CONCORDIA
Bound by trust

2013 Edition

TIKU/DIMA/DIMI Term Life Insurance

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

Information regarding TIKU/DIMA/DIMI Term Life Insurance

The present document provides you with quick and comprehensible information regarding TIKU/DIMA/DIMI (TIKU in German, DIMA in French and DIMI in Italian). In the same document, you will find the General Insurance Terms and Conditions.

Term Life Insurance without a savings component

With TIKU/DIMA/DIMI, death and/or disability resulting from an illness or accident are insured.

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

Choice of insurance sums

The insurance sums for death and for disability are freely selectable, each 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 2 ½ years old, a maximum of CHF 2,500 is paid out. Beginning with the 12th year of age, 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 sex and age of the insured person. Risk increases with age; the premiums are adjusted accordingly. From the 56th year of age, the benefit is reduced annually by 20%; as such, there is no premium adjustment for increasing risk.
The insurance provider may adjust the premium rate during the duration of the contract.
For the first calendar year, the pro rata premium is owed upon conclusion of the contract. Subsequently, the premium is to be paid every year in advance, at the beginning of the calendar year. In exchange for a small surcharge, shorter payment periods may be selected.

Start and end of insurance

The insurance proposal form (application) must be filled out truthfully and completely. If a question has been answered incorrectly or if something has been concealed, CONCORDIA may cancel the insurance and refuse to provide benefits. If the facts stated in the proposal form change afterward, they must be subsequently reported before the start of insurance. This applies, in particular, to illnesses and/or accidents that occur after submitting the proposal 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 contact duration of one year, TIKU/DIMA/DIMI may be cancelled prematurely with effect at the end of the current calendar year.
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 his place of residence abroad or stays abroad for more than 12 months and CONCORDIA has not given written consent to continue the insurance.
Further possibilities upon which the contract may be terminated appear in the General Insurance Terms and Conditions and in the Swiss federal law on insurance contracts (VVG/LCA).

Limitations regarding the 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 shorten the insurance benefits or even refuse to provide them. Further exclusions and limitations regarding the insurance protection are defined in the General Insurance Terms and Conditions (see below) and in the VVG/LCA.

Discretion and data security

CONCORDIA processes data which is necessary to conclude and execute the insurance contract. For this purpose, CONCORDIA may consult with external experts and other insurance providers. The data is stored either electronically or in paper form.

Insurance provider
The insurance provider is CONCORDIA Insurances Ltd, a corporation of the CONCORDIA Group, with its head office at Bundesplatz 15, 6002 Lucerne.

Additional information regarding the rights and duties of the contract partners – in particular regarding insurance protection, limitations on coverage, insurance sums, premiums and data protection – can be found in the insurance proposal/application, the policy, the General Insurance Terms and Conditions, and the VVG/LCA.

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1. Object of Insurance

1.1 Insured Risks

TIKU/DIMA/DIMI Term Life Insurance (TIKU in German, DIMA in French and DIMI in Italian) offers protection against the financial consequences of death or disability resulting from an illness or accident, doing so within framework of the 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 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 provided that no other written agreement has been reached with the insurance provider.

1.2 Insured Capital

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. Up until the end of the insured person's 12th year of age, 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's age is regarded to be 20, the insured capital in case of illness and in case of an 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's age is regarded to be 55. From the start of the insured person's prevailing age of 56, the insured capital decreases annually by 20 % 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 considered to be any medically and objectively detectable impairment of the physical, mental, or psychological health which cannot be attributed to an accident and which necessitates medical examination and treatment.

1.4 Accident

An accident is the sudden, unintentional and damaging effect of an unusual external factor on the human body resulting in a medically and objectively detectable impairment to 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 by oneself,
- frostbites, heatstroke, sunstroke and damage to health caused by ultraviolet rays, excluding sunburn,
- involuntary drowning.

If the accident is not insured, no entitlement to benefits shall arise 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 event.

1.5 Incapacity to Undertake Gainful Activity

Incapacity to undertake gainful activity exists when, as the result of an illness or accident,

- the gainfully employed insured person is completely or partially incapable of practising his profession or another reasonable gainful activity. Another gainful activity is reasonable if it is commensurate with the abilities and the social position of the insured person, even if the knowledge required for the activity requires retraining.
- the insured person that is not gainfully employed or that is undergoing training is completely or partially restricted from exercising in his previous field of activity.

1.6 Disability

A disability is the constant incapacity to undertake gainful activity that is expected to last until the end of the insured person's life. It is recognised by the insurer as such

- when a notable improvement in the capacity to undertake gainful activity cannot be expected from the continuation of medical treatment and the incapacity to undertake gainful activity will be lifelong in spite of rehabilitation measures, and
- when it has existed over a period of at least 12 months. If the disability is certain 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 incapacity to undertake gainful activity or disability as well as the occurrence, degree and duration thereof 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 incapacity to undertake gainful activity or disability is calculated on the basis of the loss of earnings incurred. When doing so, the income obtained prior to the onset of incapacity to undertake gainful activity is compared with the income that the insured person, following the onset of incapacity to undertake gainful activity, continues to obtain or could obtain 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 of the 36 calendar months prior to the onset of incapacity to undertake gainful activity is used as the prevailing income.

In the case of insured persons that are not gainfully employed or that are undergoing training, the degree of incapacity to undertake gainful activity or disability is calculated on the basis of a comparison of activities. Activities that were performed by the insured person in his field of duties prior to the onset of incapacity to undertake gainful activity shall be compared with those activities that may be carried out afterwards and that are reasonable.

2. Persons Involved in the Contract

2.1 Masculine and Feminine Form

In order to render the insurance Terms and Conditions easier to read, all person-related designations are expressed in the masculine form. They apply to females and legal entities as well.

2.2 Parties Involved

The following persons are involved in the insurance contract:

- the **Policy holder,** who is the person that submits the proposal form (application), takes out the insurance and is the contract partner of the insurance provider;
- the **Insured person,** who is the person whose life or capacity to undertake gainful activity is insured (the insured person may be the policy holder himself or another person);
- the **Beneficiaries,** who are the persons or institutions which, in accordance with the wishes of the policy holder, are to receive the insurance benefits in full or in part;
- the **Premium payer,** who is also the policy holder, provided that another person has not committed himself to paying the premiums; and
- the **Insurance provider** and contract partner of the policy holder, which is CONCORDIA Insurances Ltd.

2.3 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 policy holders, insured persons, premium payers, persons entitled to benefits and beneficiaries are effected in writing and sent to the last known address given.

If the policy holder lives outside of Switzerland or the Principality of Liechtenstein, he 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.

3. Bases of the Contract

3.1 The legal bases of the insurance contract are formed by, in the following order of precedence:

- the insurance proposal form (application), the questionnaire that has been completely filled out and, where applicable, the medical examination report as well as other pieces of information issued for the purpose of risk analysis,
- the provisions in the insurance policy and in any addenda that may apply, or special Terms and Conditions,
- the General Insurance Terms and Conditions on hand,
- the Swiss Federal Law on Insurance Contracts of 2 April 1908 (VVG/LCA), provided that a set of circumstances is not expressly regulated in the contract.

If certain documents contradict each other in the interpretation of the contract, the regulations 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 difference between the relevant calendar year and the year of birth applies 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 he is a resident of Switzerland or the Principality of Liechtenstein. He may be insured no earlier than from the first of the month after his birth. From the beginning of the calendar year in which the insured person attains 56 years of age, no more new insurances may be taken out and the insured capital may no longer be increased.

4.2 Submitting the Proposal Form (Application)

The policy holder must fill out the insurance proposal form truthfully and completely, sign it, and submit it to the insurance provider. The insured person or the legal representative must answer the questions concerning health and other risk factors truthfully and completely.

The policy holder is bound to his proposal form for 14 days, or for four weeks if a medical examination is required, provided that he has not set a shorter term and that he has not withdrawn from the proposal/application process.

4.3 Withdrawal

The policy holder may withdraw in writing from the proposal/application process within 14 days of the date of signature. This also applies if the insurance provider has already accepted the proposal form.

4.4 Duty to Disclose and Consequences of a Breach Thereof

The policy holder and the insured person (or the representative of the insured person) are both 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. If such facts should change at any time before the start of the insurance, the policy holder/insured person (or the representative of the insured person) must inform the insurance provider of this and amend or update what was previously declared in the application and/or the questionnaire.

A breach of the duty to disclose exists if the policy holder or the insured person (or the representative of the insured person), when taking out the insurance, conceals or miscommunicates significant facts of which he had been questioned in writing, and of which he was aware or should have been aware. In particular, illnesses or consequences of accidents that had existed at the time the insurance proposal was made or that had 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 disclose. As a consequence, the duty to provide benefits also expires for damages that have already arisen, and whose occurrence or extent was affected by the significant risk factor that had been inaccurately disclosed or not disclosed at all. In any case, for insurances with a start date up to 1 January 2006, the duty to provide benefits also ends for claims that have already arisen. 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.

5. Start, Duration and End of Insurance

5.1 Provisional Insurance Protection

5.1.1 Provisional insurance protection begins once the proposal form, which has been completely filled out and signed, has been submitted to the insurance provider, but no earlier than the insurance start date given in the proposal form.

5.1.2 If the application for insurance is submitted before the birth of the insured person, provisional insurance protection begins once the notification that the child has been born and is in perfect health 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 protection shall 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, West Europe or North America,
- is not undergoing any medical examination or treatment, or is not under medical supervision,
- is fully capable of working, provided he is gainfully employed, or
- is able to carry out all activities that a perfectly healthy person of the same age and sex can, provided the person to be insured is not gainfully employed.

5.1.4 For already existing health impairments and the consequences thereof, provisional insurance protection does not apply.

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

5.1.6 Provisional insurance protection lasts for 60 days at most. It expires

- upon entry into force of definitive insurance protection;
- as soon as the policy holder 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 Protection

The insurance provider makes a decision regarding the acceptance of 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 protection enters into force on the date specified in the policy as the start of insurance.

5.3 Contract Duration

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

5.4 Cancellation

The policy holder may terminate the insurance prematurely for the end of the current calendar year or reduce the insurance sum no earlier than one year after the start of insurance 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 policy holder withdraws from the application,
- if the policy holder gives notice to cancel,
- if the insurance provider gives notice to cancel following a breach of the duty to disclose,
- if the insured person establishes his 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 Protection

6.1 In General

The insured person is not entitled to insurance benefits in the event of
- prenatal injury, birth defects and the consequences thereof;
- death or disability following the effects of ionising radiation and damage caused by nuclear energy;
- refusal or prevention of the examinations, clarifications or measures towards professional reintegration requested by the insurance provider;
- interventions in connection with peacekeeping measures within the framework of the UN;
- 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 in the knowledge of what he is doing and in accordance with his will, or if he regards the realisation of the act as being possible and accepts this.

6.2 Deliberate Causation

No entitlement to insurance benefits exists if the insured person
- dies as a result of suicide or if he 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 his disability.

This also applies if the insured person has carried out the action that led to death or disability while in a state where he was not able to judge.

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 in the course of this, the most elementary precautionary measures, which should have been obvious to any reasonable person in the same position and under the same circumstances, are neglected.
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 himself to a particularly great danger without taking or being able to take precautions that limit the risk to a reasonable degree. However, rescue operations in favour of persons are also insured, even if they can be regarded as reckless acts.

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 2 ½ years old,
- CHF 20,000 from all existing insurances if the child is between 2 ½ 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 protection, 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 a disability occur to the insured person during the duration of the insurance protection, the insured person is entitled to the capital sum upon disability as a function of the degree of disability:

- in the case of a disability of less than 25%, there is no entitlement.
- in the case of a disability between 25% and 70%, the insured person is entitled to the capital sum upon disability which corresponds in percentage terms to the degree of disability.
- in the case of a disability of at least 70%, 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 re-evaluated 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 Entitlement to the insurance benefits is evaluated by the insurance provider once all necessary documents have been submitted. For the investigation of entitlement to benefits, all of the following documents must be submitted:

- In case of death:
  - the insurance policy in its original form,
  - 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 insurance policy,
  - the completed application for benefits,
  - a report from the treating doctor 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 with regard to the insurance provider.

7.4.3 The period of limitation for claims resulting from the insurance contract is two 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 in 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 due benefit 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 his death, the spouse or the 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 shall be taken over for a minimum of CHF 2,500, but no more than 10% of the insurance sum in case of death.

8.1.3 The policy holder 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 he has not previously made an irrevocable beneficiary designation.

8.1.4 He must express the corresponding information in writing to the insurance provider and must clearly designate the beneficiary by name. Legal entities may also be assigned as beneficiaries.

8.1.5 The policy holder may make an irrevocable beneficiary designation. To do so, he must note on the policy that he waives the right to revoke the beneficiary, sign the policy, and subsequently turn over the policy to the beneficiary.

8.2 Designation of Beneficiaries in Case of Bankruptcy and Seizure

8.2.1 If the policy holder 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 creditor of the policy holder.

Otherwise, the beneficiary designation expires with the seizure of the insurance entitlement and with

the initiation of bankruptcy proceedings against the policy holder. It shall be revived if the seizure is terminated or if the bankruptcy is revoked.

8.2.2 If the policy holder has taken out the insurance on his own life, then his spouse, his registered partner or his offspring are privileged in the liquidation of the policy holder in terms of debt collection law or bankruptcy law, subject to liens that may apply, as follows:
- If these persons have been designated beneficiaries, then neither their entitlement to insurance nor that of the policy holder is subject to debt collection procedures. Provided that they do not expressly decline the entitlement, these beneficiaries shall replace the policy holder in regards to the rights and duties of the insurance contract.
- If other beneficiaries are appointed, the spouse, the registered partner or the offspring of the policy holder may, with the approval of the policy holder, request that entitlement on the life insurance contract be transferred to them.

8.3 Assignment and Pledging

The policy holder may pledge or assign his entitlement to the insurance. To do this, all of the following conditions must be fulfilled:
- a written pledge or assignment contract between the policy holder and the pledgee/acquirer of the entitlement,
- delivery of the insurance policy to the pledgee/acquirer of the entitlement, and
- written notification to the insurance provider.

The beneficiary designation takes second place 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 calculated 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 risks.

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 policy holder in writing of the adjustment at the latest eight weeks before the adjustment takes effect. The policy holder then has the right to cancel the insurance in writing. If the policy holder exercises this right, the insurance expires upon expiration 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 policy holder omits to cancel the insurance, he is 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 corresponds to the calendar year. The premium must be paid annually in advance. During the first calendar year, the proportionate 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 policy holder is requested in writing, with reference made to the consequences of defaulting on payment, to pay the outstanding premiums within 14 days after the reminder is sent. If this reminder remains unsuccessful, the duty to provide benefits is suspended as of the end of the reminder period.
If the premium is paid after the expiration of the reminder period, the insurance protection does not automatically continue to take effect. The insurance provider may subsequently refund the paid premiums and refuse to continue the insurance, request a new health examination of the insured person, or grant insurance protection under new Terms and Conditions. There is no insurance protection for the consequences of any events that take place between the expiration of the reminder period and the acceptance of the belated premiums, along with interest and costs.

9.5 Premium Reimbursements

The insurance provider reimburses the premiums which had been paid for the period after the death or after the onset of a disability of the insured person to the premium payer registered with the insurance provider.

10. Handling Data

10.1 The insurance provider processes data that is necessary to execute the insurance contract, in particular information regarding the policy holder, the insured person, the premium payer and the beneficiaries.

10.2 Data is stored either 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 is 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 is disclosed to other third parties only with the agreement of the policy holder 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 Swiss or Liechtensteiner place of residence of the policy holder or the person entitled to benefits.

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, he examines, at the request of the policy holder, 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 included in 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 he is staying in Switzerland or abroad is insignificant.

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 days which must be regarded as the start of the war and as the end 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 which 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 as well. Furthermore, the legal and official measures issued in connection with a war, in particular those concerning the surrender of insurance, remain expressly reserved.

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