on an evaluation carried out by an official expert in Switzerland or in Liechtenstein that is recognised or designated by the insurance provider.
In the case of gainfully employed persons, the degree of earning incapacity or disability is determined on the basis of the loss of earnings. The income earned prior to the onset of incapacity is compared with the income that the insured person is able to earn following the onset of incapacity or could earn in a stable employment market. For gainfully employed persons who have an irregular or highly fluctuating income and for the self-employed, the average income subject to AHV/AVS/OASI payments of the 36 calendar months prior to the onset of earning incapacity is used as the prevailing income.
In the case of insured persons who are not gainfully employed or are undergoing training, the degree of earning incapacity or disability is determined on the basis of a comparison of activities. Activities that were performed by the insured person in their field of duties prior to the onset of earning incapacity are compared with those activities that may be carried out afterwards and are deemed reasonable.

2. Persons Involved in the Contract

2.1 Persons Involved

The following persons are involved in the insurance contract:

- the **policyholder** is the person who submits the application form, takes out the insurance and is the contract partner of the insurance provider;
- the **insured person** is the person whose life or earning capacity is insured (the insured person may be the policyholder or another person);
- the **beneficiaries** are the persons or institutions which, in accordance with the wishes of the policyholder, are to receive the insurance benefits in full or in part;
- the **premium payer** is the policyholder, unless another person has undertaken to pay the premiums; and
- the **insurance provider** and contract partner of the policyholder is CONCORDIA Insurances Ltd.

2.2 Notifications

Notifications to the insurance provider are legally effective only if they reach the insurance provider in writing.
Notifications from the insurance provider to the policyholders, insured persons, premium payers, persons entitled to benefits and beneficiaries are effected in writing and sent to the last known address.
Notifications may also be sent electronically. The insurance provider may stipulate requirements in order for electronic notifications to be deemed to have been delivered in a legally valid manner.
If the policyholder lives outside of Switzerland or the Principality of Liechtenstein, they must designate a representative in Switzerland or in the Principality of Liechtenstein to whom the insurance provider may send all notifications in a legally valid manner.

2.3 Written Form, Types of Documentation Equivalent to the Written Form

In principle, other means of documentation in the form of text are deemed to be equivalent to the conventional written form. The insurance provider may stipulate requirements on its website (www.concordia.ch) and in the customer information in accordance with Art. 3 VVG/LCA for the other forms to be accepted as equivalent to the written form. Mandatory statutory provisions and related court rulings remain reserved. The use of other forms of text may be associated with increased data protection risks. The insurance provider is not liable for actions that are the policyholder's own responsibility.

3. Basis of the Contract

3.1 The following, in order of precedence, constitute the legal basis of the contract:

- The insurance application, the fully completed questionnaires and, where applicable, the medical examination report as well as other information supplied for the purpose of risk analysis;
- The provisions in the insurance policy and in any addenda or Special Terms and Conditions;
- These General Insurance Terms and Conditions;
- The Swiss federal law on insurance contracts of 2 April 1908 (VVG/LCA) if a particular set of circumstances is not expressly dealt with in the contract.

If two or more documents contradict each other in the interpretation of the contract, the provisions in the higher-ranking document prevail.

3.2 In all situations where these General Insurance Terms and Conditions or the premium tariff refer to the age of the insured person, the numerical difference between the relevant calendar year and the year of birth is taken as the prevailing age.

3.3 The insurance year corresponds to the calendar year. The first insurance year lasts from the start of the insurance until the end of the same calendar year.

4. Concluding the Contract

4.1 Legal Residence and Entry Age

A person may be insured if they are a resident of Switzerland or the Principality of Liechtenstein. They may be insured no earlier than from the first day of the month after their birth. The insurance may no longer be taken out and the insured capital may no longer be increased from the beginning of the calendar year in which the insured person attains 56 years of age.

4.2 Submitting the Application Form

The policyholder must fill out the insurance application form truthfully and completely and submit it to the insurance provider. The insured person or their legal representative must answer the questions concerning health and other risk factors truthfully and in full.

The policyholder is bound to their application for 14 days, or for 4 weeks if a medical examination is required, provided they have not set a shorter deadline or withdrawn from the application process.

4.3 Cooling-off Period

The policyholder may withdraw their application for or acceptance of the contract in writing. The cooling-off period is 14 days from the date on which the policyholder applies for or accepts the contract.

4.4 Duty to Notify and Consequences of a Breach Thereof

The policyholder and the insured person (or their representative) are obligated, throughout the whole admission process, to report to the insurance provider all relevant facts required to assess the risk insofar as they are aware of or should be aware of such facts.

A breach of the duty to notify occurs if the policyholder or insured person (or their representative) conceals or inaccurately communicates significant facts about which they were questioned in writing and which they were aware of or should have been aware of when answering the questions. In particular, illnesses or consequences of accidents that existed at the time the application was made or existed in the past are considered to be significant facts.

The insurance provider may cancel the contract in writing within a period of four weeks of learning about a breach of the duty to notify. As a consequence, the duty to provide benefits also lapses for damages that have already arisen, and whose occurrence or extent was affected by the significant risk factor that was inaccurately disclosed or not disclosed at all. For insurances with a start date up to 1 January 2006, the duty to provide benefits ends for claims that have already arisen in all cases. If the duty to provide benefits has already been fulfilled, the insurance provider is entitled to reimbursement. There is no entitlement to the reimbursement of the premium paid.

4.5 Change in Circumstances before Start of Insurance

If, after answering the questions and before the start of insurance, there is a change in any circumstances that would lead to a significant increase in risk, the policyholder or insured person or their representative must notify the insurance provider without delay and correct their responses to the questions. The insurance provider has the right to withdraw from the contract in the event of an increase in risks or a breach of duties to notify.

5. Start, Term and End of Insurance

5.1 Provisional Insurance Cover

5.1.1 Provisional insurance cover begins once the fully completed application form has been submitted to the insurance provider, but no earlier than the insurance start date given in the application.

5.1.2 If the application for insurance is submitted before the birth of the insured person, provisional insurance cover begins once the notification that the child has been born and is perfectly healthy has been received by the insurance provider, but no earlier than the first day of the month following the birth.

5.1.3 Provisional insurance cover will only be granted if, at the time of submitting the application, the person to be insured:

- is not planning a stay outside of Switzerland, the Principality of Liechtenstein, Western Europe or North America,
- is not undergoing any medical examination or treatment, or is not under medical supervision,
- is fully capable of working, if the person to be insured is gainfully employed, or
- is able to carry out all activities that a perfectly healthy person of the same age and gender can, if the person to be insured is not gainfully employed.

5.1.4 Provisional insurance cover does not apply to pre-existing health impairments and the consequences thereof.

5.1.5 If an insured event occurs during the period of the provisional insurance cover, the insurance provider will provide the insurance benefits that have been claimed, but no more than CHF 100,000 in case of death and CHF 100,000 in case of disability for all pending applications and all existing policies on the life of the same person.

5.1.6 Provisional insurance cover lasts for 60 days at most. It expires:
- upon entry into force of definitive insurance cover,
- as soon as the policyholder cancels the application or refuses a change suggested by the insurance provider,
- as soon as the insurance provider temporarily defers or declines an application.

5.2 Definitive Insurance Cover

The insurance provider decides whether to accept the insurance application. The insurance provider may accept the application with no changes, apply provisos, impose a premium surcharge for special risks, defer the application or completely refuse to provide insurance.

Definitive insurance cover enters into force on the date specified in the policy as the start of insurance.

5.3 Contract Term

The insurance runs no longer than to the end of the calendar year in which the insured person reaches the prevailing age of 59 (term age).

5.4 Cancellation

No earlier than one year after the start of insurance, the policyholder may terminate the insurance prematurely at the end of the current calendar year or reduce the insurance sum by means of a written notification.

5.5 End of Insurance

The insurance ends:
- upon death of the insured person,
- if the insured person becomes fully disabled, provided that death is not insured, or
- when the insured person reaches the term age.

The insurance ends prematurely:
- if the policyholder withdraws from the application,
- if the policyholder gives notice to cancel,
- if the insurance provider gives notice to cancel following a breach of the duty to notify or a significant increase in risks before the start of insurance,
- if the insured person establishes their residence outside of Switzerland or the Principality of Liechtenstein or stays abroad for more than 12 months without the insurance provider having given written consent to the continuation of the insurance beforehand,
- upon expiry of the reminder period (in the event that premiums have not been paid).

6. Limitations on Insurance Cover

6.1 In General

There is no entitlement to insurance benefits in the event of:
- any health impairments that existed at birth (e.g. congenital disorders, genetic defects and illnesses, deformities, the consequences of accidents or interventions during pregnancy or birth injuries) and their consequences. The point at which this health impairment is recognised or diagnosed is immaterial;
- death or disability following the effects of ionising radiation and damage caused by nuclear energy;
- refusal or obstruction of the examinations, investigations or professional reintegration measures requested by the insurance provider;
- participation in peacekeeping operations under a UN mandate;
- participation in war, war-like actions or civil unrest. The provisions in accordance with Art. 13 regarding military service, war and unrest apply.
- the consequences of the insured person intentionally committing a felony or misdemeanour, or attempting to do so. The intent exists if the insured person carries out the act deliberately and in the full knowledge of what they are doing, or accepts the possibility that the act will be realised.

6.2 Deliberate Causation

No entitlement to insurance benefits exists if the insured person:
- dies as a result of suicide or becomes disabled in the attempt to do so within three years from the start of insurance, from increasing the insurance or from reinstating the insurance,
- has deliberately caused their disability.

This also applies if the insured person has carried out the action that led to death or disability while in a state of diminished capacity.

6.3 Gross Negligence and Reckless Venture

If an insured event is caused by gross negligence, the insurance provider may reduce the insurance benefits. Gross negligence exists when, due to culpable carelessness, the consequences of the behaviour were not considered or taken into account, and the most elementary precautions, which should have been obvious to any reasonable person in the same position and under the same circumstances, are not taken.

If the insured event is the consequence of one or more reckless ventures, the insured benefits are reduced or, in particularly serious cases, denied. Reckless ventures are acts where the insured

person exposes themselves to a particularly great danger without taking or being able to take precautions that limit the risk to a reasonable degree. However, attempts to rescue other persons are insured, even if they can be regarded as reckless ventures in themselves.

6.4 Death of a Child

The insurance provider may pay out a maximum of the following amounts on the life of an insured child, as capital sum upon death:

- CHF 2,500 if the child dies before it is 2½ years old.
- CHF 20,000 from all existing insurances if the child is between 2½ and 12 years of age at the time of death.

7. Payout of Benefits

7.1 In Case of Death

7.1.1 If the death of the insured person occurs during the duration of the insurance cover, then the entitlement to the capital sum upon death arises.

7.1.2 If the death of the insured person takes place after the capital sum upon disability has been completely or partially paid out, then the capital sum upon death shall likewise be paid out provided at least six months have elapsed between the onset of the disability and the death of the insured person. If the death occurs prior to that, and the capital sum upon death that has been insured is higher than the capital sum upon disability that has already been paid out, then the entitlement to a payout of the difference arises. Should the cause of death have no relation to the cause of disability, then the whole capital sum upon death shall be paid out.

7.2 In Case of Disability

Should the insured person become disabled during the term of the insurance cover, they are entitled to the capital sum upon disability depending on the degree of disability:

- In the case of a disability of less than 25 percent, there is no entitlement.
- In the case of a disability between 25 and 70 percent, the insured person is entitled to a proportion of the capital sum upon disability corresponding to the degree of disability.
- In the case of a disability of at least 70 percent, the insured person is entitled to the whole capital sum upon disability.

7.3 Adjustment to the Degree of Disability

Each change to the degree of disability must be communicated immediately to the insurance provider. The insurance provider has the right to have the degree of disability reevaluated at any time.

If benefits have been drawn in excess as a result of changes to the degree of disability, the excess must be paid back. If an insufficient amount of premiums have been paid, the difference must be paid.

7.4 Proof of Entitlement

7.4.1 The insurance provider evaluates the entitlement to the insurance benefits once all necessary documents have been submitted. For the investigation of entitlement to benefits, all of the documents listed below must be submitted.

In case of death:

- The original insurance policy
- The completed application for benefits
- The family record book and/or family certificate
- An official death certificate
- A medical certificate

In case of disability:

- The original insurance policy
- The completed application for benefits
- A report from the treating doctors regarding the cause, course and duration of the disability

7.4.2 The insurance provider is entitled to request further information or proof, or obtain it on its own accord as well as to have the insured person examined at any time by a doctor. The doctors of the insured person are released from professional confidentiality vis-à-vis the insurance provider.

7.4.3 The documents and evidence must be submitted in German, French, Italian or English. If documents or evidence are submitted in another language, the insurance provider may request that the person claiming benefits obtains an officially certified translation of the documents in Switzerland.

7.4.4 The period of limitation for claims resulting from the insurance contract is five years from the onset of the event upon which the duty to provide the benefit is based.

7.5 Payout

The payout of the insurance benefits is made in Swiss Francs (CHF) to an account designated by the beneficiary at a bank in Switzerland or the Principality of Liechtenstein, or at the Swiss Post.

In case of pledging, the insurance provider is only permitted to pay out the benefit owed with the written consent of the pledgee.

8. Designation of Beneficiaries

8.1 Beneficiaries

8.1.1 Unless otherwise specified, the following persons are regarded, successively in the order shown below, as beneficiaries:

1. The insured person
2. In the event of their death, the spouse or registered partner of the insured person
3. In the absence of the latter, the children of the insured person
4. In the absence of the latter, the parents of the insured person
5. In the absence of the latter, the other heirs of the insured person, with the exception of the community

8.1.2 If none of the persons entitled to benefits are available, the funeral expenses will be covered for a minimum of CHF 2,500, but no more than 10 percent of the insurance sum in case of death.

8.1.3 The policyholder may modify the order of the beneficiaries, exclude persons who are entitled or designate other beneficiaries at any time before the payout of the insurance benefit provided that they have not previously made an irrevocable beneficiary designation. The policyholder may not be represented by another person when doing so.

8.1.4 The policyholder must send this information in writing to the insurance provider and clearly designate the beneficiary by name (the other text forms equivalent to the written form are invalid). Juridical entities may also be nominated as beneficiaries.

8.1.5 The policyholder may make an irrevocable beneficiary designation. To do so, they must note on the policy that they waive their right to revoke the beneficiary, sign the policy, and subsequently hand over the policy to the beneficiary.

8.2 Designation of Beneficiaries in Case of Bankruptcy and Seizure

8.2.1 If the policyholder has declared an irrevocable beneficiary designation, the insurance entitlement that has been established owing to the beneficiary designation is not subject to debt collection procedures in favour of the policyholder's creditors.

The beneficiary designation expires with the seizure of the insurance entitlement and the initiation of bankruptcy proceedings against the policyholder. It is revived if the seizure is terminated or the bankruptcy is revoked.

8.2.2 If the policyholder has taken out the insurance on their own life, then their spouse, registered partner or offspring are privileged in the liquidation of the policyholder in terms of debt collection law and bankruptcy law, subject to liens that may apply, as follows:

- If these persons have been designated beneficiaries, then neither their entitlement nor that of the policyholder is subject to debt collection procedures. Provided that they do not expressly decline the entitlement, these beneficiaries replace the policyholder in regard to the rights and duties of the insurance contract.
- If other beneficiaries are appointed, the spouse, registered partner or offspring of the policyholder may, with the approval of the policyholder, request that entitlement on the insurance contract be transferred to them.

8.3 Assignment and Pledging

The policyholder may pledge or assign their entitlement to the insurance. To do this, all of the following conditions must be fulfilled:

- A written pledge or assignment contract must be established between the policyholder and the pledgee/acquirer of the entitlement (the other text forms equivalent to the written form are invalid).
- The insurance policy must be delivered to the pledgee/acquirer of the entitlement.
- Written notification must be given to the insurance provider (the other text forms equivalent to the written form are invalid). The beneficiary designation is subordinate to the lien and retakes its full effect as soon as the pledge is revoked. In case of assignment, the acquirer of the insurance entitlement becomes the person entitled to benefits.

9. Premiums

9.1 Tariff

The premium is set annually and appears in the policy. The premium tariff allows for risk-based age brackets. If the prevailing age of the insured person reaches the next bracket, the premium is raised on the grounds of higher risk.

9.2 Tariff Adjustment

Premium tariffs are not guaranteed. The insurance provider is permitted to adjust them if the underlying circumstances of the premium calculation have changed considerably. In order to adjust them, the insurance provider informs the policyholder in writing of the adjustment at the latest eight weeks before the adjustment takes effect. The policyholder then has the right to cancel the insurance in writing. If the policyholder exercises this right, the insurance expires at the end of the current insurance year. The notice of cancellation must reach the insurance provider no later than the last day of the current insurance year. If the policyholder does not cancel the insurance, they are deemed to have consented to the adjustment of the insurance.

If the premium increases because the insured person has reached the next bracket of the premium tariff, this does not constitute grounds for cancellation.

9.3 Duty to Pay

The insurance period is the calendar year. The premium must be paid annually in advance. During the first calendar year, the pro rata premium is due upon conclusion of the contract. During the subsequent years, the premium is always due at the beginning of each calendar year.

The annual premium may also be paid in instalments against a surcharge. The instalments must also be paid in advance. Depending on the mode of payment, the insurance provider may impose an additional surcharge on the premium or grant discounts.

9.4 Consequences of a Default

If the premium is not paid by the due date, the policyholder is requested in writing, with reference made to the consequences of defaulting on payments, to pay the outstanding premiums within 14 days of the reminder being sent. If this reminder remains unsuccessful, the duty to provide benefits is suspended as from the end of the reminder period.

If the premium is paid after the expiry of the reminder period, the insurance cover is not automatically reinstated. The insurance provider may refund the premiums that have been paid late and refuse to continue the insurance, request a new health examination of the insured person, or grant insurance cover on new terms. There is no insurance cover for the consequences of any events that take place between the expiry of the reminder period and the acceptance of the belated premiums, along with interest and costs.

9.5 Premium Reimbursements

The insurance provider will reimburse premiums paid for the period after the death or onset of a disability of the insured person to the premium payer currently registered with the insurance provider.

10. Handling Data

10.1 The insurance provider processes data required to execute the insurance contract, in particular information regarding policyholders, insured persons, premium payers and beneficiaries.

10.2 Data may be stored electronically or in paper form.

10.3 The insurance provider may transfer a portion of the risk to a reinsurer. In doing so, the insurance provider discloses personal data that are necessary for the reinsurance to the reinsurer.

10.4 For the execution of the insurance, the insurance provider may consult with external experts, such as doctors and legal experts who, on their part, are obligated to comply with data protection and maintain confidentiality. In the course of examining the application or benefits, personal data may also be collected from or disclosed to other insurance companies. Personal data are disclosed to other third parties only with the agreement of the policyholder and/or the insured person.

11. Place of Jurisdiction

Legal proceedings may be instituted against the insurance provider at its registered office in Lucerne or at the place of residence of the policyholder or person entitled to benefits in Switzerland or Liechtenstein.

12. Adjustment of the Insurance Terms and Conditions

The insurance terms and conditions apply for the entire duration of insurance. If, during the course of the contract, the insurance provider modifies the insurance terms and conditions for TIKU/ DIMA/ DIMI Term Life Insurance, it will examine, at the request of the policyholder, whether and to what extent the new insurance terms and conditions may be applied.

13. Military Service, War and Unrest

13.1 Active service for maintaining Swiss neutrality and implementing law and order internally, both without acts of war, is considered to be military service in peacetime and, as such, is automatically covered by the insurance within the framework of these General Insurance Terms and Conditions.

13.2 If Switzerland is at war or if it becomes involved in war-like actions, a one-off war contribution, which becomes due one year after the end of the war, is owed from the start of the war onwards. Whether or not the insured person takes part in the war and whether they are located in Switzerland or abroad is immaterial.

13.3 The war contribution serves to cover the damage directly or indirectly caused by war insofar as it concerns insurances to which these Terms and Conditions apply. The insurance provider assesses this war damage and the available means of cover and fixes the war contribution and the repayment options thereof, where necessary by reducing the

insurance benefits, with the approval of the Swiss supervisory authority.

13.4 If benefits from the insurance become due before the war contribution has been fixed, the insurance provider is authorised to postpone a reasonable part of the payment until one year after the end of the war. The proportion of the benefit to be postponed and the interest rate at which this proportion is to bear interest are determined by the insurance provider with the approval of the Swiss supervisory authority.

13.5 The start and end dates of the war in the sense of the above provisions are stipulated by the Swiss supervisory authority.

13.6 If the insured person takes part in a war or war-like actions without Switzerland itself being at war or involved in war-like actions, and the insured person dies during such a war or within six months of the peace settlement or the end of the hostilities, the insurance provider owes the mathematical reserve calculated for the day of death, however no more than the benefit insured in case of death. If survivors' pensions are insured, the mathematical reserve is replaced by the pensions that correspond to the mathematical reserve calculated for the day of death, but no more than the insured pensions.

13.7 The insurance provider reserves the right to modify the provisions of this article, with the approval of the Swiss supervisory authority, with effect on this insurance. Furthermore, the legal and official measures issued in connection with a war, in particular those concerning the surrender of insurance, remain expressly reserved.

If there are differences in content between the English and the German, French or Italian Insurance Terms and Conditions, the Insurance Terms and Conditions in the language in which the policy is written apply.

The following abbreviations, with corresponding translations in German, French, Italian and English, are used in these General Insurance Terms and Conditions:

VVG/LCA
VVG: Bundesgesetz über den Versicherungsvertrag
LCA: Loi fédérale sur le contrat d'assurance
LCA: Legge federale sul contratto d'assicurazione
Swiss federal law on insurance contracts

AHV/AVS; OASI
AHV: Eidgenössische Alters- und Hinterlassenenversicherung
AVS: Assurance-vieillesse et survivants
AVS: Assicurazione vecchiaia e superstiti
OASI: Swiss Old Age and Survivors' Insurance

CONCORDIA
your health, our priority

CONCORDIA
Bundesplatz 15
6002 Lucerne
Phone +41 41 228 01 11
www.concordia.ch
info@concordia.ch

2.10.E.04 (09.23)