CONCORDIA
Bound by trust

Supplementary Care 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 the VVG/LCA. The rights and duties of the contracting parties arise from the insurance proposal form/insurance policy, the General and Additional 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 and Additional Insurance Terms and Conditions. A description of the benefits of the individual insurance products can be found in the brochure «Insurance Options and Services».

No insurance cover exists for, amongst other things:
- treatments of illnesses and accidents in connection with the consumption of drugs, the abuse of alcohol and pharmaceuticals as well as with an attempted suicide, an accomplished suicide or a self-inflicted injury;
- treatments of overweight as well as strengthening and cellular therapies (including complications and after-effects of these);
- artificial insemination and sterility treatments (including complications and after-effects of these);
- cosmetic treatments and sex-change operations (including complications and after-effects of these);
- cost sharing (deductibles and retention fees) in the mandatory health care insurance and other insurances.

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

How much is the premium?

The amount of the premium depends on the insured person's age and place of residence according to Swiss civil law, the respective insured risks as well as the desired cover and cost sharing (deductible and retention fee). All details of the premium and cost sharing appear in the insurance proposal form/insurance policy as well as in the Additional Insurance Terms and Conditions. Collective insurance contracts may contain provisions that differ from these.

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. In the event that CONCORDIA makes direct payments to the service providers (doctors, hospitals, pharmacies, etc.), the policy holder is obligated to refund the stipulated cost sharing amount within 30 days of issue of the invoice by CONCORDIA.

Which other duties does the insured person have?

- **Duty to Minimise Damage**
  In the event of illness or accident, the insured person must arrange for professional medical treatment as soon as possible. He is obligated to comply with the orders of the doctor and to refrain from anything that could lead to a deterioration of his physical condition.
- **Duty to Notify**
  The insured person must notify the insurance provider of admission into a hospital without delay, but no later than five days after the admission.
- **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.

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

When does the insurance begin?
The insurance begins on the date indicated in the insurance proposal form/insurance policy.

How long does the contract last?
The contract is taken out for life provided that the policy or the Additional Insurance Terms and Conditions do not contain a fixed contract duration. The minimum duration of a contract that is taken out for life is one year, provided that the insurance proposal form/insurance policy does not provide for another minimum contract duration. In the case of hospital insurances with an optional deductible, it is only possible to change to a lower deductible after an insurance duration of three years.

When does the contract end?
The policy holder may cancel the contract:
- in the case of an insurance that has been taken out for life: after the expiration of the minimum contract duration, at the end of each calendar year, subject to a three-month cancellation 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 of notice;
- in the case of a contract with a fixed duration: at the end of the contract duration, subject to a three-month cancellation 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 of notice. If the contract is not cancelled, it is tacitly renewed for one year at a time;
- after each insurance case for which a benefit must be provided, but no later than 14 days of obtaining knowledge of the payout by CONCORDIA;
- if CONCORDIA modifies the premiums. In this case, the notice of cancellation must reach CONCORDIA by the last day of the calendar year.

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

Otherwise, CONCORDIA waives its right to cancel, provided that there are no contrary regulations in the Additional Insurance Terms and Conditions or in the insurance policy.

CONCORDIA may withdraw from the contract:
- if the insured person 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.

The contract expires automatically if the insured person transfers his place of residence according to Swiss civil law abroad, or transfers his habitual place of residence abroad for more than 12 months.

Further possibilities upon which the contract is terminated arise from the General and Additional 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, in particular to coinsurers and reinsurers. Furthermore, CONCORDIA may request relevant information, particularly 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.

CONCORDIA
Bound by trust

2007 Edition

Supplementary Care Insurances

General Insurance Terms and Conditions

		Article
I.	**General Information**	
	Basis	1
	Insurance Provider, Insured Persons	2
	Submitting the Proposal Form	3
II.	**Scope of Insurances**	
	Object of Insurances	4
	Admission into the Insurances	5
	Geographical Area of Validity	6
III.	**Definitions**	
	Masculine and Feminine Form	7
	Illness, Maternity	8
	Accident	9
	Benefit Providers	10
	Insurance Period	11
IV.	**Start and End of Insurances**	
	Start of Insurance Protection	12
	Contract Duration	13
	Replacement Policy	14
	End of Insurances	15
	Cancellation	16
	Waiving the Legal Right to End the Contract	17
	Expiration of Entitlement to Benefits	18
V.	**Premiums and Cost Sharing**	
	Premium Tariff	19
	Due Date, Payment of Premiums	20
	Reminder, Payment Default	21
	Reimbursement of Premiums	22
	Adjustment of the Premium Tariff	23
	Modification of the Premium Grading	24
	Repayment of Cost Sharing	25
VI.	**Duties and Proof of Entitlement**	
	Duty to Seek Medical Treatment, Duty to Give Information	26
	Duty to Notify in Case of Outpatient Treatment	27
	Duty to Notify in Case of Inpatient Treatment	28
	Duty to Notify in Case of Cures at a Spa/Institution	29
	Proof of Entitlement	30
VII.	**Limitations on Insurance Protection**	
	Exclusions	31
	Reductions	32
	Third-Party Benefits, Secondary Liability	33
	Advance Benefits, Right of Recourse	34
VIII.	**Miscellaneous**	
	Duty to Pay	35
	Fee Agreements and Tariffs	36
	Place of Performance and Place of Jurisdiction	37
	Notifications	38
	Special Agreements	39
	Offsetting, Assignment, Pledging and Reimbursement	40
	Adjustment of the Insurance Terms and Conditions	41

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, the Additional Insurance Terms and Conditions, any Special Insurance Terms and Conditions which may apply, and the provisions in the policy and in any addenda which may apply;

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

1.2 Differing provisions in the Additional or Special Insurance Terms and Conditions take precedence over these General Insurance Terms and Conditions. The respective applicable Special Insurance Terms and Conditions apply in particular to insured persons who have a special form of mandatory health care insurance (such as HMO or the family doctor model) according to Art. 62 of the Swiss federal law on health insurance (KVG/LAMal).

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, Insured Persons

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

2.2 Persons insured are the persons listed in the policy.

3 Submitting the Proposal Form

3.1 In order to be admitted into the insurance or in the event of modifications to the insurance, applicants shall fill out the designated proposal 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.

3.2 A newborn child may be insured from the day of birth if the proposal form has reached the insurance provider prior to the birth.

3.3 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.

II. Scope of Insurances

4 Object of Insurances

4.1 Insurance cover is available for the financial consequences of illness, maternity and accident in addition to mandatory health care insurance according to the KVG/LAMal and accident insurance according to the Swiss federal law on accident insurance (UVG/LAA/LAINF). Benefits are furnished subsequently to the benefits of these mandatory insurances.

4.2 Details of the different insurances are regulated in the Additional Insurance Terms and Conditions.

5 Admission into the Insurances

5.1 The insurance provider is entitled to apply a pre-existing condition exclusion to particular illnesses or consequences of accidents or to decline to provide the insurances completely.

5.2 No pre-existing condition exclusion is applied to the admission of children if the insurance proposal form is submitted before the birth. Differing provisions in the Additional Insurance Terms and Conditions remain reserved.

6 Geographical Area of Validity

6.1 The insurances are valid worldwide.

6.2 Benefits abroad are provided insofar as this is provided for in the Additional Insurance Terms and Conditions.

6.3 In the case of cross-border commuters, the area stretching 20 km from the Swiss border is equated to Switzerland.

III. Definitions

7 Masculine and Feminine Form

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

8 Illness, Maternity

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

8.2 Pregnancy and births are deemed equivalent to illness provided that the mother has been insured for at least one year before childbirth.

9 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 as per the definition in the obligatory accident insurance.

10 Benefit Providers

Benefit providers, in the sense of the contract, are considered to be persons, institutions and facilities that are licensed to practise within the framework of mandatory health care insurance according to Art. 35 et seqq. of the KVG/LAMal or within the framework of accident insurance according to Art. 53 of the UVG/LAA/LAINF, and that meet the conditions fixed in such legislation.

11 Insurance Period

The insurance period is considered to be the calendar year.

IV. Start and End of Insurances

12 Start of Insurance Protection

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

13 Contract Duration

13.1 The contract is concluded for the fixed contract duration given in the policy. It is tacitly extended for one year at a time unless the policy holder has cancelled the contract at the end of its duration.

13.2 If no fixed contract duration is stipulated in the policy, the insurances are taken out for the lifetime of the insured person.

14 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.

15 End of Insurances

15.1 The insurances expire:

15.1.1 upon death of the insured person;

15.1.2 upon cancellation;

15.1.3 upon withdrawal of the policy holder or the insurance provider (Art. 21.2);

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

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

15.2 The special provisions for employees posted abroad in accordance with Art. 4 of the health insurance ordinance (KVV/OAMal) remain reserved.

16 Cancellation

16.1 The policy holder may cancel the insurances:

- in the case of contracts with a fixed duration: for the end of the contract duration, subject to a three-month cancellation period;
- in the case of insurances taken out for life: after a minimum contract duration of one year, for the end of each insurance period, subject to a three-month cancellation period. The Additional Insurance Terms and Conditions or the policy may provide for a longer minimum contract duration for particular insurances;
- if premium tariffs or cost-sharing regulations are adjusted (Art. 23);
- if the insurance terms and conditions are adjusted (Art. 41);
- after each case of damage for which the insurance provider has furnished benefits, but no later than 14 days of obtaining knowledge of the payout.

16.2 Notice of cancellation must be given in writing. The notice of cancellation is considered to have been given on time if it has reached CONCORDIA no later than the last day prior to the start of the cancellation period.

16.3 Except in the event of a breach of the duty to disclose, the insurance provider waives the right to cancel the insurance, provided that there are no contrary regulations in the Additional Insurance Terms and Conditions or in the policy.

17 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 of attempted or accomplished insurance fraud.

18 Expiration of Entitlement to Benefits

The entitlement to benefits (including the benefits for the previous or ongoing treatment of illnesses and accidents or dental treatment) expires at the end of the insurance or when corresponding insurance coverage is excluded from the contract.

V. Premiums and Cost Sharing

19 Premium Tariff

19.1 Premiums are calculated per insurance period (Art. 11) and incorporated into the premium tariff.

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

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

20 Due Date, Payment of Premiums

20.1 The annual premium shall be paid in advance. It is always 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.

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

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

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

20.5 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.

21 Reminder, Payment Default

21.1 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.

21.2 If payment of the outstanding premium is not legally demanded within two months of the end of the reminder period in accordance with Art. 21.1, it is assumed that the insurance provider, by waiving payment of the outstanding premium, is withdrawing from the contract.

21.3 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 reminder period is over.

22 Reimbursement of Premiums

22.1 If the insurance is revoked for legal or contractual reasons before the expiration of the stipulated insurance period, the insurance provider reimburses the premiums paid for the insurance period that has not expired and/or does not demand payment of instalments due later.

22.2 These regulations do not apply if the policy holder cancels the contract in a case of damage before the expiration of the first insurance year.

23 Adjustment of the Premium Tariff

If the premium tariffs or the cost sharing regulations are 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 contract terms and conditions no later than 25 days before they 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.

24 Modification of the Premium Grading

24.1 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 or the domicile of the policy holder causes a modification in premiums, the insurance provider may adjust the premiums accordingly as from the time of the modification.

24.2 No grounds for cancellation in the sense of Art. 23 exist other than when premiums are modified due to an age-related modification to the premium grading.

25 Repayment of Cost Shares

25.1 In the event that direct payments are made to service providers, the policy holder is obliged to refund the stipulated deductibles and retention fees to the insurance provider within 30 days of issue of the bill.

25.2 If the policy holder does not comply with his duty to pay, Art. 21 applies by analogy.

VI. Duties and Proof of Entitlement

26 Duty to Seek Medical Treatment, Duty to Give Information

26.1 If an illness or accident is likely to lead to the insured person receiving benefits, he shall arrange for professional medical treatment as soon as possible. The insured person is obligated to comply with the orders of the doctor or the orders of other service providers.

26.2 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 case of damage as well as to past illnesses and accidents, and releases the service providers that are treating or have treated him from the professional duty of confidentiality with regard to the insurance provider.

26.3 Moreover, the insured person is obligated on order to undergo an examination performed by doctors appointed by the insurance provider.

27 Duty to Notify in Case of Outpatient Treatment

In the case of outpatient treatment, the corresponding detailed original bills and documentary proof shall be sent in upon completion of treatment, however at least once per year.

28 Duty to Notify in Case of Inpatient Treatment

28.1 Notification of admission into a hospital shall be given without delay, but no later than five days after admission.

28.2 A guarantee of payment is issued upon admission into a hospital at the request of the service provider or the insured person.

29 Duty to Notify in the Case of Cures at a Spa/Institution

The doctor's prescription for a cure at a spa/institution centre shall be submitted in a timely manner before the cure begins, with name of the health spa/institution and the date the cure begins.

30 Proof of Entitlement

30.1 If the right to benefits is asserted by the insured person, all original doctor's certificates, reports, documentary proof and bills issued by service providers shall be submitted.

30.2 If other social or private insurance providers (e.g. disability insurance, military insurance, other health and accident insurances), in addition to the insurance provider, are also liable to provide benefits for an illness or for the consequences of an accident, the statements of account of these insurance providers shall also be submitted in addition to the documents mentioned.

30.3 The policy holder/insured person must inform the insurance provider about the type and extent of all benefits that he may claim from or that are paid out to him, in case of illness or accident, by third parties liable to provide benefits arising out of tort, from contract or due to the law.

VII. Limitations on Insurance Protection

31 Exclusions

31.1 Illnesses and accidents, as well as the complications and after-effects of these, arising in connection with the following events, are excluded from the insurance:

- 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 by 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 injuries 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.

31.2 Furthermore, no benefits are provided for:
- cellular therapy, the treatment of obesity (overweight), strengthening therapies (incl. complications and after-effects);
- treatments of which the effectiveness, appropriateness and cost effectiveness are not proven by scientific methods;
- artificial insemination and sterility treatments (including complications and after-effects);
- cosmetic treatments (including complications and after-effects);
- sex-change operations (including complications and after-effects);
- cost-sharing (deductibles and retention fees) in mandatory health care insurance and other insurances.

32 Reductions

The insured benefits shall be reduced or, in particularly serious cases, denied:
- if the policy holder/insured person does not fulfil his obligations and responsibilities unless he can prove that the breach of duty occurred through no fault of his own;
- in the event that the insured event is caused by the gross negligence of the policy holder/insured person;
- 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 reckle ventures in themselves.

33 Third-Party Benefits, Secondary Liability

33.1 Benefits from the supplementary care insurances are provided subsequently to those in accordance with the Swiss federal legislation on health insurance, accident insurance, military insurance and invalidity insurance and to those of corresponding foreign insurance carriers. If the insured person is entitled to benefits from the social insurances mentioned above, benefits are only granted if these insurance carriers have been notified of the case in a timely manner.

33.2 If insurance contracts exist under private law with a number of insurance providers that are liable to provide benefits, 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.

33.3 If liable third parties or the liability insurance providers are liable to provide benefits for the consequences of illness and accident, benefits are only granted if these have provided their benefits and only to the extent that, in consideration of these benefits, no profit accrues for the insured person. Advance benefits in accordance with Art. 34 remain reserved.

33.4 If another insurance provider reduces or denies its benefits on grounds which, in accordance with Art. 32, entitle the insurance provider to reduce its benefits, the loss resulting from the reduction in benefits of the other insurance provider is not replaced.

34 Advance Benefits, Right of Recourse

34.1 The insurance provider may pay benefits in advance on condition that the insured person assigns his rights with regard to third parties up to the amount of the advance benefits that have already been provided and commits himself not to undertake anything that may stand in the way of the insurance provider asserting a possible right of recourse with regard to third parties.

34.2 No duty to provide benefits exists when the insured person has made an agreement with a third party liable to provide benefits, to partially or totally waive insurance benefits, benefits for damages or a lump-sum settlement without the consent of the insurance provider.

VIII. Miscellaneous

35 Duty to Pay

In principle, the insured person is the debtor of fees with regard to the service providers. However, the policy holder/insured person accepts contracts made to the contrary between the insurance provider and the service providers, which provide for direct payments to be made to the service providers.

36 Fee Agreements and Tariffs

36.1 Fee agreements made between the insured person and the service provider are not binding for the insurance provider. Entitlement to benefits exists only within the framework of the tariffs recognised by the insurance provider.

36.2 The insurance provider recognises the tariffs valid for Swiss social insurances as well as the private tariffs that are generally applied. Differing provisions in the Additional Insurance Terms and Conditions remain reserved.

37 Place of Performance and Place of Jurisdiction

37.1 The obligations arising from this contract shall be fulfilled in Switzerland and in Swiss currency.

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

38 Notifications

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

38.2 If the supplementary insurances of CONCORDIA are provided by another insurance provider, the notifications and announcements directed to that insurance provider have the same validity as if they were directed to CONCORDIA.

38.3 Notifications from the insurance provider are legally valid when sent to the policy holder's last given address in Switzerland.

39 Special Agreements

The insurance provider is only bound by agreements extraneous to these provisions if they have been confirmed in writing by its head office.

40 Offsetting, Assignment, Pledging and Reimbursement

40.1 The policy holder/insured person is not entitled, with regard to the insurance provider, to offset outstanding premiums against benefit entitlements.

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

40.3 Benefits which are wrongly drawn by the insured person shall be reimbursed to the insurance provider.

41 Adjustment of the Insurance Terms and Conditions

41.1 The insurance provider is entitled to adjust the insurance terms and conditions, in particular in case of:

41.1.1 the expansion of the number of or the establishment of new types of service providers;

41.1.2 the development of modern medicine;

41.1.3 the establishment of new or cost-intensive forms of therapy (medicines, types of operations, diagnostic techniques, etc.);

41.1.4 changes to the benefit provisions of the KVG/LAMal or its implementing enactments.

41.2 If the insurance terms and conditions are adjusted for such reasons, the new terms and conditions apply to the policy holder/insured person and the insurance provider. The insurance provider notifies the policy holder of the modifications in writing no later than 25 days before they enter 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 considered to have agreed to the adjusted insurance policy.**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

KVG/LAMal
KVG: Bundesgesetz über die Krankenversicherung; Krankenversicherungsgesetz
LAMal: Loi fédérale sur l'assurance-maladie
LAMal: Legge federale sull'assicurazione malattie
Swiss federal law on health insurance

UVG/LAA/LAINF
UVG: Bundesgesetz über die Unfallversicherung
LAA: Loi fédérale sur l'assurance-accidents
LAINF: Legge federale sull'assicurazione contro gli infortuni
Swiss federal law on accident insurance

KVV/OAMal
KVV: Verordnung über die Krankenversicherung; Krankenversicherungsverordnung
OAMal: Ordonnance sur l'assurance-maladie
OAMal: Ordinanza sull'assicurazione malattie
Health insurance ordinance

CONCORDIA
Bound by trust

CONCORDIA
Bundesplatz 15
6002 Lucerne
Phone 041 228 01 11
www.concordia.ch
info@concordia.ch

2.08.E.02 (04.17)