

PERSPECTIVE

General Terms and Conditions of Insurance for Daily Sickness Benefit
Insurance

Part I

For the IKTF and IKTS Tariffs

General Terms and Conditions of Insurance (GTCI) for Daily Sickness Benefit Insurance

Part I

General Provisions for Daily Sickness Benefit Insurance

The Insurance Cover

§ 1

Purpose, Scope and Validity of Insurance Cover

- 1) The insurer offers insurance cover against loss of earnings as a result of illnesses or accidents, insofar as incapacity to work is occasioned thereby. It provides a Daily Sickness Benefit in the contractually agreed amount upon occurrence of the insured event for the duration of unfitness for work.
- 2) An accident occurs if the insured involuntarily suffers damage to his health through an external event having an effect on his body (accident occurrence).

If a joint is dislocated or muscles, tendons, ligaments or capsules are strained or torn by increased exertion on limbs or the spinal column, this is also considered to be an accident.

- 3) The insured event is the medically necessary curative treatment of an insured person for illness or the consequences of an accident, in the course of which incapacity to work is medically established. The insured event begins with the curative treatment; it ends, when according to medical findings, the incapacity to work has ended and there is no further requirement for treatment. If, during treatment, a new illness or accident consequence arises for treatment, in the course of which incapacity to work is medically established, this only produces a new insured event if it is not causally connected with the original illness or accident consequence. If incapacity to work is brought about by several illnesses or accident consequences at the same time, the daily sickness benefit is paid once only.
- 4) Within the meaning of these conditions, incapacity to work is defined as existing if, according to medical findings, the insured person is temporarily unable to perform his professional activity in any way, does not perform this activity and is not engaged in any other gainful activity.
- 5) The extent of the insurance cover is shown in the insurance certificate, any subsequent agreements in writing, the General Terms and Conditions of Insurance (including tariff with tariff conditions) and the statutory provisions in Luxembourg.
- 6) The insurance protection covers the Grand Duchy of Luxembourg. During stays in other European countries the daily sickness benefit will be paid in the contractually agreed amount for serious illnesses or accidents arising abroad, for the duration of medically necessary in-patient treatment in a public hospital. If incapacity to work occurs abroad, the commencement of incapacity to work is considered to be the time at which a doctor or dentist in Luxembourg certifies the incapacity to work (date of issue).

§ 2

Commencement of Insurance Cover

- 1) The insurance cover commences at the time indicated in the insurance certificate (commencement of insurance), but **not before the conclusion of the insurance contract** – that is to say, not before the insurance certificate has been

signed by both contracting parties (facsimiles suffice) – **and not before the end of any waiting periods. No payment will be made in respect of insured events which have occurred before the commencement of insurance cover. Insured events occurring after conclusion of the insurance contract are only excluded from the payment obligation in respect of the part falling in the period before commencement of insurance or during waiting periods.**

In the event of tariff upgrades, contractual amendments or extensions sentences 1-3 shall apply accordingly for the additional payment and/or for the additional part of the insurance cover.

- 2) The contract is concluded per person and per tariff initially for the duration of one insurance year. It will be tacitly extended by one insurance year on each occasion, provided it is not terminated in writing in accordance with § 14.
- 3) The first insurance year of the respective tariff is counted from the commencement of insurance and ends on 31 December of the relevant calendar year. The subsequent insurance years coincide with the calendar year.

§ 3

Waiting Periods

- 1) The waiting periods are calculated from the commencement of insurance.
- 2) **The general waiting period is three months.** It does not apply to accidents.
- 3) **The special waiting periods for psychotherapy, dental treatment, dental replacement, including preparatory and restorative measures, and orthodontics are eight months.**
- 4) The general waiting period may be waived if insurance is applied for with a medical examination and a medical examination report is submitted on the insurer's form provided for this purpose.

§ 4

Scope and Payment Obligation

- 1) The daily sickness benefit will be paid in the insured amount as from the agreed time. It shall be at least EUR 5 and may be increased by units of EUR 1.

The daily sickness benefit is paid for an unlimited period, subject, however, to the provisions of § 15.

- 2) The daily sickness benefit together with other daily sickness benefits and sickness benefits may not exceed the net income derived from the professional activity apportioned to the calendar day. The calculation of the net income is based on the average earnings over the last 12 months before making the application or before the incapacity to work arises. For freelancers and other self-employed persons the net income is considered to be the profit – Art 10 No. 1 to 3 of the Income Tax Law of 04.12.67 – from the activity stated in the insurance application.
- 3) The policy holder is obliged to advise the insurer immediately of any reduction which is not of a temporary nature in the net income derived from the professional activity.
- 4) If the insurer becomes aware that the net income of the insured person has fallen below the amount of income used as a basis for the contract, it may, irrespective of whether the insured event has already taken place or not, reduce the daily sickness benefit and the premium in accordance with the reduced net income with effect from the beginning of the second month after becoming aware of this. Up to the time of reduction the obligation to pay benefit in the previous amount for incapacity to work which has already arisen remains unaffected.

- 5) Payment of daily sickness benefit is subject to the insured person being treated by a licensed, practising doctor or dentist or in a hospital for the duration of the incapacity to work.
- 6) The insured person has a free choice between licensed practising doctors and dentists.
- 7) The occurrence and duration of the incapacity to work must be evidenced by a certificate from the doctor or dentist providing treatment. The certificate must also contain a designation of the illness. The policy holder shall bear any costs incurred in connection with furnishing the relevant evidence. **Certificates from spouses, parents or children are not sufficient as evidence of incapacity to work.** If the doctor providing treatment refuses to state the designation of the illness, the insurer is entitled to make its payments subject to a medical examination in accordance with § 9 subsection 3.
- 8) In the event of in-patient curative treatment which is medically necessary, the insured person has a free choice between the public and private hospitals which are under permanent medical management, have adequate diagnostic and therapeutic facilities, work in accordance with generally recognised scientific methods and hold medical records.
- 9) In the event of in-patient curative treatment which is medically necessary in clinics which also conduct health cures or sanatorium treatment or accept convalescents, but otherwise meet the requirements of subsection 8, the tariff benefits will only be provided if the insurer has agreed to them in writing before the commencement of treatment.

§ 5

Restriction of the Payment Obligation

- 1) There shall be no obligation to pay in the event of incapacity to work
 - a) caused by such illnesses, including the consequences thereof, and by the consequences of accidents which are caused by wartime events or recognised as military service injuries and which are not expressly included in the insurance cover;
 - b) caused by illnesses and accidents based on intent, including the consequences thereof, and by withdrawal measures, including withdrawal treatments. Measures for habit breaking and detoxification are also considered to be withdrawal measures;
 - c) caused by illnesses or accident consequences which are attributable to a condition of mental disturbance brought about by the consumption of alcohol;
 - d) caused by pregnancy related illnesses, termination of pregnancy, sterilisation, miscarriage and delivery, including the consequences thereof;
 - e) during the statutory employment ban for expectant mothers and women who have just given birth while in an existing employment relationship (maternity protection). This time-limited restriction on the payment obligation applies analogously to self-employed women, unless the incapacity work is in no way related to the events named under d);
 - f) if the insured person is not residing at his domicile in the Grand Duchy of Luxembourg, unless – notwithstanding paragraph 3 - he is undergoing medically necessary in-patient treatment (cf. § 4 subsections 8 and 9). If the insured person becomes unfit for work in the Grand Duchy outside his domicile, he is still entitled to sickness benefit, provided that the illness or accident consequence render a return impossible in accordance with medical findings;
 - g) during health cure and sanatorium treatment and during rehabilitation measures;

- h) on account of measures which are not directly required to remedy conditions of illness, in particular cosmetic measures of any type and the consequences thereof.
- 2) In the event of mental and psychiatric illnesses, daily sickness benefit is only paid if and insofar as the insurer has given its agreement in writing, after notification of incapacity to work in accordance with § 9 subsection 1, on the basis of a report from a doctor appointed by it.
 - 3) There shall be no obligation to pay during a stay in a spa or health resort - even in the case of a hospital stay. This restriction does not apply if the insured person has his permanent residence there or if during a temporary stay he becomes unfit for work through a serious illness unrelated to the reason for the stay or an accident which occurs there, provided that according to medical findings return is thereby rendered out of the question.

§ 6

Payment of Insurance Benefits

- 1) The insurer is only obliged to make payment if it is provided with the evidence it requires, which becomes the property of the insurer.
- 2) The insurer is entitled to pay to the bearer or sender of proper evidence.
- 3) Costs for the remittance of the insurance payments and for translations may be deducted from the payments.
- 4) Claims to insurance payments may not be assigned or pledged.

§ 7

End of Insurance Cover

The insurance cover ends – even for pending insured events – upon termination of the insurance relationship (§§ 14 and 15). If the insurance relationship ends because one of the conditions specified in the tariff for eligibility for insurance ceases to apply or because occupational disability arises, the obligation to pay is determined in accordance with § 15 subsection 1, letter a) or b).

Obligations of the Policy Holder

§ 8

Payment of Premiums, Calculation of Premiums

- 1) The policy holder must pay the agreed contribution (premium) and the incidental expenses including taxes.

The premium is set on conclusion of the insurance contract in accordance with the age of the insured person upon admission. The admission age is considered to be the difference between the year of birth and the year of the commencement of insurance.

- 2) The premium is an annual premium and is calculated from the commencement of insurance. It is payable at the beginning of each insurance year, but may also be paid in the monthly premium instalments laid down in the tariff, which are considered in each instance to be deferred until the due date of the premium instalment. The premium instalments are due on the first of each month – even after occurrence of an insured event. If, notwithstanding the final sentence of subsection 10, the annual premium is revised during the insurance year, the difference in amount from the amendment date to the beginning of the next insurance year is to be paid in addition or refunded, as applicable.

- 3) The first premium or the first premium instalment is payable immediately after delivery of the insurance certificate at the latest, but not before commencement of the insurance.
- 4) The premiums or the premium instalments are to be paid until the end of the month in which the insurance relationship ends; premiums paid beyond that date will be refunded. If the insurer is required to pay incidental costs beyond the end of the insurance relationship, these will be chargeable to the policy holder in full and will be due at the end of the insurance relationship at the latest.
- 5) The premiums are claimable at the domicile or place of residence of the policy holder.
- 6) If the premium has not been paid within a period of ten days after the due date, the insurer may demand payment from the policy holder at the end of this period. This payment demand is to be effected by a reminder in the form of a registered letter addressed to the last known domicile of the policy holder. The costs of the above-mentioned demands for payment are to be refunded with the premium payment and are payable by the policy holder under all circumstances.
- 7) **If payment of the premium or the costs referred to in subsection 6 is not made within thirty full days from receipt of the reminder, the insurer shall be released from payment for any treatment cases arising after expiry of this time limit.**

The payment obligation of the insurer is reinstated for all new treatment cases arising, if the policy holder has paid the premiums due up to this date and the proven costs of the collection procedure. **However there is no obligation to pay if the policy holder does not pay until a time at which the occurrence of the insured event is no longer uncertain.**

- 8) If the conditions referred to in the first sentence of subsection 7 exist, the insurer may terminate the contract within 10 days – apart from being released from payment.
- 9) The premiums are calculated using technical calculation principles.
- 10) Within the contractual payment commitment, the payments of the insurer may change, for example because of an increase in the number of days of incapacity to work. The insurer shall accordingly compare the required insurance payments with the estimated payments at least once a year. If the results of this comparison show a change of more than 10%, all tariff premiums will be reviewed by the insurer and, if necessary, adjusted in agreement with an independent trustee. In the event of a change of more than 5%, all the tariff premiums may be reviewed by the insurer and, if necessary, adjusted with the agreement of an independent trustee.

A premium adjustment may be dispensed with if the change in the amount of insurance benefit is considered to be temporary.

In the event of a change in the premiums, including changes arising through a change in the insurance cover, the sex and the tariff-related age of the insured person at the time at which the change enters into effect will be taken into account.

The policy holder shall be advised of the amount of the adjustment in writing. The premium adjustment enters into effect at the beginning of the next insurance year if the policy holder receives the notification of the premium adjustment at least three months before it enters into effect.

- 11) If there is an increased risk in the event of contractual amendments, an appropriate supplement is to be paid for the additional part of the insurance cover, in addition to the premium.
- 12) In the event of changes in premiums the insurer may also change specially agreed premium supplements.

§ 9

Obligations

- 1) The insurer is to be notified immediately of medically established incapacity to work, at the latest by the time at which the tariff-related right to sickness benefit begins. A certificate from the doctor providing treatment stating the diagnosis in respect of the previous and estimated further duration of the incapacity to work – if possible on a printed form from the insurer – is to be enclosed with the notification or must be submitted subsequently within three days. **If the notification is received late, the sickness benefit will only be paid from the date of receipt onwards**, but not before the time laid down in the tariff. In the event of continuing incapacity to work, a certificate of this kind must be produced every week. **No daily benefit will be paid without this evidence.**

The insurer is to be advised accordingly within three days of the person concerned regaining fitness for work.

- 2) The policy holder and the insured person shall, at the request of the insurer, provide any information and produce any items of proof which are necessary to establish the insured event or the payment obligation of the insurer and the scope thereof. The requested information is also to be given to an agent of the insurer.
- 3) At the request of the insurer, the insured person is obliged to undergo an examination by a doctor appointed by the insurer. **If he refuses to undergo this additional examination, sickness benefit may be withdrawn for the period of the refusal.**
- 4) The insured person shall endeavour to regain fitness for work; he shall in particular follow the doctor's instructions conscientiously and refrain from all acts which are an obstacle to recovery.
- 5) Any change in occupation of the insured person is to be advised immediately.
- 6) Conclusion of further insurance elsewhere for the first time or an increase in insurance existing elsewhere giving the right to daily sickness benefit may only be effected with the consent of the insurer.

§ 10

Consequences of Breach of Obligation

- 1) **The insurer shall be released from the obligation to pay benefit if one of the obligations referred to in § 9 subsections 1 to 4 is deliberately breached.** In the event of breach with gross negligence the insurer shall only remain liable to payment insofar as the breach has not had an effect either on the establishment of the insured event or on the establishment or the extent of the payments incumbent upon the insurer.
- 2) If one of the obligations referred to in § 9 subsections 5 and 6 is culpably breached, the insurer may terminate the contract with immediate effect within three months from the time at which it became aware of the breach. **In the event of termination the insurer is released from the payment obligation.**
- 3) The knowledge and the fault of the insured person are equal to the knowledge and fault of the policy holder.

§ 11

Obligation to Notify if Insurance Eligibility Ceases

The insurer must be notified immediately if one of the conditions specified in the tariff for eligibility for insurance ceases to apply or in the event of occupational disability (cf. § 15b) of an insured person. If the insurer does not become aware of such event until later, both parties shall be obliged to restore to one another the payments received for the period after the insurance relationship has ended. The insurer is also to be advised immediately of the drawing of retirement pension (cf. § 15 c). Sentence 2 of the above provision also applies here.

§ 12 Offsetting

The policy holder may only offset against claims of the insurer insofar as the counter claim is established without dispute or with legally binding effect. A member of an insurance association may not, however, offset against a claim arising from the premium liability.

§ 13 Statute-barring

Any claim arising from the contract shall lapse under the statute of limitations upon three years from the time of the event on which it is based.

§ 14 Termination and Invalidity of the Insurance Relationship

- 1) The policy holder may
 - a) terminate the insurance relationship overall or in respect of individual insured persons or tariffs at the end of any insurance year, with a notice period of three months.
 - b) In the event of an increase in premium in accordance with § 8 subsection 10 or reduction in his benefits in accordance with § 18, terminate the insurance relationship in respect of the insured person concerned within one month as from receipt of the amendment notification at the time of the entry into effect of the amendment.
 - c) In the cases set out at subsection 4, demand the cancellation of the insurance relationship in respect of the persons not affected within two weeks from receipt of the statement of the insurer at the end of the month in which he received the statement.
- 2) The insurer may terminate the insurance relationship without notice if the policy holder or an insured person have fraudulently acquired insurance benefits or attempt to acquire insurance benefits in a fraudulent manner. The right to termination expires if it is not exercised within one month from the time at which the insurer became aware of the facts giving rise to the right to termination.

Other extraordinary rights of termination of the insurer remain unaffected. The ordinary right of termination of the insurer is excluded.

- 3) The contract shall be void if, by culpable breach of the obligation to notify, the assessment of the risk is changed in such a way that the insurer would not have concluded the contract at all, or not on the same conditions, if it had been aware of the withheld circumstances. The same applies to breach of the obligation to notify in the case of contracts in respect of the revision or reinstatement of insurance cover.

The policy holder is obliged to pay back insurance benefits received. The insurer must repay the premiums paid, unless the breach of the obligation to notify was deliberate.

- 4) If, in the case of insurance relationships which cover several insured persons, the conditions for termination under subsection 2 or invalidity under subsection 3 exist with reference to individual insured persons only, the exercise of the above rights may be restricted to those persons.

§ 15

Other Grounds for Termination

- 1) The insurance relationship shall end with respect to the insured persons concerned
 - a) if a condition specified in the tariff for eligibility for insurance ceases to apply, at the end of the month in which the condition ceased to apply. If, however, at that time there is still incapacity to work in an insured event which has already taken place, the insurance relationship shall not end before the time up to which the insurer is required to provide benefits for this incapacity to work as listed in the tariff, at the latest however, three months after the condition has ceased to apply.
 - b) in the event of occupational disability. Occupational disability is defined as existing if the insured person is, in accordance with medical findings, more than 50% incapable of gainful employment in the occupation in which he was previously engaged, for the non-foreseeable future. If, however, at that time there is still incapacity to work in an insured event which has already taken place, the insurance relationship shall not end before the time up to which the insurer is required to provide benefits for this incapacity to work as listed in the tariff, at the latest however, three months after occupational disability has arisen.
 - c) upon the drawing of retirement pension, at the latest on reaching the age of 65 years, at the end of the month in which the age limit is reached.
 - d) upon death. In the event of the death of the policy holder the insured persons have the right to continue the insurance relationship by appointing the future policy holder. The declaration is to be made within two months from the death of the policy holder.
 - e) upon moving from the Grand Duchy of Luxembourg, unless a different agreement is concluded.
- 2) In the event of a change in occupation the insured person may apply for continued insurance in a different sickness benefit tariff which is open for the new subscription, provided that the conditions for eligibility for insurance contained therein are met. The period of the previous insurance will be counted towards the waiting periods and taken into account in the setting of the premium. The application for continued insurance must be made within a time limit of two months from the end of the previous insurance; if the insurance cover is increased the provisions at § 3 subsections 1-3 shall apply to additional benefits as a result of reduction in the qualifying period or an increase in the daily sickness benefit.

Other Provisions

§ 16

Declarations of Intention and Notifications

- 1) Declarations of intention and notifications to the insurer must be made in writing. Insurance agents are not authorised to accept them. This does not apply to applications for the conclusion or amendment of health insurance contracts.
- 2) If the policy holder has not advised the insurer of a change of residence, it is sufficient for a declaration of intention made to the policy holder to be legally valid if it is sent to the last address known to the insurer. The declaration becomes effective at the time at which it would have reached the policy holder by normal post if there had been no change of address.

§ 17

Place of Jurisdiction

The courts of the Grand Duchy of Luxembourg shall be exclusively competent for all disputes arising from the contract between the policy holder and the insurer.

§ 18

Amendments to the General Terms and Conditions of Insurance

- 1) The General Terms and Conditions of Insurance may be amended with the agreement of an independent trustee with effect for existing insurance relationships, even for the unexpired part of the insurance year, insofar as they concern provisions in respect of insurance cover, obligations of the policy holder, other grounds for termination, declarations of intention and notifications and the place of jurisdiction.
- 2) Amendments in accordance with subsection 1 become effective at the beginning of the second month following the notification of the policy holder.

The General Terms and Conditions of Insurance in English are just a translation, and the German General Terms and Conditions represented the legal documents.