CONCORDIA
Bound by trust

STANDARD and PLUS Individual Daily Allowance Insurances

General Insurance Terms and Conditions

Customer Information in Accordance with the Swiss Federal Law on Insurance Contracts (VVG/LCA)

Customer information

The customer information below provides an overview of the identity of the insurance provider and the essential content of the insurance contract in accordance with Art. 3 of VVG/LCA. The rights and duties of the contracting parties arise from the insurance proposal form/insurance policy, the General Insurance Terms and Conditions, and the applicable laws, in particular the VVG/LCA.

Who is the insurance provider?
The insurance provider is CONCORDIA Insurances Ltd, hereinafter referred to as CONCORDIA, whose registered head office is located at Bundesplatz 15, 6002 Lucerne. CONCORDIA is a corporation according to Swiss law.

Which risks are insured and what is the scope of the insurance protection?
The insurance covers the financial consequences of the following risks:
- illness and/or
- accident and/or
- maternity.

The specific insured risks and the scope of the insurance protection arise from the insurance proposal form/insurance policy as well as from the General Insurance Terms and Conditions.

No insurance cover exists for, amongst other things, incapacity to work connected with:
- consumption of drugs, alcohol and pharmaceutical abuse;
- attempted suicide, accomplished suicide or self-inflicted injury;

and as a result of:
- cellular therapies, diets and strengthening therapies;
- cosmetic treatments and sex-change operations (including complications and after-effects of these).

The insured benefits are reduced and, in particularly serious cases, denied:
- if the policy holder/insured person does not fulfil his commitments and obligations with regard to the insurance provider unless he can prove that the breach of duty has occurred through no fault of his own;
- if the incapacity to work is caused by the gross negligence of the policy holder/insured person;
- in the event of accidents resulting from reckless ventures.

The insured benefits from STANDARD Individual Daily Allowance Insurance are reduced by the benefits from other private and social insurances as well as by the income that may reasonably be obtained from gainful activity.

Further exclusions and reductions arise from the General Insurance Terms and Conditions.

How much is the premium?
The amount of the premium may depend on the insured person's age, gender, occupation, activity or place of residence according to Swiss civil law, the respective insured risks, the amount of daily allowance, the waiting period and the stipulated duration of benefits. All details of the premium appear in the insurance proposal form/insurance policy.

When shall the premium be paid?
The annual premium shall be paid in advance and is always due on 1 January of each year or, if paying by instalments, on the first of each stipulated month.

Which other duties does the insured person have?
- **Duty to Minimise Damage:** In the event that the insured person is incapable of working as a result of illness or accident, he must arrange for professional medical treatment as soon as possible. He is obligated to comply with the orders of the doctor. The insured person who is expected to be either completely or partially incapable in the long term of working in his profession or traditional activity must make use of any possible remaining capacity to work.
- **Duty to Notify:** CONCORDIA must be immediately notified of the insured event.
- **Duty to Cooperate:** The insured person shall give CONCORDIA complete and truthful information concerning everything relating to the insurance case (illness, accident, pregnancy) as well as to past illnesses and accidents, and releases the health professional treating him (doctor, etc.) from the professional duty of confidentiality with regard to CONCORDIA. The insured person is obligated to register to draw benefits with possible social insurance companies, in particular with the disability insurance office (IV/AI), if a doctor or the insurance provider orders this. The insured person is obligated to undergo additional medical examinations on the orders of the insurance provider.

Further duties arise from the General Insurance Terms and Conditions and the VVG/LCA.

When does the insurance cover begin?
Insurance protection begins as soon as the insurance provider has accepted the proposal form in writing, however no earlier than the date of the proposed start of insurance, or the date indicated in the policy.

How long does the contract last?
The insurance is taken out for the duration that has been stipulated in the contract with effect at the end of an insurance period (calendar year) and is tacitly renewed for one year at a time at the end of the contract duration.

When does the contract end?
The insurance expires:
- upon death of the insured person;
- upon cancellation;
- upon withdrawal of the policy holder or the insurance provider;
- upon drawing an AHV/AVS pension;
- upon opening of bankruptcy proceedings in the event of the policy holder's bankruptcy;
- upon reaching the stipulated maximum duration of benefits;
- upon cessation of gainful activity or of running one's own household;
- upon transfer abroad of one's place of residence according to Swiss civil law;
- upon transfer abroad of one's habitual place of residence for more than twelve months, provided that a written agreement has not been expressly made to the contrary.

The insurance may be cancelled in writing, subject to a three-month cancellation period, no earlier than at the end of the contract duration and thereafter at the end of each insurance period. The notice of cancellation is considered to have been given on time if it reaches CONCORDIA no later than the last day before the start of the three-month period.
Furthermore, in the event that premium tariffs are modified, the policy holder may cancel the insurance in writing with effect at the end of the current insurance period. The notice of cancellation is considered to have been given on time if it reaches CONCORDIA no later than the last day of the current insurance period.

Furthermore, CONCORDIA may cancel the contract:
- if important facts concerning risks have been concealed or falsely communicated (breach of the duty to disclose).

CONCORDIA may withdraw from the contract:
- if the policy holder is in arrears with the payment of the premium, has been sent a reminder and CONCORDIA gives up demanding payment of the premium;
- in the case of insurance fraud.

Further possibilities upon which the contract is terminated arise from the General Insurance Terms and Conditions and the VVG/LCA.

How does CONCORDIA process data?
CONCORDIA processes data derived from the contractual documents or the execution of the contract and uses this data in particular to determine premiums, clarify risks, process insurance cases and for statistical evaluation and marketing purposes. The data is stored physically or electronically. CONCORDIA may, to the extent that is required, forward data for processing to third parties involved in the execution of the contract. Furthermore, CONCORDIA may request relevant information, in particular concerning the claims history, from authorities and other third parties. This applies regardless of whether the contract materialises. The insured person has the right to request from CONCORDIA the information provided for by law concerning the processing of personal data.

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2006 Edition

STANDARD and PLUS Individual Daily Allowance Insurances

General Insurance Terms and Conditions

I. General Information

1 Basis

1.1 The basis of the contract is formed by the following:

1.1.1 the General Insurance Terms and Conditions, any Additional Insurance Terms and Conditions which may apply, the provisions of the policy and any addenda which may apply;

1.1.2 the written statements submitted by the policy holder (applicant) and the insured persons (the persons to be insured) in the proposal form, in the report of the examining doctor and in further documents.

1.2 Differing provisions in the Additional Insurance Terms and Conditions take precedence over these General Insurance Terms and Conditions.

1.3 Insofar as a set of circumstances is not expressly regulated in these documents, the VVG/LCA of 2 April 1908 applies.

2 Insurance Provider

2.1 The insurance provider, in the sense of the following provisions, is CONCORDIA Insurances Ltd, hereinafter referred to as CONCORDIA, in Lucerne.

II. Scope of Insurance

3 Object of Insurance

3.1 Within the framework of the following provisions and the benefits that are stipulated in the policy as well as of any Additional Insurance Terms and Conditions which may apply, the insurance provider guarantees insurance protection for the financial consequences of illness and, if stipulated, of births and accidents, which arise in the event of incapacity to work.

3.2 Insurance may be taken out as fixed sum insurance (PLUS Individual Daily Allowance Insurance) or as indemnity insurance (STANDARD Individual Daily Allowance Insurance).

4 Admission into the Insurance

4.1 The insurance is only open to persons who undertake gainful activity and those who run their own household.

4.2 The applicant is admitted into the insurance upon undergoing a health check.

4.3 In order to be admitted into the insurance or in the event of modifications to the insurance, applicants shall fill out the designated application form truthfully and completely and send it to the insurance provider. The same applies to any additional information which may be requested. The decision may be made subject to the outcome of a medical examination.

4.4 If the applicant or the insured person, when taking out the insurance, has concealed or miscommunicated a significant fact of which he was aware or should have been aware, in particular concerning illnesses or consequences of accidents that existed at the time the insurance proposal form was submitted or that had existed in the past, the insurance provider is entitled to cancel the contract in writing within four weeks of learning about the breach of the duty to disclose. The cancellation takes effect upon the policy holder receiving notification of this.

4.5 The insurance provider is entitled to apply a pre-existing condition exclusion to illnesses and consequences of accidents or to decline to provide insurance completely.

5 Geographical Area of Validity

5.1 The insurance is valid worldwide.

5.2 In the event of an incapacity to work while abroad, the insured benefits are only paid out for the duration of a hospital stay.

5.3 If the insured person is working abroad for a Swiss employer, the full insured benefits are granted. In addition to the medical certificate, the insured person must also have his incapacity to work confirmed by the employer.

5.4 The daily allowance benefits are only granted in the event that the insured person receives hospital treatments in the actual country in which he is staying. No benefits may be claimed for transfers to and treatments in a third country.

5.5 No benefits are granted if insured persons go abroad for treatment, care or childbirth.

5.6 For cross-border commuters, the area stretching 20 km from the Swiss border is equated to Switzerland.

III. Insurance Options

6 Options

6.1 The following insurance options may be chosen:
- daily allowance in case of illness;
- daily allowance in case of accident;
- daily allowance in case of illness or accident for persons who run their own household.

6.2 These insurance options may be taken out with various durations of benefits.

6.3 Persons who run their own household may only take out daily allowance insurance in the form of fixed sum insurance (PLUS Individual Daily Allowance Insurance) with a duration of benefits of 365 days.

7 Waiting Periods

The daily allowance insurances may be taken out with waiting periods of various durations. The corresponding premium tariffs prevail.

8 Maximum Permissible Insurance

8.1 The insurance provider arranges the insured daily allowance with the policy holder.

8.2 Persons who run their own household may insure a daily allowance in increments of ten from CHF 10 up to a maximum of CHF 50.

8.3 The maximum amounts may not be exceeded by the accumulation of various insurance contracts with the insurance provider.

IV. Definitions

9 Masculine and Feminine Form

The masculine form used in these General Insurance Terms and Conditions and other provisions also applies to females.

10 Indemnity Insurance

Indemnity insurance covers the loss of earnings resulting from illness and, if stipulated, from childbirth and accidents. The employer's obligation to continue paying wages and the benefits from other private and social insurances or other parties that are liable to pay are taken into account. The provision of the

insured benefit depends on whether and to what extent the insured person has suffered damage as a result of illness and, if stipulated, of childbirth and accidents. Art. 41 is applicable.

11 Fixed Sum Insurance

In the case of fixed sum insurance, benefits in case of illness and, if stipulated, of childbirth and accidents are provided regardless of the resulting damage. The benefits from other private and social insurances or from other parties that are liable to pay are not taken into consideration. Neither are benefits reduced nor is overcompensation taken into account in the event that third-party benefits are provided. Arts. 40 and 41 are not applicable.

12 Incapacity to Work

Incapacity to work exists when the insured person is completely or partially incapable of practising his current profession or another reasonable gainful activity as a result of an insured illness or an insured accident. Another gainful activity is considered to be reasonable when it is commensurate with the knowledge, abilities and social position the insured person has held to date.

13 Illness

An illness is considered to be any medically detectable physical or mental health disorder, independent of the insured person's will, which necessitates medical treatment and which cannot be attributed to an accident, to accident-like bodily injuries or to an occupational illness as per the definition in obligatory accident insurance.

14 Accident

An accident is considered to be the sudden, involuntary, damaging effect of an unusual external factor on the human body as well as accident-like bodily injuries and occupational illnesses as per the definition in the obligatory accident insurance.

15 Relapse, New Insurance Case

15.1 Illnesses and accidents that are medically related to previous illnesses and accidents are considered to be a relapse.

15.2 A new insurance case exists when the insured person has neither received medical treatment nor been completely or partially incapable of working for at least 180 days due to the same cause.

15.3 If a new case of illness with a different cause, further to an insurance case that was liable for benefits, directly leads to a renewed incapacity to work, both cases of illness are jointly considered, with regard to the duration of benefits, to be one case of illness, provided that the insured person has not been completely capable of working for at least 30 days between both insurance cases.

16 Insurance Period

The insurance period is considered to be the calendar year.

V. Start and End of Insurance

17 Start of Insurance Protection

The insurance may be taken out for the first of any month. Insurance protection begins as soon as the insurance provider has accepted the proposal form in writing, but no earlier than the date of the proposed start of insurance, or the date indicated in the policy.

18 Contract Duration

The insurance is taken out for the duration that has been stipulated in the contract with effect at the end of an insurance period (calendar year) and is tacitly renewed for one year at a time at the end of the contract duration.

19 Replacement Policy

If a policy is replaced, previously drawn benefits which are subject to contractual restrictions with regard to amount or time are taken into account when calculating future benefits.

20 End of Insurance

20.1 The insurance expires:

20.1.1 upon death of the insured person;

20.1.2 upon cancellation;

20.1.3 upon withdrawal of the policy holder or the insurance provider (Art. 33.2);

20.1.4 upon drawing an AHV/AVS pension;

20.1.5 upon opening of bankruptcy proceedings in the event of the policy holder's bankruptcy;

20.1.6 upon reaching the stipulated maximum duration of benefits;

20.1.7 upon cessation of gainful activity or of running one's own household;

20.1.8 upon transfer abroad of one's place of residence according to Swiss civil law;

20.1.9 upon transfer abroad of one's habitual place of residence for more than twelve months provided that a written agreement has not been expressly made to the contrary.

20.2 The policy holder/insured person is obligated to inform the insurance provider immediately in writing as soon as one of the grounds mentioned in Arts. 20.1.7 – 20.1.9 exists. If the insured person

fails to inform CONCORDIA of this, the insurance provider is no longer bound to the contract.

21 Cancellation

21.1 The insurance may be cancelled, subject to a three-month cancellation period, no earlier than at the end of the duration of the contract, and thereafter for the end of each insurance period (Art. 16).

21.2 Furthermore, the policy holder may cancel the insurance in the event that premium tariffs are modified in accordance with Art. 34.

21.3 Notice of cancellation must be given in writing. It is considered to have been given on time if it reaches the insurance provider/policy holder no later than the last day prior to the start of the cancellation period.

22 Waiving the Legal Right to End the Contract

The insurance provider expressly waives its legal right to end the contract after the occurrence of an insured event except in the event of a breach of the duty to disclose or in the event of attempted or accomplished insurance fraud.

23 Expiration of Entitlement to Benefits

Entitlement to benefits (including the benefits for existing incapacities to work) expires at the end of the insurance. The insurance provider's claim for reimbursement in the event of a breach of the duty to disclose remains reserved.

VI. Insured Benefits

24 Entitlement to Benefits

24.1 The insured person becomes entitled to benefits if he is, according to medical findings, completely or partially incapable of working and the incapacity to work has existed for longer than the waiting period stipulated in the contract. The entitlement exists no earlier than five days prior to the first medical treatment and for no longer than the stipulated duration of benefits.

24.2 In the event of a partial incapacity to work, the benefit is calculated according to the degree of the incapacity to work. An incapacity to work of less than 50 % results in no entitlement to benefits.

24.3 If the illness/accident is only partly the cause of the incapacity to work, the insurance provider only furnishes the corresponding proportion of the benefits. Art. 24.2 also applies in this case.

25 Waiting Period

25.1 The waiting period begins on the first day of a medically certified incapacity to work, but no earlier than five days prior to the first medical treatment.

25.2 For the calculation of the waiting period, days with a partial incapacity to work of at least 50 % are counted as days with a complete incapacity to work.

25.3 The waiting period is calculated separately for each insurance case.

25.4 If a new case of illness with a different or the same cause, further to an insurance case that was liable for benefits, directly leads to a renewed incapacity to work, both cases of illness are jointly considered, with regard to the waiting period, to be one case of illness provided that the insured person has not been completely capable of working for at least 30 days between both insurance cases.

26 Duration of Benefits

26.1 The insured benefits are provided for the duration stipulated in the contract.

26.2 If reduced benefits are provided as a result of a partial incapacity to work or of third-party benefits, days with reduced benefit are regarded as full days for the calculation of the duration of benefits.

26.3 The insured person may not prevent the stipulated maximum duration of benefits being reached by waiving benefits.

26.4 Waiting periods are counted in the maximum duration of benefits.

27 Short-Term Residents and Seasonal Employees

Short-term residents and seasonal employees are not entitled to receive benefits during low season. In the new season, benefits are paid out at the previous year's rate after the season has begun provided that it is proven that a work permit would have been obtained and a seasonal position taken up in the event that the person concerned had been capable of working.

28 Benefits Abroad

28.1 During a vacation abroad, benefits are furnished provided that a doctor's certificate attesting the incapacity to work and the medical diagnosis is presented and for as long as return travel is unreasonable for the insured person.

28.2 If an insured person who is incapable of working goes abroad without the consent of the insurance provider, he loses his entitlement to insurance benefits.

29 Pregnancy

29.1 In the case of pregnancy, entitlement to benefits exists only in the event of a medically certified incapacity to work resulting from complications.

29.2 The insured benefits are only provided if the insurance protection has existed for at least one year before the expected date of delivery.

29.3 The duty to provide benefits ceases for eight weeks after the birth. If gainful activity is not resumed by

the 16th week after the birth, the duty to provide benefits ceases until this time.

30 Birth

30.1 In the case of fixed sum insurance, in addition to the maternity compensation in accordance with the Swiss federal law on compensation for loss of earnings for anyone serving in the armed forces, in the civilian service or in the protection and support services as well as for women on maternity leave (EOG/LAPG/LIPG), a childbirth allowance may be contractually stipulated. If a pregnancy already exists at the time of admission into the insurance, no childbirth allowance is provided.

30.2 The stipulated waiting period is counted in the duration of benefits.

30.3 Childbirth allowance is only provided if the insurance protection has existed for at least one year before the expected date of delivery.

30.4 Provided that no childbirth allowance is stipulated, the duty to provide benefits ceases for eight weeks after the birth. If gainful activity is not resumed by the 16th week after the birth, the duty to provide benefits ceases until this time.

VII. Premiums

31 Premium Tariff

31.1 Premiums are calculated per insurance period (Art. 16) and incorporated into the premium tariff.

31.2 The premium tariff may provide for a grading of the premiums according to age, gender, profession, activity or place of residence according to Swiss civil law. If changes occur in the insured person's profession, activity or place of residence according to Swiss civil law, the insurance provider shall be notified of these immediately in writing. Premiums may be adjusted as from the time of the change.

31.3 Premiums are adjusted annually to the premium tariff that corresponds with the current age of the insured person.

32 Due Date, Payment of Premiums

32.1 The annual premium shall be paid in advance. It is due on 1 January of each year or, in the event that insurance starts during the course of the year, upon delivery of the invoice for the corresponding remainder of a year.

32.2 In return for a premium surcharge, payment by instalments may be stipulated. The instalments shall also be paid in advance.

32.3 If the policy holder has taken out several insurances (including Mandatory Health Care Insurance), he must opt for one standard mode of payment.

32.4 If payment by instalments is stipulated, the instalments that fall due in the course of the year are only considered as deferred.

32.5 If the policy holder is in arrears with the payment of a stipulated instalment, the remainder of the premium for the current insurance period shall become immediately due.

33 Reminder, Payment Default

33.1 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 payments, 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 from the end of the reminder period.

33.2 If payment of the outstanding premium is not legally demanded within two months of the end of the reminder period in accordance with Art. 33.1, it is assumed that the insurance provider, by waiving payment of the outstanding premium, is withdrawing from the contract.

33.3 If payment of the premium is legally demanded or subsequently accepted by the insurance provider, the duty to provide benefits retakes effect at the moment the outstanding premium, along with interest and costs, is paid. The insurance provider is not liable to provide benefits for insurance cases that occur during the duration of the default and after the waiting period is over.

34 Adjusting the Premium Tariff

If the premium tariff is modified, the insurance provider may require the insurance to be adjusted for the first day of the forthcoming insurance period. This requires the insurance provider to notify the policy holder in writing of the new terms and conditions of the contract no later than 30 days before the new premiums come into force. The policy holder then has the right to cancel the insurance with effect at the end of the current insurance period. If he exercises this right, the insurance expires at the end of the current insurance period. The notice of cancellation must reach the insurance provider no later than the last day of the current insurance period. If the policy holder omits to cancel the insurance, he is deemed to have consented to the adjustment of the insurance.

35 Modifying the Premium Grading

If a modification in the premium grading according to the age, profession, activity or place of residence according to Swiss civil law of the insured person causes a modification in premiums, the insurance provider may adjust the premiums accordingly as from the time of the modification. The policy holder has the right to cancel the insurance within thirty days of being notified of the new premium.

VIII. Duties and Proof of Entitlement

36 Duties and Obligations

36.1 In every case of incapacity to work that is likely to lead to the insured person receiving benefits from the insurance provider, the insured person shall arrange for professional medical treatment as soon as possible. The insured person is obligated to comply with the orders of the doctor or those of other service providers.

36.2 The insurance provider is entitled to obtain additional documentary proof and information, in particular doctor's certificates, from service providers. Furthermore, the policy holder/insured person shall provide complete and truthful information concerning everything relating to the incapacity to work as well as to past illnesses and accidents. At the request of the insurance provider, the insured person releases service providers that are treating or have treated him to from the professional duty of confidentiality with regard to the insurance provider.

36.3 The insured person is obligated on the orders of the insurance provider to undergo additional medical examinations.

36.4 The insurance provider reserves the right to make inspection visits at any time to insured persons that are incapable of working. The insured person may not refuse to receive inspection visits by the insurance provider or by third parties the insurance provider has commissioned.

36.5 The insured person who is expected to be either completely or partially incapable in the long term of working in his profession or traditional activity must make use of any possible remaining capacity to work (duty to minimise damage). Reasonable activity in another profession, area of gainful activity or duties is taken into consideration.

36.6 The insured person is obligated to register to draw benefits with possible social insurance companies, in particular with the disability office (IV/AI), if a doctor or the insurance provider orders this.

37 Proof of Entitlement

37.1 Proof of entitlement must be submitted by the policy holder/insured person on the form provided by the insurance provider.

37.2 Insured persons shall notify the insurance provider of incapacity to work by enclosing a medical certificate no later than five days after the end of the stipulated waiting period, but in any case within 30 days of becoming incapable of working. In the event of inexcusable delayed notification, entitlement to insured benefits exists no earlier than the moment notification is received.

37.3 If other social or private insurance providers, in addition to the insurance provider, are also liable to provide benefits for incapacity to work (e.g. disability insurance, military insurance, accident insurance, occupational pension fund, other daily allowance insurances), the insured benefits are only granted if the insurance case has been declared in a timely manner to the corresponding insurance companies. In addition to the documents mentioned in Arts. 37.1 and 37.2, the policy holder shall also submit the confirmation of declaration of insurance, the statements of accounts and any rulings of other insurance carriers that may exist to the insurance provider.

37.4 A doctor's certificate providing information about the duration of the pregnancy and the date of the birth shall be submitted to the insurance provider in order to assert the right to a childbirth allowance that has been stipulated in the contract.

IX. Limitations on Insurance Protection

38 Exclusions

38.1 Incapacity to work arising in connection with the following events is excluded from insurance cover:

- the consequences of war-like incidents in Switzerland and abroad. However, if the insured person is caught unaware by the outbreak of such events in the country in which he is staying, the insurance protection does not lapse until 14 days after their initial occurrence;
- military service abroad;
- participation in acts of war or terrorism;
- participation in disturbances, demonstrations or similar occasions;
- crimes and offences committed wilfully or through gross negligence;
- participation in brawls and fights unless the insured person has been injured by the persons fighting while otherwise uninvolved or while assisting a defenceless person;
- dangers to which the insured person exposes himself by seriously provoking others;
- the effects of ionising radiation and damage caused by nuclear energy;
- the consumption of drugs, narcotics and other addictive substances as well as the abuse of alcohol and pharmaceuticals;
- attempted or accomplished suicide or self-inflicted injury.

38.2 Furthermore, no benefits are provided for incapacity to work as a result of:

- cellular therapies, diets, strengthening therapies;
- treatments of which the effectiveness, appropriateness and cost effectiveness are not proven by

scientific methods;
- cosmetic treatments (including complications and after-effects);
- sex-change operations (including complications and after-effects).

39 Reduction and Refusal of Benefits

The insured benefits are reduced and, in particularly serious cases, denied:

39.1 if the policy holder/insured person does not fulfil his commitments and obligations (Art. 36) with regard to the insurance provider unless he can prove that the breach of duty occurred through no fault of his own;

39.2 in the event that the incapacity to work is caused by the gross negligence of the policy holder/insured person;

39.3 in the event of accidents resulting from reckless ventures. 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, human rescue attempts are insured, even if they may be regarded as reckless ventures in themselves.

40 Multiple Insurance

If private insurance contracts exist with a number of insurance providers that are liable to provide benefits, the benefits are provided only once in total. In this case, it is determined how much each insurance provider would have to pay out of its particular insurance if it were solely liable to provide benefits, and the total sum of these benefits is then calculated. Each insurance provider must only bear the proportion that corresponds to its share of the total sum.

41 Provision of Benefits, Overcompensation and Reclamation

41.1 The insured benefits from STANDARD Individual Daily Allowance Insurance – for unemployed persons in the sense of the Swiss federal law on unemployment insurance (AVIG/LACI/LADI), no more than the amount of the unemployment benefit – are reduced by the benefits from other private and social insurances as well as by the income that may reasonably be obtained from gainful activity (Art. 36.5).

41.2 In the event that social insurance providers may be liable to provide benefits, the insurance provider is entitled to reclaim benefits that it has provided in advance directly from these social insurance providers. In particular, the insurance provider reclaims benefits that he provides with regard to a disability pension directly from the Swiss federal disability insurance as from the date that the pension begins. The amount reclaimed corresponds to the amount of overcompensation in accordance with Art. 41.1. Benefits from fixed sum insurance are excluded from this.

41.3 If a claim is made on the insurance provider instead of on the liable third party or the liability insurance provider of that third party, the insured person shall assign his claims to the insurance provider within the framework of the benefits that have been provided.

41.4 Compensation which is borne by a liable third party or the liability insurance provider of that third party is deducted from the benefits of the insurance provider.

41.5 Any reductions that may have been made in other insurances are not covered by STANDARD Individual Daily Allowance Insurance.

41.6 Benefits which have been wrongly drawn by the insured person shall be refunded to the insurance provider.

42 Advance Benefits and Recourse

42.1 The insurance provider may provide benefits in advance on condition that the insured person assigns to the insurance provider his claims against third parties liable to provide benefits, up to the amount of the benefits that have been provided by the insurance provider, and on condition that he commits himself to undertaking nothing that would stand in the way of the insurance provider asserting a possible right of recourse.

42.2 Agreements with third parties into which insured persons have entered without the consent of the insurance provider and which concern a partial or total waiving of insurance benefits or claims for compensation for damage cause the insurance provider's duty to provide benefits to cease.

X. Miscellaneous

43 Offsetting, Assignment and Pledging

43.1 The policy holder/insured person is not entitled to offset outstanding premiums against benefit claims with respect to the insurance provider.

43.2 The entitlement to insured benefits may neither be assigned nor pledged without the express consent of the insurance provider before the benefits are definitively fixed.

44 Performance of Contractual Obligations

44.1 The obligations arising from the contract shall be fulfilled in Switzerland and in Swiss currency.

44.2 If benefits subject to tax deducted at the source are paid out directly to the insured persons, they are reduced at the source by the amount of tax owed.

45 Notifications

45.1 All notifications may be directed in legally valid form

to the head office of CONCORDIA or the agency designated in the policy.

45.2 If the daily allowance insurance of CONCORDIA is offered by another insurance provider, the notifications and announcements directed to that insurance provider have the same validity as if they were directed to CONCORDIA.

45.3 The insured person shall notify CONCORDIA in writing of any change of address or change in his personal circumstances, provided that they may be decisive for the assessment of the duty to provide benefits, as well as of any change of occupation or activity. Notifications from the insurance provider are legally valid when sent to the insured person's last given address in Switzerland.

46 Place of Jurisdiction

In the event of disputes arising from this contract, either the place of jurisdiction of Lucerne or the place of jurisdiction of his Swiss place of residence are at the disposal of the policy holder/insured person as desired.

The following abbreviations, with corresponding translations in German, French, Italian and English, are used in these Regulations:

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

IV/AI
IV: Invalidenversicherung
AI: Assurance-invalidité
AI: Assicurazione per l'invalidità
Swiss federal disability insurance

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

EOG/LAPG/LIPG
EOG: Bundesgesetz über den Erwerbsersatz für Dienstleistende und bei Mutterschaft; Erwerbsersatzgesetz
LAPG: Loi fédérale sur les allocations pour perte de gain en cas de service et de maternité; Loi sur les allocations pour perte de gain
LIPG: Legge federale sulle indennità di perdita di guadagno per chi presta servizio e in caso di maternità; Legge sulle indennità di perdita di guadagno
Swiss federal law of on compensation for loss of earnings for anyone serving in the armed forces, in the civilian service or in the protection and support services as well as for women on maternity leave

AVIG/LACI/LADI
AVIG: Bundesgesetz über die obligatorische Arbeitslosenversicherung und die Insolvenzentschädigung; Arbeitslosenversicherungsgesetz
LACI: Loi fédérale sur l'assurance-chômage obligatoire et l'indemnité en cas d'insolvabilité; Loi sur l'assurance-chômage
LADI: Legge federale su l'assicurazione obbligatoria contro la disoccupazione e l'indennità per insolvenza; Legge sull'assicurazione contro la disoccupazione
Swiss federal law on unemployment insurance

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