CONCORDIA
your health, our priority

2023 Edition

STANDARD and PLUS Individual Daily Allowance Insurances

Customer information regarding the General Insurance Terms and Conditions of STANDARD and PLUS Individual Daily Allowance Insurances

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). The rights and duties of the contracting parties are specified in the application, the 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 (CONCORDIA), whose registered office is located at Bundesplatz 15, 6002 Lucerne. CONCORDIA is a public limited company (Aktiengesellschaft / société anonyme / società anonima) under Swiss law.

What risks are insured and what is the scope of the insurance cover?
The insurance covers the financial consequences of the following risks:
- Illness
- Accident
- Maternity

The specific insured risks and the scope of the insurance cover are set out in the application, the policy and the General Insurance Terms and Conditions.

The insurance can be taken out as fixed-sum insurance (PLUS Individual Daily Allowance Insurance) or indemnity insurance (STANDARD Individual Daily Allowance Insurance).

Incapacity to work caused by the following is not covered (non-exhaustive list):
- Consumption of drugs, narcotic and other addictive substances and abuse of alcohol and pharmaceuticals (including complications and long-term effects);
- Attempted or accomplished suicide or self-inflicted injury (including complications and long-term effects);
- Treatment of obesity (including complications and long-term effects);
- Cosmetic treatments and gender affirmation surgery (including complications and long-term effects).

The insured benefits will be reduced – and in particularly serious cases denied – in the event of the following:
- The policyholder or insured person does not fulfil their obligations to the insurance provider, unless they can demonstrate that the breach of duty occurred through no fault of their own, or the breach had no effect on the occurrence of the insured event and the amount of benefits paid out by the insurance provider.
- The incapacity to work is caused by gross negligence on the part of the policyholder or insured person.
- The accident results from reckless ventures.

The aforementioned grounds for exclusion also apply if they are only partly responsible for an illness or accident.

The insured benefits in 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 are set out in the General Insurance Terms and Conditions.

How much is the premium?
The level of the premium depends on the insured person's age, gender, occupation, activity or place of residence according to Swiss civil law, the insured risks, the daily allowance amount, the waiting period and the duration of benefits. All details of the premium are set out in the application and the insurance policy.

When is the premium payable?
The annual premium is payable in advance and is due on 1 January of each year or, if paying by instalments, on the first day of each month.

What other duties does the insured person have?
- **Time-limited duty to notify:** If important facts that lead to an increase in risk change between completing the health questionnaire and the insurance being taken out, the applicant or insured person is obliged to notify the insurance provider promptly in writing and correct the answers in the health questionnaire. The duty to notify ceases to apply once the insurance has been taken out.
- **Duty to mitigate loss:** If the insured person is incapable of working as a result of illness or accident, they must ensure that they obtain appropriate medical treatment as soon as possible. They must comply with medical instructions. Insured persons who are expected to be either partially or completely incapable of working in their profession or usual activity in the long term must utilise any remaining capacity to work.
- **Duty to notify:** Incapacity to work on the part of the insured person must be reported to the insurance provider, enclosing a medical certificate from a doctor or chiropractor, at the latest five days after the end of the stipulated waiting period, in any case within 30 days of the onset of the incapacity to work. If notification is delayed without good reason, entitlement to insured benefits begins at the earliest from when the report is received.

- **Duty to cooperate:** The insured person must provide CONCORDIA with complete and truthful information on all matters relating to the insured event (illness, accident, pregnancy) as well as past illnesses and accidents, and releases the health professional treating them (doctors, etc.) from their professional duty of confidentiality with regard to CONCORDIA. The insured person is obligated to register to draw benefits from interested social insurance providers, in particular the disability insurance office (IV/AI), if instructed to do so by a doctor or the insurance provider. The insured person is obligated to undergo additional medical examinations at the insurance provider's request.

Further duties are set out in the General Insurance Terms and Conditions and the VVG/LCA.

When does the insurance cover begin?
Insurance cover begins as soon as the insurance provider accepts the application in writing, but no earlier than the start of insurance date indicated in the application or policy.

The policyholder may cancel 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.

How long does the contract last?
The insurance is taken out for the term stipulated in the contract to the end of an insurance period (calendar year) and is tacitly renewed for one year at a time at the end of the contract term.

When does the contract end?
The insurance expires in the event of any of the following:
- The insured person dies.
- The contract is cancelled or terminated.
- The policyholder or insurance provider withdraws from the contract.
- The insured person begins to draw an AHV/AVS/OASI pension.
- Bankruptcy proceedings are opened following the policyholder's bankruptcy.
- The stipulated maximum duration of benefits is reached.
- The insured person ceases gainful activity or ceases to maintain their own household.
- The insured person moves their Swiss civil law place of residence abroad.
- The insured person moves their habitual place of residence abroad for more than twelve months, unless there is an express written agreement to the contrary.

The policyholder may cancel the insurance in writing, subject to a three-month notice period, no earlier than at the end of the contract term 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 policyholder may cancel the insurance in writing with effect from 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 communicated inaccurately (breach of duty to notify).

CONCORDIA may withdraw from the contract:
- if the policyholder is in arrears with the payment of the premium, has been sent a reminder and CONCORDIA opts not to take legal action to recover the premium;
- in the case of insurance fraud;
- if important facts that lead to an increase in risk change during the period between completing the health questionnaire and taking out the insurance and the applicant or insured person does not notify CONCORDIA in writing immediately of this increase in risk.

Further grounds for terminating the contract are set out in the General Insurance Terms and Conditions and the VVG/LCA.

When does the entitlement to benefits expire?
The entitlement to benefits (including the benefits for existing incapacities to work) expires at the end of the insurance.

What types of documentation are equivalent to the written form?
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 forms of text 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.

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.

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General Insurance Terms and Conditions

I. General Information

1 Basis of the Contract

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 that may apply, the provisions of the policy and any applicable addenda;

1.1.2 the written statements made by the policyholder (applicant) and the insured persons (persons to be insured) in the application, the report of the examining doctor and 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 Swiss federal law on insurance contracts (VVG/LCA) of 2 April 1908 applies.

2 Insurance Provider

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

II. Scope of Insurance

3 Object of Insurance

3.1 The insurance provider grants insurance cover for the financial consequences of incapacity to work resulting from illness and, where stipulated, childbirth and accidents, on the basis of the provisions in these General Insurance Terms and Conditions and the benefits stipulated in the policy and any applicable Additional Insurance Terms and Conditions.

3.2 Insurance may be taken out as fixed-sum insurance (PLUS Individual Daily Allowance Insurance) or 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 Admission into the insurance is subject to a health check.

4.3 In order to be admitted into the insurance or to adjust the insurance cover, the designated application form muss be filled out truthfully and in full and submitted to the insurance provider. The same applies to any additional information which may be requested. The decision on whether or not to admit a person may be conditional on the outcome of a medical examination.

4.4 If, in answering questions in the application form, the applicant or insured person conceals or miscommunicates a significant fact of which they were aware or should have been aware, in particular concerning illnesses or consequences of accidents that existed at the time of the insurance application or existed in the past, the insurance provider is entitled to cancel the contract in writing within four weeks of becoming aware of the breach of the duty to notify. The cancellation takes effect when it is received by the policyholder.

4.5 **If an insured person's state of health changes after answering the questions in the application, but before the insurance is concluded, the applicant or insured person must notify the insurance provider without delay in writing and correct their responses to the questions.** In the event of a breach of this duty to notify, the insurance provider is entitled to cancel the contract within four weeks of becoming aware of the breach. The cancellation takes effect when it is received by the policyholder.

4.6 The insurance provider is entitled to apply a pre-existing condition exclusion to particular illnesses and consequences of accidents or to decline to conclude the contract altogether.

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 paid. In addition to obtaining a medical certificate, the insured person must also have their incapacity to work confirmed by their employer.

5.4 The daily allowance benefits are only granted in the event that the insured person receives hospital treatment in the country in which they are 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.

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 different terms.

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

Daily allowance insurance may be taken out with waiting periods of various durations. The corresponding premium tariffs apply.

8 Maximum Permissible Insurance

8.1 The insurance provider arranges the insured daily allowance with the policyholder.

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

8.3 The maximum amounts may not be exceeded by combining different insurance contracts with the insurance provider.

IV. Definitions

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

In principle, 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.

10 Indemnity Insurance

Indemnity insurance covers the loss of earnings resulting from illness and, if stipulated, childbirth and accident. The employer's obligation to continue paying wages and any benefits from other private and social insurances or other parties who 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 loss as a result of illness and, if stipulated, childbirth and accident. Arts. 39 and 40 are applicable.

11 Fixed-Sum Insurance

In the case of fixed-sum insurance, benefits in case of illness and, if stipulated, childbirth and accident are provided regardless of the loss suffered. Benefits from other private and social insurances or other liable parties are not taken into consideration. Benefits are not reduced and nor is overcompensation taken into account if third-party benefits are provided. Arts. 39 and 40 are not applicable.

12 Incapacity to Work

Incapacity to work exists when the insured person is completely or partially incapable of practising their 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 insured person's skills, abilities and previous social position.

13 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, accident-like bodily injuries or an occupational illness as per the definition in mandatory accident insurance.

14 Accident

An accident is defined as 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 mandatory 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 not received medical treatment or been completely or partially incapable of working for the same cause for at least 180 days.

15.3 If an illness that is eligible for benefits is followed by a new illness with a different cause that leads directly to a renewed incapacity to work, both illnesses are considered, for the purposes of the duration of benefits, to be a single illness, unless the insured person has been fully able to work for at least 30 days between both insured events.

16 Insurance Period

The insurance period is the calendar year.

V. Start and End of Insurance

17 Start of Insurance Cover/Cooling-off Period

17.1 The insurance may be taken out from the first day of any month. Insurance cover begins as soon as the insurance provider has accepted the application in writing, but no earlier than the start date of insurance indicated in the application or policy.

17.2 The policyholder may cancel 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.

18 Contract Term

The insurance is taken out for the term stipulated in the contract up to the end of an insurance period (calendar year) and is tacitly renewed for one year at a time at the end of the contract term.

19 Replacement Policy

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

20 End of Insurance

20.1 The insurance expires in the event of any of the following:

20.1.1 The insured person dies.

20.1.2 The contract is cancelled or terminated.

20.1.3 The policyholder or insurance provider withdraws from the contract (Art. 32.2).

20.1.4 The insured person begins to draw an AHV/AVS/OASI pension.

20.1.5 Bankruptcy proceedings are opened following the policyholder's bankruptcy.

20.1.6 The stipulated maximum duration of benefits is reached.

20.1.7 The insured person ceases gainful activity or ceases to maintain their own household.

20.1.8 The insured person moves their Swiss civil law place of residence abroad.

20.1.9 The insured person moves their habitual place of residence abroad for more than twelve months, unless there is an express written agreement to the contrary.

20.2 The policyholder or insured person is obligated to inform the insurance provider immediately

in writing if any of the grounds listed in Arts. 20.1.7-20.1.9 occurs. If they fail to inform CONCORDIA of this, the insurance provider is no longer bound to the contract.

21 Cancellation

21.1 The policyholder may cancel the insurance, subject to a three-month notice period, no earlier than at the end of the contract term, and thereafter at the end of each insurance period (Art. 16).

21.2 Furthermore, the policyholder may cancel the insurance in the event that premium tariffs are adjusted in accordance with Art. 33.

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 no later than the last day prior to the start of the notice period.

21.4 The contract may be terminated at any time for grave cause within the meaning of Art. 35b VVG/LCA.

21.5 The insurance provider does not have a right of cancellation, including in the event of a claim. The insurance provider's right of cancellation remains reserved in the event of breaches of notification duties or attempted or accomplished insurance fraud.

22 Expiry of Entitlement to Benefits

Entitlement to benefits (including benefits for existing incapacities to work) expires at the end of the insurance, subject to any periodic benefit obligations within the meaning of Art. 35c VVG/LCA. The insurance provider's entitlement to reimbursement in the event of a breach of the duty to notify remains reserved.

VI. Insured Benefits

23 Entitlement to Benefits

23.1 The insured person becomes entitled to benefits when a medical practitioner confirms that they are 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 begins no earlier than five days prior to the first medical treatment and continues no longer than the stipulated duration of benefits.

23.2 In the event of a partial incapacity to work, the benefit is calculated according to the degree of the incapacity to work. There is no entitlement to benefits if the incapacity to work is less than 50 percent.

23.3 If the illness or accident is only partly the cause of the incapacity to work, the insurance provider only pays the corresponding proportion of benefits. Art. 23.2 also applies in this case.

24 Waiting Period

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

24.2 In calculating the waiting period, days with a partial incapacity to work of at least 50 percent are counted as days with a complete incapacity to work.

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

24.4 If an illness that is eligible for benefits is followed by a new illness with the same or a different cause that leads directly to a renewed incapacity to work, both illnesses are considered, for the purposes of the waiting period, to be a single illness, unless the insured person has been fully able to work for at least 30 days between both insured events.

25 Duration of Benefits

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

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

25.3 The insured person may not waive benefits in order to prevent the stipulated maximum duration of benefits from being reached.

25.4 Waiting periods count towards the maximum duration of benefits.

26 Short-Term Residency and Seasonal Employment

Short-term residents and seasonal employees are not entitled to receive benefits between two stays or during low season. After the new season begins, benefits are paid out at the previous year's rate, provided the insured person can demonstrate that they would have obtained a work permit and would have taken up a seasonal position if they had been capable of working.

27 Benefits Abroad

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

27.2 If an insured person who is incapable of working goes abroad without the consent of the insurance provider, they lose their entitlement to insurance benefits.

28 Pregnancy

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

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

28.3 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.

29 Childbirth

29.1 In the case of fixed-sum insurance, in addition to maternity pay in accordance with the Swiss federal law on compensation for loss of earnings (EOG/LAPG/LIPG), a childbirth allowance may be stipulated in the contract. If an insured person is pregnant at the time of admission into the insurance, no childbirth allowance is provided.

29.2 The stipulated waiting period counts towards the duration of benefits.

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

29.4 If 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

30 Premium Tariff

30.1 Premiums are set for each insurance period (Art. 16) and incorporated into the premium tariff.

30.2 The premium tariff may provide for a grading of the premiums according to age, gender, profession, activity or place of residence under Swiss civil law. If changes occur in the profession, activity or place of residence according to Swiss civil law of the insured person, the insurance provider must be notified of these immediately in writing. Premiums may be adjusted with effect from the date of the change.

30.3 The following age classes apply to the illness and accident fixed-sum insurance variants (PLUS Individual Daily Allowance Insurance):

- 16-30 years
- then age classes in 10-year increments
- up to the final age class of 61 and above

The following age classes apply to the illness and accident indemnity insurance variants (STANDARD Individual Daily Allowance Insurance):

- 16-25 years
- then age classes in 5-year increments
- up to the final age class of 61 and above

The following age classes apply to fixed-sum insurance for persons maintaining a household (PLUS Individual Daily Allowance Insurance):

- 16-20 years
- then age classes in 5-year increments
- up to the final age class of 61 and above.

The premium increases upon reaching the next age class.

31 Due Date, Payment of Premiums

31.1 The annual premium is payable 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 remainder of a year.

31.2 The annual premium may also be paid in instalments against a surcharge. The instalments must also be paid in advance.

31.3 If the policyholder has taken out several insurance policies (including mandatory health insurance), they must opt for one standard mode of payment.

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

31.5 If the policyholder is in arrears with the payment of an instalment, the remainder of the premium for the current insurance period immediately becomes due.

32 Reminder, Payment Default

32.1 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 from the end of the reminder period.

32.2 If legal action is not taken to recover the outstanding premium within two months of the end of the reminder period in accordance with Art. 32.1, it is assumed that the insurance provider, by waiving payment of the outstanding premium, is withdrawing from the contract.

32.3 If the premium is recovered by legal action, or the insurance provider accepts a payment of arrears, the duty to provide benefits resumes from the date on which 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 end of the reminder period.

33 Adjustment of the Premium Tariff

If the premium tariff is modified as a result of the development of costs, risks or claims history, the insurance provider may require the insurance to be adjusted from the first day of the next insurance period. The insurance provider must notify the policyholder in writing of the new terms and conditions of the contract no later than 30 days before the new premiums come into force. The policyholder then has the right to cancel the insurance with effect from the end of the current insurance period. If they exercise 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 policyholder does not cancel the insurance, they are deemed to have consented to the adjustment of the insurance.

34 Modification of the Premium Grading

If a change in age, profession, activity or place of residence according to Swiss civil law of the insured person leads to a reclassification within the

premium grading, the insurance provider may adjust the premiums accordingly with effect from the time of the change. The policyholder has the right to cancel the insurance within 30 days of being notified of the new premium.

VIII. Duties and Proof of Entitlement

35 Duties and Obligations

35.1 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 must arrange for professional medical treatment as soon as possible. The insured person is obligated to comply with the instructions of the doctor or other healthcare providers.

35.2 The insurance provider is entitled to obtain additional documentary proof and information, in particular doctor's certificates, from healthcare providers. Furthermore, the policyholder or insured person must provide complete and truthful information on all matters relating to the incapacity to work as well as to past illnesses and accidents. At the insurance provider's request, the insured person will release healthcare providers that are treating or have treated them from the professional duty of confidentiality with regard to the insurance provider.

35.3 The insured person is obligated to undergo additional medical examinations at the insurance provider's request.

35.4 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 third parties engaged by the insurance provider.

35.5 An insured person who is expected to be either completely or partially incapable of working in their profession or usual activity in the long term must make use of any potential remaining capacity to work (duty to mitigate loss). This includes work in another profession or employment activity that may be considered reasonable.

35.6 The insured person is obligated to register to draw benefits from interested social insurance providers, in particular the disability office (IV/AI), if requested by a doctor or the insurance provider.

36 Proof of Entitlement

36.1 Proof of entitlement must be submitted by the policyholder or insured person on the form supplied by the insurance provider.

36.2 Insured persons must 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. If notification is delayed without good reason, entitlement to insured benefits begins no earlier than the date on which notification is received, unless the policyholder or insured person can prove that the delayed notification had no influence on the occurence of the insured event and on the scope of the benefit payable by the insurance provider.

36.3 If other social or private insurance providers (e.g. disability insurance, military insurance, accident insurance, occupational pension fund, other daily allowance insurances) are also liable to provide benefits for incapacity to work in addition to the insurance provider, the insured benefits are only payable if the insurance case has been declared in a timely manner to the other insurance providers. In addition to the documents listed in Arts. 36.1 and 36.2, the confirmations of notification, statements of account and any rulings of the other insurance providers must also be submitted to the insurance provider.

36.4 To claim a childbirth allowance that has been stipulated in the contract, a doctor's certificate providing information about the duration of the pregnancy and the date of the birth must be submitted to the insurance provider.

36.5 The insurance provider's benefits under the insurance contract lapse five years after the occurrence of the event that gives rise to the benefit obligation.

IX. Limitations on Insurance Cover

37 Exclusion from Benefits

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

- The consequences of war-like incidents in Switzerland or abroad. However, if the insured person is caught unaware by the outbreak of such events in the country in which they are staying, the insurance cover 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 events;
- Crimes and offences committed deliberately or through gross negligence;
- Participation in brawls and fights unless the insured person has been injured as a bystander or while coming to the aid of a defenceless person;
- Dangers to which the insured person exposes themselves by serious provocation of 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.

The above grounds for exclusion also apply if they are only partly responsible for an illness or accident.

37.2 Furthermore, no benefits are provided for incapacity to work as a result of:
- Treatment of obesity (including complications and long-term effects);
- Treatments (including complications and long-term effects) whose effectiveness, appropriateness and cost-effectiveness has not been demonstrated by scientific methods;
- Cosmetic treatments (including complications and long-term effects);
- Gender affirmation surgery (including complications and long-term effects).

38 Reduction and Refusal of Benefits

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

38.1 if the policyholder or insured person does not fulfil their duties and obligations to the insurance provider (Art. 35), unless they can prove that the breach of duty occurred through no fault of their own, or the breach had no impact on the occurrence of the insured event and the scope of benefits payable by the insurance provider;

38.2 in the event that the incapacity to work is caused by the gross negligence of the policyholder or insured person;

38.3 in the event of accidents resulting from reckless ventures. 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 may be regarded as reckless ventures in themselves.

39 Multiple Insurance

If private insurance contracts are held 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.

40 Provision of Benefits, Overcompensation and Reclamation

40.1 The insured benefits in STANDARD Individual Daily Allowance Insurance – in the case of unemployed persons as defined by the Swiss federal law on unemployment insurance (AVIG/LACI/LADI), no more than the amount of 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. 35.5).

40.2 In the event that social insurance providers are liable to provide benefits, the insurance provider is entitled to reclaim benefits it has paid out in advance directly from these social insurance providers. In particular, the insurance provider reclaims benefits it pays out for a disability pension directly from the Swiss federal disability insurance (IV/AI) from the date that the pension begins. The amount reclaimed corresponds to the amount of overcompensation in accordance with Art. 40.1. Benefits in fixed-sum insurance are excluded from this.

40.3 If a claim is made on the insurance provider instead of a liable third party or the liability insurer of that third party, the insured person must assign their claims to the insurance provider up to the amount of the benefits that have been provided.

40.4 Compensation paid by a liable third party or the liability insurer of that third party is deducted from the insurance provider's benefits.

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

40.6 Benefits which have been received by the insured person illegitimately or in error must be refunded to the insurance provider.

41 Advance Benefits and Recourse

41.1 The insurance provider may provide benefits in advance on condition that the insured person assigns their claims against third parties liable to provide benefits to the insurance provider, up to the amount of the benefits it has paid, and on condition that the insured person undertakes not to do anything that would prevent the insurance provider from asserting a possible right of recourse.

41.2 The duty to provide benefits ceases if the insured person, without the consent of the insurance provider, makes any agreement with a third party liable to provide benefits under which the insured person waives insurance benefits or compensation for damage in part or in full.

X. Miscellaneous Provisions

42 Offsetting, Assignment and Pledging

42.1 The policyholder or insured person is not entitled to offset outstanding premiums owed to the insurance provider against benefit entitlements.

42.2 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.

43 Performance of Contractual Obligations

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

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

44 Notifications

44.1 All notifications may be directed in legally valid form to the head office of CONCORDIA or the agency designated in the policy.

44.2 If CONCORDIA's daily allowance insurance 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.

44.3 The insured person must notify CONCORDIA in writing of any change of address or change in their personal circumstances, if they could be relevant to the decision to provide benefits, as well as 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.

44.4 Notifications may also be sent electronically. 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 electronic forms of notification to be deemed to have been delivered in a legally valid manner. Mandatory statutory provisions and related court rulings remain reserved.

45 Place of Jurisdiction

In the event of disputes arising from the contract, the policyholder or insured person may choose either Lucerne or their Swiss place of residence as the place of jurisdiction at their discretion.

46 Grandfathering Provisions for the Amendments from 1 January 2022

46.1 If the amendments to these General Insurance Terms and Conditions from 1 January 2022 are disadvantageous for the insured person, the provisions of the General Insurance Terms and Conditions in force until 31 December 2021 will apply to contracts concluded before 2022. In all other circumstances the new General Insurance Terms and Conditions apply.

46.2 The grandfathering provisions apply in particular with regard to the geographical area of validity for cross-border commuters (Art. 5.6 General Insurance Terms and Conditions, 2006 edition).

47 Application of the Revised Swiss Federal Law on Insurance Contracts effective 1 January 2022

For contracts concluded before 2022, only the transitional provisions in Art. 103a of the revised Swiss federal law on insurance contracts (VVG/LCA) of 2 April 1908 entered into force on 1 January 2022 apply.

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

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
LAPG: Loi fédérale sur les allocations pour perte de gain en cas de service et de maternité
LIPG: Legge federale sulle indennità di perdita di guadagno per chi presta servizio e in caso di maternità
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

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

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