ENDOWMENT INSURANCE KTI

GENERAL INSURANCE CONDITIONS (GIC) ENDOWMENT INSURANCE IN THE EVENT OF DEATH OR DISABILITY AS A RESULT OF ILLNESS KTI.

Edition 2014

BECAUSE HEALTH IS EVERYTHING SWICA

Information on KTI endowment insurance

This information is intended as a quick and comprehensible explanation of what endowment insurance KTI is all about. You will find the General Insurance Conditions (GIC) in the same document.

Term life insurance without savings component
KTI insurance covers the risks of disability and/or death as the result of illness.

- In the event of death, the insured death lump sum is paid.
- In the event of permanent disability, the insured disability lump sum is paid. For disability levels starting at 40 %, the lump sum is prorated to the level of disability. In the case of a disability level of at least 70 %, the insured person will receive the full disability lump sum.
- The insurance has no savings component and no surrender value.

Exemption from premiums
In cases with an extended period of occupational disability, the insured person is exempt from having to pay premiums.

- If the insured person is occupationally disabled as the result of an illness or accident, the obligation to pay premiums ends after a waiting period of 180 days. Insurance cover remains in effect without change.
- In cases with occupational disability starting at 40 %, the premium is prorated to the level. From occupational disability levels of 70 % or more, you will be fully exempt from premiums.

Selectable sum insured
The sum insured on death or disability can be freely selected in tranches of CHF 10,000. The minimum amount for disability or death is CHF 10,000.

KTI for children
For children up to the age of 12, the maximum sum insured on death is CHF 20,000. If a child dies before having reached the age of two and a half, a maximum of CHF 2,500 is paid. For children between the ages of 12 and 15, the insurer pays a death lump sum of maximum CHF 200,000. For children above the age of 15, the same sums insured as for adults apply.

Premium and payment
The total premium is the sum of the premiums for death, disability and occupational disability, whereby the amount depends on the insured lump sum as well as on the insured person's gender and age. Risk increases together with the insured person's age, and the premiums are adjusted accordingly. From the age of 56 on, the disability lump sum undergoes an annual linear reduction until the final age; in exchange, the premium is not adjusted to the increase in risk. The death lump sum, on the other hand, remains constant. The insurer can adjust the premium rates during the contract term.

Beginning and end of the insurance
The insurance application must be completed truthfully and in full. If a question was answered incorrectly or information was withheld, the insurer can terminate the insurance and refuse to pay benefits. Any later changes in circumstances that are indicated in the application must be notified before the insurance begins. This applies in particular to illnesses and/or accidents that occur after the application is submitted. The insurance starts on the date shown in the policy. Under normal circumstances it ends on 31 December of the year in which the insured person reaches the age of 60, or on the insured person's death. After a minimum contract term of one year, a KTI policy can be terminated early to the end of the current calendar year. If premium payments are in arrears, the insurer can cancel the policy after having sent a reminder. In addition, the insurance ends if the insured person moves his or her residence abroad and the insurer does not confirm continuation of cover in writing. Other possibilities to terminate the insurance are laid out in the GIC and the Insurance Contract Act (VVG).

Benefit restrictions
If death or disability is caused intentionally, through gross negligence, or results from an act of daring, the insurer can reduce or refuse benefits. Further exclusions and restrictions of insurance cover are laid out in the GIC (see reverse side) and the VVG.

Non-disclosure and data protection
The insurer processes the information it needs in order to conclude and manage the insurance contract. For this it can involve an external expert and other insurers. The information is stored electronically and filed as a hard copy.

Insurer
Your insurer is CONCORDIA Versicherungen AG, a stock corporation of CONCORDIA Group with its registered office at Bundesplatz 15, 6002 Lucerne.

Your contact
SWICA Healthcare Insurance Ltd (hereinafter referred to as "SWICA") acts as the agent for KTI endowment insurance from CONCORDIA and provides customer care, issues policies, collects premiums, and sends reminders. For this purpose, it has entered into a contract with CONCORDIA.

For more information about the rights and obligations of the contracting parties, in particular regarding cover, exclusions, sums insured, premiums and data protection, please refer to the insurance application, policy, GIC and the Insurance Contract Act (VVG).

Endowment insurance KTI
Flexible pension (Pillar 3b)
General Insurance Conditions (GIC)

I Subject of the insurance

1.1 Insured risks
Endowment insurance KTI is a form of flexible pension (Pillar 3b) that offers protection against the economic consequences of death or disability as the result of illness.
If the insured person is occupationally disabled for more than 180 days as the result of an illness or an accident, exemption from the obligation to pay premiums applies.
KTI is a form of pure risk insurance. Its premiums do not include a savings component, which means the insurance has no surrender value and pays no benefits when the policy matures, except in the case of disability and occupational disability.
The insurance is valid worldwide.

1.2 Insured lump sum
1.2.1 A death lump sum and/or a disability lump sum can be insured for every insured person.

1.2.2 The amount of the insured lump sum per risk is defined in the policy. The amount is at least CHF 10,000 on death and at least CHF 10,000 on disability. Until the insured person reaches the age of 12, at maximum CHF 20,000 can be insured on death.

1.2.3 The insured death lump sum remains constant until the contract ends.

1.2.4 The insured disability lump sum remains constant until the end of the calendar year in which the insured person reaches the age of 55. It then undergoes an annual linear reduction (rounded to the nearest CHF 5,000 in each case) until the final age is reached.

1.2.5 If a part of the disability lump sum is paid out, the other part remains insured. It is not possible to reinstate or increase the original insured lump sum.

1.3 Illness
An illness is defined as a medically and objectively identifiable physical, mental, or psychological impairment of a person's health that is not the consequence of an accident and that requires medical examination and treatment.

1.4 Accident
An accident is defined as a sudden, unintended and damaging effect of an unusual external factor on the body that results in physical, mental or psychological impairment that can be medically and objectively established, or that leads to death. The definition of accident also includes
– health impairment from involuntary inhalation of gases or vapours, or from unintentional consumption of poisonous or caustic substances;
– dislocations, sprains, and the tearing of muscles and tendons due to a sudden exertion;
– freezing, heatstroke, sunstroke, and health impairment from ultraviolet radiation, except for sunburn;
– involuntary drowning.

There is no entitlement to benefits if death or disability is caused by an accident or a physical injury that is similar to an accident. If there are multiple causes, the insurance pays benefits in the amount that excludes the portion attributable to the accident.

1.5 Occupational disability
Occupational disability is defined as a condition resulting from an illness or accident whereby
- a gainfully employed insured person is no longer able to work fully or partially in his occupation or in another occupation that can be reasonably expected. Another occupation is deemed to be reasonable if it matches with the insured person's abilities and position in life, even if the person has to retrain in order to acquire the necessary skills.
- an insured person who is not gainfully employed or in training is fully or partially restricted in the activities he was able to perform up to this time.

1.6 Disability
Disability is defined as occupational disability that can be expected to last until the end of the person's life. It is recognized by the insurer if
- continued medical treatment is not expected to lead to a significant improvement in capacity for work and the person will remain occupationally disabled despite reintegration measures, and
- the condition has lasted for at least 12 months. If disability is confirmed in less than twelve months, the insurer can recognise it earlier.

1.7 How the insurer establishes a condition
The insurer relies on a recognized or appointed proxy in Switzerland or the Principality of Liechtenstein to conduct an assessment in order to establish whether occupational disability or disability exists, as well as its start, degree and duration.

In the case of gainfully employed persons, the level of occupational disability or disability is assessed on the basis of the person's lost earnings, whereby the income achieved prior to the disability is compared to the income the person achieves, or could be expected to achieve in a stable labour market, after the onset of the occupational disability. In the case of gainfully employed persons with irregular or highly fluctuating income or those who are self-employed, the average income subject to AHV contributions achieved during the 36 calendar months prior to occupational disability is used as the basis.

For persons who are not gainfully employed or who are in training, the level of occupational disability or disability is assessed based on a comparison of activities, whereby the activities the insured person is able to perform in his field before the onset of occupational disability are compared against those that can be performed or could be reasonably expected after the disability has set in.

II Parties to the contract

2.1 Use of masculine and feminine forms
In order to enhance readability of the General Insurance Conditions, only the masculine form is used throughout this text. It also refers to females and legal entities.

2.2 Parties
The following persons are parties to the insurance contract:
- The **policyholder** is the person who submits the application, concludes the insurance and is the contracting party of the insurer.
- The **insured person** is the person whose life or capacity for work is insured. This can be the policyholder himself or another person.
- **Beneficiaries** are the persons or institutions that the policyholder appoints as the recipient of some or all of the insured benefits.
- The **premium payer** is the policyholder, unless another person undertakes to pay the premiums.
- The **insurer** and contracting party of the policyholder is CONCORDIA Versicherungen AG.
- The **client adviser** acting on behalf of the insurer is SWICA Healthcare Insurance Ltd (hereinafter referred to as "SWICA").

SWICA can advise policyholders, insured persons, premium payers and beneficiaries in all matters relating to KTI insurance, as well as send and receive notifications to and from them. The insurer can also instruct SWICA to carry out tasks in connection with managing the insurance.

2.3 Notifications
Notifications to the insurer become legally valid only if they reach the insurer or SWICA in writing.
The insurer or SWICA must send notifications to the policyholder, insured persons, premium payer, eligible claimants and beneficiaries in writing to the most recent address on file.
If the policyholder resides outside of Switzerland or the Principality of Liechtenstein, he must appoint a representative in Switzerland to whom the insurer or SWICA can legally address all notifications.

III Basis of the contract

3.1 The following documents, in order of precedence, constitute the legal basis of the insurance contract:
- the insurance application, the completed questionnaire and any medical reports that may be needed, as well as any further information provided for the risk assessment,
- the provisions of the insurance policy and any addenda or special conditions,
- the General Insurance Conditions (GIC),
- the Federal Insurance Contract Act (ICA) of 2 April 1908, if a particular circumstance is not expressly defined in the contract.

If individual documents prove to be contradictory in the interpretation of the contract, the provision in the next higher ranking document prevails.

3.2 Wherever these GIC or the premium rates refer to the insured person's age, the difference between the calendar year in question and the year of birth count as the definitive age.

3.3 The insurance year is the same as the calendar year. The first insurance year lasts from the start date of the insurance until the end of the same calendar year.

IV Conclusion of the contract

4.1 Place of residence and age of admission
In order to be eligible for insurance, a person's place of residence must be in Switzerland or the Principality of Liechtenstein. He can be insured at the earliest from the first day of the month after birth. It is not possible to purchase new insurance or to increase the insured lump sum after the start of the calendar year in which the insured person reaches the age of 56.

4.2 Application
The policyholder must complete the insurance application truthfully and in full and submit it to the insurer with his signature. The insured person or his legal representative must answer the questions on health and other risk characteristics fully and truthfully. SWICA uses these documents to inform the insurer about these persons' requests for enrolment.
The policyholder is bound by this application for 14 days; if a medical examination is required, the period is four weeks, unless he has defined a shorter period or withdrawn the application.

4.3 Withdrawal
The policyholder can withdraw the application in writing within 7 days from the date of signature. This applies also if the insurer has already accepted the application.

4.4 Notification obligation and consequences of its violation
During the entire application procedure, the policyholder and the insured person or their representatives must notify the insurer about all relevant circumstances that apply in connection with assessing the risk to the extent that they are or should be known. They must inform the insurer about any changes in these circumstances that occur up to the time when the insurance starts and amend or correct the information they entered in the application or questionnaire.
The policyholder or insured person or their representative is deemed to have violated the notification obligation if he withholds information or falsifies answers to written questions about any relevant circumstances that he knew or should have known at the time when he purchased the insurance. In particular, relevant circumstances refers to information about current or prior illnesses or the consequences of an accident.
The insurer can terminate the contract in writing within four weeks from the date on which it became aware of a violation of the notification obligation. In this case, its obligation to pay benefits no longer applies for prior claims whose occurrence or scope was influenced by the relevant risk circumstances that were withheld or falsified. In the case of policies that came into effect up to 1 January 2006, the obligation to pay benefits for loss that already occurred ends in every case and the insurer is entitled to a reimbursement of any benefits that were paid. There is no entitlement to a reimbursement of premiums.

4.5 Supplementary insurance
An increase in the sum insured is deemed to be the same as a new contract.

V Beginning, term and end of the insurance

5.1 Beginning of cover
The decision of accepting the insurance application rests with the insurer. The insurer can accept the application without change, implement provisos, request higher premiums for special risks, defer the application, or reject it altogether.
Insurance cover becomes effective on the start date defined in the policy.

5.2 Contract term
The insurance lasts at the most to the end of the calendar year in which the insured person reaches the age of 60 (final age).

5.3 Termination
The policyholder can terminate the insurance early to the end of the current calendar year or reduce the sum insured by means of written notice at the earliest one year after the insurance begins.

5.4 End of insurance
The insurance ends
- with the death of the insured person,
- on full disability of the insured person, provided that death is not insured,
- on reaching the final age.

The insurance ends early if the
- policyholder withdraws the application,
- policyholder terminates it,
- insurer terminates it due to a violation of the notification obligation,
- insured person moves his place of residence outside of Switzerland or the Principality of Liechtenstein,
- premium is unpaid when the reminder period ends.

VI Restrictions in insurance cover

6.1 General
Entitlement to benefits does not apply in the event of
- death, occupational disability or disability caused by the effects of ionizing rays or nuclear energy;
- death or disability from occupational illnesses as defined in the Federal Law on Accident Insurance (UVG);
- refusal or obstruction of investigations, enquiries or measures to reintegrate the insured person into working life as requested by the insurer;
- deployment in UN peacekeeping missions;
- participation in a war, in warlike acts or in civil commotions. The provisions of Art. 13 on military service, war and civil commotions apply;
- the consequences of a premeditated crime or an offence that the insured person commits or attempts to commit. Premeditation refers to an act the insured person commits intentionally and wilfully, or one that he believes he can realize and takes into consideration.

6.2 Intentional acts
There is no entitlement to benefits if the insured person
- commits suicide or becomes incapacitated or disabled from attempted suicide within three years from the date when the insurance begins, increases or is reinstated,
- causes the occupational disability of disability intentionally.

This applies also if the insured person causes the actions leading to the death, occupational disability or disability while not of sound mind.

6.3 Gross negligence and acts of daring
The insurer can reduce the benefits if an insured event is caused through gross negligence. Gross negligence refers to conduct whose consequences are not taken into account because of a disregard for or absence of the necessary due care and while ignoring even the most basic precautionary measures that any sensible person would have taken when faced with the same situation and circumstances.
If the insured event is the consequence of one or several acts of daring, the insured benefits will be reduced, or refused in particularly serious cases. Acts of daring refers to actions in which the insured person exposes himself to particularly high risk without taking or being able to take precautions that would reduce the risk to a reasonable level. Attempts to rescue others are insured even when such acts are to be considered as acts of daring.

6.4 On death of a child
The insurer pays at maximum the following amounts on the life of a child in the event of death:
– CHF 2,500 if the child dies before the age of two and a half,
– CHF 20,000 from all policies in effect if the child is between the ages of two and a half and twelve,
– CHF 200,000 if the child dies before he has reached the age of 15.

VII Payment of benefits

7.1 On death
Entitlement to the death lump sum arises if the insured person dies while the insurance cover is in effect.
If the insured person dies after a part or all of the disability lump sum has been paid, the insured death lump sum will also be paid if at least six months have passed from the date on which the disability began and the date of the insured person's death. If death occurs earlier and the insured death lump sum is larger than the disability lump sum that has already been paid, the difference between these amounts will be paid. The full death lump sum will be paid if the cause of death is in no way related to the cause of disability.

7.2 On disability
If the insured person becomes disabled while insurance cover is in effect, entitlement to the disability lump sum is contingent on the level of disability.
In this case, a disability level of 70 % results in entitlement to the full lump sum; a disability level below 40 % results in no entitlement.

Disability level	Entitlement as % of the full insured lump sum
0–39	0
40–49	25
50–59	50
60–69	75
from 70	100

7.3 Exemption from premiums on occupational disability
7.3.1 If the insured person is occupationally disabled without interruption because of an accident or illness for more than 180 calendar days, the insurer pays the additional premiums owed and exempts the policyholder from the obligation to pay premiums.

7.3.2 The waiting period of 180 days starts over each time that the person is again able to work, unless the occupational disability repeats itself from the same cause within twelve months.

7.3.3 Entitlement to exemption from premiums is determined based on the degree of occupational disability as follows:
- Occupational disability below 40 % results in no entitlement.
- Occupational disability between 40 % and 70 % results in entitlement as a prorated per cent of the level of the occupational disability.
- Occupational disability of at least 70 % results in full entitlement to exemption from premiums.

7.3.4 The policyholder who claims exemption from premium payments in connection with occupational disability must notify the insurer no later than one month after the waiting period ends and submit the required documents.

7.3.5 In case of late notification, the insurer can deny exemption from premiums for the period of late notification, unless the delay was not caused culpably, given the circumstances.

7.3.6 The policyholder must continue to pay the premium until the insurer has reached a decision. Any excess premiums paid will be refunded.

7.4 Adjustment to the level of occupational disability or disability
The insurer must be informed immediately of any change in the level of occupational disability or disability. The insurer has the right to review the occupational disability or disability level at any time.
Exemption from premiums is adjusted or suspended in accordance with a change in level. The adjustment applies as of the day on which the occupational disability level changed. If it becomes apparent that excess benefits were paid because of a change in disability level, the excess amount must be refunded. Any shortfall in premium must be paid retroactively.

7.5 Basis for entitlement
7.5.1 The insurer reviews entitlement to insurance benefits when all the necessary documents have been submitted. All of the following documents must be submitted in order to establish entitlement to benefits:
- on death:
  - the original insurance policy,
  - the completed application for benefits,
  - the family register or family certificate,
  - an official death certificate,
  - a medical certificate.
- on disability:
  - the insurance policy,
  - the completed benefits application,
  - a report by the doctor about the cause, course and duration of the disability.
- on occupational disability, at the latest one month after the waiting period ends:
  - a detailed medical report about the illness or consequences of the accident and the disability level, as well as
  - a description of the activity the insured person performed before the occupational disability set in.

7.5.2 The insurer has the right to request or obtain of its own accord further information and proof and to have the insured person examined by a doctor at any time. The insured person's doctors are released from their professional secrecy obligations towards the insurer.

7.5.3 Claims arising from the insurance contract become time-barred two years after the event on which the obligation to pay benefits is based.

7.6 Payment
Insurance benefits are paid in Swiss francs (CHF) to the account with a bank in Switzerland or the Principality of Liechtenstein or with Swiss Post that the beneficiary has specified.
In the case of a pledge, the insurer must first obtain the pledge holder's written approval before any benefits are paid.

VIII Beneficiary clause

8.1 Beneficiaries
8.1.1 Unless other provisions prevail, the order of beneficiaries applies as follows:
1. the insured person, on this person's death
2. the insured person's spouse or registered partner; if none,
3. the insured person's children; if none,
4. the insured person's parents; if none,
5. the insured person's remaining legal heirs, to the exclusion of the community.

8.1.2 In the absence of any beneficiaries, the insurer will pay the funeral expenses up to 10 % of the insured death lump sum, at minimum CHF 2,500.

8.1.3 The policyholder can change the order of beneficiaries or exclude or appoint other beneficiaries at any time up to the date on which insurance benefits are paid, unless he included an irrevocable beneficiary clause previously. Furthermore, he can include a beneficiary clause in his will or inheritance contract or issue an informal unilateral declaration of intent.

8.1.4 He must direct such notifications to the insurer in writing and designate the beneficiary unambiguously by name. Legal entities can also be designated as the beneficiary.

8.1.5 The policyholder can issue an irrevocable beneficiary clause, in which case he must confirm his intent to refrain from revoking the beneficiary clause in the policy with his signature and provide the beneficiary with a copy.

8.2 Beneficiary clause in the case of bankruptcy or pledge
8.2.1 If the policyholder has signed an irrevocable beneficiary clause, entitlement to benefits arising from this clause is exempt from collection proceedings by the policyholder's creditors.
In other respects the beneficiary clause becomes invalid if benefits are pledged or bankruptcy proceedings are instituted against the policyholder. However, it is reinstated if the pledge is removed or bankruptcy proceedings are discontinued.

8.2.2 If the policyholder has purchased insurance on his own life, then his spouse, registered partner or heir have the following privileges, subject to any rights of lien, in debt collection or bankruptcy proceedings from the proceeds of the policyholder's assets:
- If such persons are privileged, neither their nor the policyholder's entitlement to insurance benefits is subject to enforcement proceedings. Unless they expressly reject such arrangements, these beneficiaries will assume the policyholder's rights and obligations arising from the insurance contract.
- If other beneficiaries have been appointed, the policyholder's spouse, registered partner or heir can, with the policyholder's approval, request to have the entitlements arising from the life insurance contract transferred to them.

8.3 Assignment and pledging
The policyholder can assign or pledge is entitlement to benefits. In this case the following conditions must be met:
- a written pledge or assignment contract must exist between the policyholder and the pledge holder or party now entitled,
- the policy must be transferred to the pledge holder or party now entitled, and
- written notification must be sent to the insurer.

The pledge takes precedence over the beneficiary status, but the beneficiary status becomes fully effective again as soon as the pledge is removed. If the pledge is assigned, the party becoming entitled to insurance benefits becomes the eligible claimant.

IX Premiums

9.1 Rate
The premium is calculated annually and shown in the policy. The premium rates provide for risk-based age categories. If the insured person's definitive age reaches the next category, the premium will increase based on the higher risk involved.

9.2 Rate adjustments
The premium rates are not guaranteed. The insurer can adjust the rates if the underlying circumstances on which the premium calculation is based change significantly. The insurer must inform the policyholder in writing about the new rates no later than 30 days before they come into effect. The policyholder then has the right to terminate the insurance in writing. If the policyholder exercises this right, the insurance

ends at the end of the current insurance year. The insurer must receive the notice of termination no later than on the last day of the current calendar year. The contract change is deemed to have been accepted unless the policyholder terminates the contract.

9.3 Payment obligation
The premium is calculated annually and shown in the policy.

9.4 Default penalties
If the premium remains unpaid on the due date, the policyholder is notified of the consequences of default and requested in writing to pay the outstanding amount within 14 days of the stamp date of the reminder. If the reminder is ignored, insurance cover ceases on expiry of the reminder period.
If the premium is paid after the reminder period ends, insurance cover is not reinstated automatically. The insurer can refund any premium paid in arrears, reject continuation of the insurance, request that the insured person undergo a new medical examination, or grant insurance cover under changed conditions. No insurance cover is granted for the consequence of any events that occur between the date on which the reminder period ends and the date of acceptance of the late premiums, including interest and fees.

9.5 Refunded premiums
The insurer must refund to the designated premium payer any premiums that were paid for the period following the insured person's death or disability.
Any premiums that were paid for the exemption period are refunded in full.

X Data management

10.1 The insurer processes the data necessary for managing the insurance contract, in particular information about the policyholder, insured person, premium payer and beneficiaries.

10.2 The data is stored electronically and as a hard copy.

10.3 SWICA provides advisory services to customers. SWICA provides the insurer with the personal data that is necessary to conclude the contract. On conclusion of the contract, the insurer passes on to SWICA the data it needs in order to issue the policy, collect the premiums, send reminders and provide customer care.

10.4 The insurer can transfer part of the risk to a reinsurer. For this it must disclose to the reinsurer the necessary personal data.

10.5 To administer the insurance, the insurer can engage external experts (e.g. doctors, legal experts), who in turn must comply with data protection and non-disclosure provisions. Personal data can also be obtained from or passed on to other insurance companies in connection with reviewing applications and benefit entitlement. Personal data is passed on to third parties only with the consent of the policyholder or insured person.

XI Place of jurisdiction

Legal action can be taken against the insurer before a court at the insurer's registered office in Lucerne or at the policyholder's or beneficiary's place of residence in Switzerland or the Principality of Liechtenstein.

XII Changes to the General Insurance Conditions

The General Insurance Conditions are valid for the duration of the insurance. If the insurer changes the General Insurance Conditions during the contract term of KTI endowment insurance, it must, at the policyholder's request, review the extent to which the new General Insurance Conditions can be applied.

XIII Military service, war and civil commotions

13.1 Military service in times of peace is defined as active service to maintain Switzerland's neutrality and ensure peace and order within Switzerland, both excluding warlike actions, and is included in the GIC without restrictions.

13.2 If Switzerland wages war or becomes involved in warlike actions, a single war contribution is due from the beginning of the war and payable one year after the war ends. Whether the insured person participates in the war and whether this person is in Switzerland or abroad is of no consequence.

13.3 The war contribution is intended to cover any loss caused directly or indirectly by the war, provided that the damage concerns insurance policies that are subject to these provisions. The insurer, with the approval of the Swiss supervisory authorities, establishes the extent of the war damage and the available covering funds, as well as the amount of the war contribution and the possibility of its repayment – by reducing insurance benefits, if necessary.

13.4 If insurance benefits are due before the amount of the war contribution has been established, the insurer is authorized to defer a reasonable part of the payment for up to one year after the war ends. The insurer, with the approval of the Swiss supervisory authorities, determines the amount to be deferred and the interest rate that applies to this amount.

13.5 The Swiss supervisory authorities determine the dates that mark the beginning and end of the war as defined in the provisions above.

13.6 If the insured person participates in a war or in warlike actions that Switzerland itself does not wage or is not involved in and if the insured person dies during such a war or within six months after peace is concluded or hostilities end, the insurer must pay the actuarial reserves calculated on the date of death, at maximum up to the insured death benefit. If the insurance includes a survivorship annuity, the annuities as of the date of death apply instead of the actuarial reserves, up to the amount of the insured annuity.

13.7 The insurer reserves the right to amend the provisions of this article, with effect on this policy, with the approval of the Swiss supervisory authorities. Furthermore, any legal and official measures enacted in connection with a war, in particular as regards the surrender of the policy, are expressly reserved.

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SWICA Healthcare Organisation
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