Terms and conditions of insurance for Krankentagegeld Inbound rates (group insurance) [*daily sickness allowance*]

As part of the Krankentagegeld Inbound rates (group insurance), we offer insurance cover against loss of earnings as a consequence of illness or accident to the extent that this results in the inability to work. In an insured event, we pay – for the duration of said inability to work – a daily sickness allowance within the contractual scope. In addition, we offer female →insured persons cover against loss of earnings during the statutory maternity protection periods.

These terms and conditions of insurance are aimed at you, the →main insured person under the →group insurance policy. The Policyholder also has to observe the terms and conditions of insurance. If other policies are in place for the insured person in addition to a Krankengeld Inbound rate (group insurance), other terms and conditions of insurance may be agreed for these. The terms and conditions of insurance for the Krankengeld Inbound rates (group insurance) do not apply to these policies.

These rates bear the abbreviations KTI07W, KTI14W und KTI27W. Information on which daily sickness allowance rate has been agreed upon for you can be found in your Insurance Certificate / Schedule.

The premiums for these rates do not contain any shares to set up ageing provisions.

Section A – Benefits

Here, you can find provisions on the scope of cover and a description of the benefits that we provide in an insured event.

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Section B – Your obligations

Here, you can find provisions on the duties and rules of conduct (obligations) associated with the insurance and the consequences if these are breached.

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Section C – General provisions

This section sets out the regulations governing the inception of cover. You and the Policyholder can also find the provisions governing the adjustment of the premium and the terms and conditions of insurance, as well as general provisions on the execution of the insurance policy here.

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Explanation of specialist terms

We have tried to make the terms and conditions of insurance as comprehensible as possible and to use as few specialist terms as possible. Not every specialist term can be replaced by an expression used in everyday language. This is why you will find explanations of specialist terms that cannot be avoided at the end of your terms and conditions of insurance. We have marked specialist terms that are explained in this section with a "→" in the text.

Example: "→written form"

Section A – Benefits

Here, you can find provisions on the scope of cover and a description of the benefits that we provide in an insured event.

1. Provisions governing the insured event and insurance cover

Content of this section:

1.1 When is an insured event deemed to have occurred?

(1) Insured event due to inability to work

a) Insured event

The insured event is a situation in which the →insured person undergoes medically necessary curative treatment due to illness or the consequences of an accident and during which the inability to work is ascertained by a doctor.

b) Inability to work covered by this policy

Inability to work within the meaning of these provisions shall be deemed given if the →insured person

- is temporarily unable to discharge any of their professional duties, and
- neither discharges their professional duties nor is otherwise employed.

c) Beginning and end of the insured event

The insured event starts at the time of curative treatment. It ends when the →insured person no longer requires treatment based on the medical findings. If, during the treatment, a new illness or consequence of an accident occurs and necessitates treatment, a new insured event shall be deemed given only if the newly ascertained inability to work has no causal link to the initial illness or consequence of an accident.

Should several illness or consequences of an accident result in the inability to work, the daily sickness allowance shall be paid only once.

(2) Insured event during statutory maternity protection periods

a) Insured event

The loss of earnings on the part of a female →insured person shall also be deemed an insured event during the following periods:

- und during the protection periods pursuant to §3 (1) and (2) of the law on the protection of working mothers (German Maternity Protection Act –MuSchG) and
- on the day of delivery

This is subject to the proviso that she is not working or working only to a limited extent during these periods.

b) Scope of our duty to indemnify

In an insured event in accordance with paragraph a), we pay the insured daily sickness allowance to the extent that the →insured person is not entitled to maternity allowance, parental allowance or any other adequate form of compensation during these periods.
We offset the claim to any other form of adequate compensation against the amount of the insured daily sickness allowance.

c) Relevant provisions governing the inability to work

When we refer to the insured event in connection with the inability to work in the terms and condition of insurance, they shall also apply correspondingly to the insured event during statutory maternity protection periods.

(3) Occurrence of both insured events

If the female →insured person is unable to work in an insured event during statutory maternity protection periods pursuant to paragraph 1 b), we pay the insured daily sickness allowance only once. This is due to the fact that, during the insured event in statutory maternity protection periods, the claim to indemnity shall apply only thereto.

When both insured events occur, the agreed →deferred benefit period has to expire only once.

1.2 What is the scope of cover based on?

The scope of cover is based on

- the insurance certificate,
- the →written agreements
- the terms and conditions of insurance for the Krankengeld Inbound rates (group insurance),
- the statutory provisions governing insurance law and
- other statutory provisions.

1.3 Which characteristics does the insured person have to meet for insurance under this rate and what happens if such a characteristic no longer applies (eligibility for insurance)?

The →insured person is eligible for insurance at this rate for as long as

- they have their habitual place of abode in Germany only on a temporary basis,
- they are in gainful employment and
- a fixed-term insurance covering costs of illness has been taken out for them with us under the rates InboundMed

If one of these characteristics no longer applies, the rate will expire for the insured person affected.

Gainful employment shall be deemed given if the insured person is in a fixed employment relationship from which they draw remuneration.

1.4 How significant is membership of the group of individuals eligible for insurance?

The →insured person must belong to the group of individuals eligible for insurance pursuant to the →group insurance policy. If this characteristic no longer applies, the rate shall end pursuant to Section C item 4.4. paragraph 8.

1.5 When does participation in the group insurance policy begin (inception of cover)?

Participation in the →group insurance policy shall commence, for the Krankentagegeld Inbound rates, at the point in time agreed for this rate (inception of cover). The inception of cover cannot be before the start date of the group insurance policy.

1.6 In which countries is insurance cover provided?

(1) Insurance cover in Germany

Insurance cover is provided in Germany.

(2) Insurance cover for temporary stays abroad

If the →insured person is abroad on a temporary basis, the daily sickness allowance shall be paid within the contractual scope

- for the duration of an in-patient curative treatment deemed medically necessary in a state-run hospital,
- for the duration of an in-patient curative treatment deemed medically necessary in a private hospital.

We shall also provide the benefits within the scope of the rate for illnesses (including chronic illnesses) or consequences of an accident that were pre-existing at the start of the stay abroad. This also applies if the insured person's state of health deteriorates considerably while they are abroad, or the insured person travels abroad for the purpose of receiving treatment.

2. Prerequisites for indemnification and scope of benefits

Content of this section:

2.1 What are the prerequisites for the payment of the daily sickness allowance in the event of the inability to work?

We pay the daily sickness allowance only if the →insured person is treated by a licensed and registered doctor or dentist, at medical care centre or in a hospital for the duration of the inability to work.

2.2 Which service providers can the insured person choose from?

The →insured person is free to choose from any of the following service providers.

(1) Selection of doctor or dentist

The →insured person is free to choose a licensed doctor or dentist, irrespective of whether they are community-based or working in a medical care centre.

(2) Selection of hospital

If in-patient curative treatment is deemed medically necessary, the →insured person is free to choose from all state-run and private hospitals which

- have their own permanent medical management,
- have sufficient diagnostic and therapeutic facilities of their own and
- keep medical records.

2.3 Which deferred benefit period has been agreed upon?

Depending on the insured rate, the following →deferred benefit period has been agreed upon:

- KTI07W - 6 weeks
- KTI14W - 13 weeks
- KTI27W - 26 weeks

The deferred benefit period selected may not be shorter that the period of continued salary payment by the employer.

2.4 Which benefits are included under this rate?

In an insured event, we pay

- for every day in the event of the inability to work or loss of earnings during the statutory maternity protection periods
- following the expiry of the →deferred benefit period agreed (item 2.3)
- the insured daily sickness allowance without a maximum benefit period (including Sundays and public holidays).

Our indemnification begins when the claim to continued salary payment by the employer ceases, however, not prior to the expiry of the deferred benefit period agreed upon.

If the →insured person is unable to work again within 6 months following the previous inability to work due to the same illness of consequence of an accident, we shall credit the periods of the previous inability to work due to the same illness or consequence of an accident which have been proven in the 12 months preceding the commencement of the new inability to work to the deferred benefit period.

2.5 What applies in the event of reintegration into working life (benefits in the event of a partial inability to work)?

(1) Insured benefits

We pay the insured daily sickness allowance up to the amount of the actual net income if the →insured person undergoes gradual reintegration into working life directly after their inability to work, and they thus partially discharge their professional duties (partial inability to work).

(2) Offsetting other payments

We shall offset

- payments rendered by the employer in order to compensate for the loss of earnings,
- an interim allowance that is paid by a state rehabilitation provider or a professional pension fund, and
- an interim allowance that is paid by a workers‘ compensation board against our payment of the insured daily sickness allowance.

This offsetting shall, however, only take place to the extent that, due to the payment rendered by the employer, the state rehabilitation provider or the workers’ compensation board as well as due to other daily sickness allowances, the net income that the →insured person draws from their employment as calculated per calendar day is exceeded.

(3) Maximum benefit period

We pay the daily sickness allowance pursuant to paragraphs 1 and 2 for a maximum period of 3 months, however, for no longer than until the end of the partial inability to work.

3. Due dates and processing of our benefits, as well as the right to disclosure

Content of this section:

3.1 When do our benefits fall due?

(1) Due dates of our benefits

We provide our benefits after we have completed the investigations involved in determining the insured event and the scope of our duty to indemnify. This requires us to be provided with the required evidence in this regard (see item 3.2). This evidence becomes our property.

(2) Your claim to interim payments for monetary benefits

If we have not completed our investigations within one month of the notification of the insured event, you can request interim payments corresponding to the minimum amount we are likely to have to pay. If, however, you are to blame for the fact that our investigations are delayed, the one-month deadline shall be postponed accordingly.

3.2 What evidence is required with regard to full and partial inability to work?

(1) Full inability to work
You have to provide us with evidence of the occurrence of the inability to work without delay, no later than on the day on which the benefits commence as agreed upon under this rate.

In the event of a continuing inability to work, you have to provide us with evidence thereof every 2 weeks.

Failure to adhere to these deadlines shall result in legal consequences pursuant to Section B item 2.3.

Evidence of the occurrence and duration of the inability to work shall be provided via attestation by the attending doctor or dentist using the form provided by us for this purpose. Any costs incurred hereby shall be borne by you.

Any attestation issued by spouses, registered life partners, parents or children shall not suffice as evidence of the inability to work.

(2) Partial inability to work
In order to ascertain our duty to indemnify and the scope thereof, we shall be entitled to request the submission of the following evidence:

- The reintegration plan completed by the attending doctor, to which the →insured person and their employer have expressed their agreement.
- The approval of the benefits issued by the statutory rehabilitation provider or the professional pension fund (both the initial and subsequent notices).
- The approval of the benefits issued by the workers' compensation board (both the initial and subsequent notices).
- Evidentiary documents with regard to the amount of the payments rendered by the employer.

3.3 To whom can we provide the benefits?

We provide benefits to you or to the person who furnishes the required evidence. If we have justified doubts as to the identity of the person furnishing the evidence, we shall only provide benefits to you.

3.4 What provisions apply to bank transfer and translation costs?

The bank transfer of the insurance benefits is free of charge for you if you provide us with a domestic bank account. The costs associated with bank transfers into foreign accounts and the translation of evidentiary documents may be deducted from the benefits.

3.5 What is the right to disclosure in respect of expert opinions and statements and who has to pay for these documents?

(1) Right to information and inspection (disclosure)
We disclose expert opinions and statements (documents). Disclosure is effected by way of information provided to, and inspection by, the eligible individual (in this respect, see paragraph 2).

Disclosure requires us to have obtained the document because we are assessing our duty to indemnify, the existence of an inability to work or of an occupational incapacity.

(2) Eligible individuals
Disclosure can only be requested by the individual to whom the document relates (affected individual). This individual's statutory representative can also request disclosure in their place.
Subject to this proviso, we disclose the document to the following individuals:

- the →insured person or their statutory representative. This does not apply if there are material treatment-related or other material reasons running contrary to such disclosure.
- a doctor or lawyer whose name has been provided to us.

(3) Assumption of costs by us
If we obtain the document ourselves, we shall bear the costs. If you have obtained the expert opinion or the statement because we asked you to do so, we shall reimburse you for the expenses incurred in this regard.

4. Exclusions and restrictions

Content of this section:

4.1 In which cases is our duty to indemnify fully excluded?

We do not provide benefits in the event of an inability to work
a) due to illnesses, the consequences of illnesses or the consequences of accidents caused by events of war.

We do, however, pay out benefits in the event that the →insured person is caught off guard by the occurrence of the war event outside of Germany and is prevented from leaving the affected area for reasons for which they are not responsible. For example, such reason exists if they cannot leave the area without threat to life or physical condition.

The war event is deemed to have caught the individual off guard if, for example, the German Foreign Office has not issued any travel warning due to (imminent) war for the destination and period of travel. If this sort of warning is only published during the trip, the war event is deemed to have caught the individual off guard up until then.

Terrorist attacks do not constitute war events pursuant to sentence 1.

b) for illnesses, consequences of illnesses or consequences of accidents recognised as injuries sustained while on military service.
c) for illnesses and accidents caused by the →insured persons themselves with willful intent, including their consequences.
d) for stays in health resorts or sanatoriums.

4.2 In which cases is our duty to indemnify excluded only for the duration of the statutory prohibition of work?

We do not provide benefits for the inability to work during a period during which a prohibition of work applies in accordance with the German Maternity Protection Act (MuSchG).

We do, nonetheless, provide benefits during the statutory maternity protection periods for the protection periods pursuant to § 3 (1) and (2) of the German Maternity Protection Act (MuSchG) and on the day of delivery.

4.3 In which cases is our duty to indemnify restricted?

(1) Absence from habitual place of abode

a) Leaving the habitual place of abode during inability to work
We do not provide benefits for inability to work if the insured person does not remain at their usual place of residence.

We do, however, provide benefits in the following cases:

aa) Hospital treatment
The insured person who is unable to work undergoes in-patient treatment deemed medically necessary and the prerequisites for indemnification pursuant to item 2.2 paragraph 2 are satisfied.

bb) Following our prior written commitment
We shall provide benefits to the extent that we have issued a →written commitment pertaining to the payment of the insured daily sickness allowance prior to the change of location. We issue this prior commitment if

- the →insured person has a legitimate interest in the change of location
- the change of location does not impair the restoration of their ability to work or recovery
- we have been informed of the address and telephone number at which the insured person may be reached at the other location

b) Occurrence of the inability to work while the insured person is not at their habitual place of abode.

aa) Return ruled out by medical diagnosis
If the →insured person becomes unable to work outside of their habitual place of abode, they shall be entitled to the daily sickness allowance to the extent that the sickness or consequence of an accident prevents the insured person from returning to their habitual place of abode.

bb) Following our prior written commitment
If the →insured person becomes unable to work outside of their habitual place of abode and changes their location during the course of said inability to work, which is also not their habitual place of abode, we shall provide benefits to the extent that we have issued a →written commitment pertaining to such payment prior to the change in location.

We issue this prior commitment if
- the insured person has a legitimate interest in the change of location
- the change of location does not impair the restoration of their ability to work or recovery
- we have been informed of the address and telephone number at which the insured person may be reached at the other location.

(2) Rehabilitation measures
We do not provide benefits for inability to work during rehabilitation measures of the rehabilitation provider or of the professional pension fund.

We do however, provide benefits if the →insured person commences, on medical grounds, a rehabilitation measure of a statutory rehabilitation provider or professional pension fund during a period of inability to work which lasts at least 14 consecutive days.

We offset payments rendered by the rehabilitation provider or the professional pension fund for the purpose of compensating for a loss of earnings (compensation payment) against the payment of the insured daily sickness allowance. This offsetting shall, however, be carried out only to the extent that the compensation payment as well as other daily sickness allowances exceeds the net income within the contractual meaning that the insured person draws as calculated per calendar day.

(3) Withdrawal measures and withdrawal programmes

a) Requirement of commitment
As a general rule, we do not provide indemnity for withdrawal measures, including withdrawal programs. We shall, however, provide indemnity for withdrawal measures if we have issued a →written commitment for our benefits prior to the start of treatment.

We shall issue a commitment if the following requirements are met and we are obliged to provide indemnity in line with the other contractual provisions:

- Withdrawal measure
  The measure involves in-patient or out-patient treatment aimed at curing the →insured person from addiction to drugs, alcohol or other addictive substances (withdrawal measure). The withdrawal treatment is not, however, being performed exclusively as a result of the insured person's addiction to nicotine.

- Sufficient chances of success
  The withdrawal measures have sufficient chances of success - where appropriate based on an expert opinion drawn up by a doctor commissioned by us.

- No more than a total of 3 withdrawal measures during the policy term.
  We have provided the reimbursement of expenses for no more than 2 withdrawal measures for the insured person during the entire period of insurance with us. This means that we will offer insurance cover for no more than a total of 3 withdrawal measures. This applies irrespective of whether the withdrawal measures are conducted on an out-patient or on an in-patient basis.

b) Scope of our duty to indemnify
There shall be no duty to indemnify for withdrawal measures insofar as these are to treat the →insured person's addiction to nicotine. If the insured person is addicted to nicotine and also to another addictive substance, this means that we shall only provide indemnity for the measures relating to withdrawal from the other substance.

aa) Benefits for withdrawal measures
To the extent that we have issued a prior →written commitment to provided benefits, we shall pay the insured daily sickness allowance pursuant to item 2.4 within the contractual scope as follows:
- 100 percent of the insured daily sickness allowance for the first withdrawal measure.
- 70 percent of the insured daily sickness allowance for the second and third withdrawal measures.

bb) Offsetting of compensation payments by other benefit providers
If, however, other benefit providers (for example statutory rehabilitation providers or a professional pension fund) render payments as compensation for a loss of earnings on the part of the →insured person (compensation payment), we shall offset this compensation payment against the payment of our daily sickness allowance.

Section B – Your obligations

Here, you can find provisions on the duties and rules of conduct (obligations) associated with the insurance and the consequences if these are breached.

1. Duties in connection with premium payment

Content of this section:

1.1 Where can I find the premium to be paid?

The monthly premium that is to be paid is set out in the valid insurance certificate.

1.2 How is the premium calculated?

The premiums are calculated based on the provisions set out in the German Insurance Supervision Act (VAG) and the principles set out in our →technical basis of calculation.

1.3 Will ageing provisions be formed?

The premiums for the Krankentagegeld Inbound rates (group insurance) do not include any shares for the formation of →ageing provisions.

1.4 What does the Policyholder have to bear in mind as far as premium payments are concerned?

(1) Payment period
The premiums for the policy must be paid as ongoing monthly premiums.

(2) Due date for insurance premiums

a) Initial premium
The initial premium must be paid without delay once the policy has been taken out. If the →Policyholder has agreed with us that the insurance cover shall not commence until a later date, the initial premium shall not fall due until this date.

b) Subsequent premiums
Unless otherwise agreed, subsequent premiums are due for payment on the first of each month.

(3) Timeliness of payment

Premium payments are deemed to have been made in a timely manner if the →Policyholder immediately takes all of the measures required to make sure that we receive the amount on the due date. If it has been agreed that the premium is to be collected from an account (direct debit), the premium payment is deemed to have been made in a timely manner if

- we can collect the premium on the due date and
- the account holder does not object to an authorized debit.

If we cannot collect a premium that is due for payment and if this is not the Policyholder's fault, the payment is deemed to have been made in a timely manner if it is made immediately after we have issued the Policyholder with a payment request in written or electronic form (e.g. by letter, fax, e-mail).

(4) Special obligation for payment by direct debit
If it has been agreed that the premium is to be debited from an account (direct debit), we must have been issued with a SEPA direct debit authorization. We can request that this authorization be issued in written or electronic form (e.g. by letter, fax, e-mail).

(5) Transfer risk
The premiums shall be transferred at the →Policyholder's own risk and expense.

(6) Calculation of the daily premium
If we are only entitled to the premium on a pro rata basis, then the daily premium shall correspond to 1/30 of the monthly premium to be paid in each case. When calculating the daily premium, the amounts are rounded up to full cents.

2. Obligations

Content of this section:

2.1 Under what circumstances is our consent required if another insurance is taken out or increased for the insured person?

Our consent is required if

- another insurance with claims to daily sickness allowance is taken out, or
- if another insurance already in place with claims to daily sickness allowance is increased.

2.2 Which further obligations must be observed after the occurrence of an insured event?

In addition to the obligations set forth in Section A item 3.2. paragraph 1, the following further →obligations have to be observed following the occurrence of an insured event:

(1) Provision of information
You are obliged to provide us, on request, with any information that is required in order to determine

- whether an insured event has occurred or
- whether or not, and to what extent, we have a duty to indemnify.

This duty shall also apply vis-à-vis persons whom we have commissioned to obtain such information.

(2) Medical examination
The →insured person is obliged to undergo an examination by a physician commissioned by us at our request.

(3) Restoration of the ability to work
The →insured person is obliged to ensure that their ability to work is restored. In particular, they shall following instructions issued by the doctor diligently and refrain from any actions that may impair their recovery.

(4) Obligation to provide proof of the restored ability to work
You have to inform us accordingly within 3 days when the →insured person is able to work once again.

2.3 What are the legal consequences of breaches of obligation?

(1) Negative impact on our duty to indemnify
If you breach an →obligation, this may result in us being released from our duty to indemnify in full or in part. In detail, the following applies:
- If you breach the obligation with willful intent, we have no duty to indemnify.
- If you breach the obligation in a grossly negligent manner, we are entitled to reduce our insurance benefits. The reduction is based on the severity of your fault. It may result in the total loss of the claim. The payment shall not be reduced if you furnish proof that you did not act with gross negligence.

Even in the event of willful intent or gross negligence, we are still obliged to indemnify if you furnish proof that the act in breach of obligation
- was not the cause of the occurrence or the determination of the insured event
- or the cause of the ascertainment or the scope of our duty to indemnify.

This does not apply if you fraudulently breached the obligation.

(2) Our right of termination
If you breach any of the →obligations under this contract which you have to fulfill prior to the occurrence of the insured event, we shall, in addition to the rights set forth in paragraph 1, be entitled to terminate the contract without notice. We shall be entitled to issue said termination only within one month of gaining knowledge of the breach.

The termination shall be excluded if you are able to demonstrate that the breach of obligation was committed neither intentionally nor in gross negligence.

2.4 How is the knowledge and conduct of the individual included in the scope of cover imputed to you?

The knowledge and the conduct of the →insured person shall be considered tantamount to your knowledge and conduct. As a result, the →obligations have to be met not only by you, but also by the insured person.

3. Duties to provide information

What duty to provide information applies if the duration of the insured person’s continued salary payment changes?

The →deferred benefit period may not be shorter than the duration of the continued salary payment by the employer. The →Policyholder shall inform us without delay if the duration of the →insured person’s continued salary payment changes.

Section C – General provisions

This section sets out the regulations governing the inception of cover. You and the Policyholder can also find the provisions governing the adjustment of the premium and the terms and conditions of insurance, as well as general provisions on the execution of the insurance policy here.

1. Inception of cover

1.1 When does insurance cover commence?

(1) Basic principle
The insurance cover shall commence on the agreed date, provided that the →Policyholder pays the initial premium in good time within the meaning of Section B item 1.4 paragraph 2 a).

(2) Insured events before the inception of cover
We shall also provide benefits for insured events that occurred before the inception of cover. However, this only applies to the part of the insured event that lies after the inception of cover.
However, we shall not provide benefits for insured events that have been excluded from the insurance cover due to default in payment on the initial premium.

(3) Extension of insurance cover
If the scope of insurance cover is extended at a later date, paragraphs 1 and 2 shall also apply to this extension of insurance cover

1.2 Do waiting periods apply?

No waiting periods apply.

2. Adjustment of premium and terms and conditions of insurance

2.1 Subject to what conditions can we adjust the premium?

(1) Requirements
If the insurance benefits change, we will adjust the premium during the policy term. The requirements set out in § 203 (2) of the German Insurance Contract Act (VVG) must be met in respect of the adjustment.
In order for the adjustment to be made, a comparison of the required and calculated insurance benefits for the observation unit in question must show a deviation of more than 10 percent.

(2) Entry into force of a premium adjustment
We will inform the Policyholder in written or electronic form (e.g. by letter, fax, e-mail) of

- the adjustment of the premium, and
- the grounds for the adjustment.

The adjustment shall become effective at the start of the second month after this information is provided.

(3) Policyholder's right to termination
If we increase the premium pursuant to paragraph 1, then →Policyholder has a right to termination subject to the prerequisites set out in item 3.1 paragraphs 1 and 4.

2.2 Subject to what conditions are we entitled to amend the terms and conditions of insurance?

(1) Adjustment with the consent of the trustee

The terms and conditions of insurance can be adjusted with the consent of an independent →trustee pursuant to § 203 (3) of the German Insurance Contract Act (VVG).

(2) Replacement of the terms and conditions of insurance
The terms and conditions of insurance can be replaced by new provisions pursuant to § 203 (4) in conjunction with § 164 of the German Insurance Contract Act (VVG).

(3) Effectiveness of the amendments
We will inform the →Policyholder of any amendments pursuant to paragraph 1 in written or electronic form (e.g. by letter, fax, e-mail). The adjustment shall become effective at the start of the second month after we provide this information.
We will inform the Policyholder of any replacement pursuant to paragraph 2 in written or electronic form (e.g. by letter, fax, e- mail). The replacement shall become effective 2 weeks after we provide this information.

(4) Policyholder's right to termination
If we reduce our benefits pursuant to paragraph 1, the →Policyholder has a right to termination subject to the prerequisites set forth in item 4.1. paragraphs 1 and 4.

3. Amount and adjustment of the insured daily sickness allowance

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Content of this section:

3.1 How much is the maximum daily sickness allowance (maximum daily sickness allowance benefit)?

(1) Principle
The daily sickness allowance may, together with other daily sickness allowances, not exceed the net income within the contractual meaning, which the →insured person draws as calculated per calendar day.

(2) Daily sickness allowance during periods of statutory maternity protection
The daily sickness allowance under the benefits provided by us during periods of statutory maternity protection may, together with the maternity allowance, parental allowance and any other adequate form of compensation, not exceed the net income within the contractual meaning, which the →insured person draws as calculated per calendar day.

(3) Daily sickness allowance during parental leave
The daily sickness allowance may, together with other forms of daily sickness allowance, not exceed the net income during parental leave within the contractual meaning and as calculated on per calendar day.

3.2 How is the net income within the contractual meaning calculated?

(1) Net income within the contractual meaning
Net income within the contractual meaning refers to the net income drawn by the →insured person from employment. In addition, contributions towards their statutory pension or their professional pension fund may be taken into account when calculating the net income within the contractual meaning, but only up to the proportional amount that the insured person's employer assumes in each case. In this case, the net income within the contractual meaning refers to the insured person's net income as drawn from

their employment plus the employer's contribution shares pursuant to sentence 2, which are taken into account.

(2) Relevant period for the calculation of the net income within the contractual meaning
The average net income within the contractual meaning drawn over the previous 12 months prior to occurrence of the inability to work shall be used as the basis for the calculation of the net income within the contractual meaning (average 12-month earnings). With regard to our benefits, the average 12-month earnings during periods of statutory maternity protection are calculated based on the average net income within the contractual meaning drawn during the previous 12 months prior to the commencement of the protection period pursuant to § 3 (3) of the German Maternity Protection Act (MuSchG).

This shall not apply if the payment of the daily sickness allowance is asserted for the →insured person, and we are able to demonstrate that the insured person
- had, based on provisions set forth in an employment contract, drawn a net income
- that is lower than the average 12-month earnings prior to the occurrence of the inability to work.

This shall also apply if the insured person had drawn in lower net income within the contractual meaning under the same conditions prior to the commencement of the protection period pursuant to § 3 (1) of the Germany Maternity Protection Act (MuSchG).

During parental leave, the net income within the contractual meaning shall be defined as follows:
- the →insured person's average monthly earnings employment as of the commencement of parental leave

3.3 How can the policy be amended if the insured person is on parental leave?

If the →insured person
- is on parental leave and
- continues to fulfil the requirements in order to be eligible for insurance (see Section A item 1.3),

we shall reduce the insured daily sickness allowance to the amount resulting from item 3.2 paragraph and item 3.2 paragraph 2, and lower the premium to the extent that this is necessitated by the reduction. The policy amendment shall take place as per the commencement of the parental leave.

3.4 When can an increase in the insured daily sickness allowance be applied for?

If the →insured person's net income within the contractual meaning as drawn from employment increases, the →Policyholder may submit an application to us for
- a corresponding percentage increase in the insured daily sickness allowance
- within 2 months following the increase in the net income within the contractual meaning
- with effect from the first of the month.

The 2-month time limit pursuant to sentence 1 shall be deemed adhered to only if we receive the application no later than 2 months following the increase to the insured person's net income.

The insurance cover shall increase with effect from the first of the month following the application. This shall, however, not apply to the insured person's inability to work which had already existed prior to the application for the increase. In this case, we shall pay the insured daily sickness allowance in the same amount within the contractual scope as long as the inability to work continues uninterrupted even after the respective increase.

4. End of the insurance policy and the insurance cover

Content of this section:

4.1 Subject to what conditions is the Policyholder entitled to terminate the policy or demand its rescission?

(1) General requirements
All notices of termination pursuant to paragraphs 2 through 4 and requests for rescission pursuant to sub-section 5 must be in writing (for example, by letter, fax or e-mail).
If the →Policyholder terminates the rate for individual →insured persons, the termination shall only be effective if the Policyholder proves that the insured persons in question are aware of the notice of termination. This shall apply accordingly if the Policyholder demands rescission pursuant to paragraph 5.

(2) Termination for convenience
The →Policyholder is entitled to terminate the rate with effect from the end of each insurance year, subject to a notice period of 3 months. The termination may be limited to individual →insured persons.

(3) Situation in which a compulsory health insurance requirement, an entitlement to family insurance or to medical assistance for civil servants arises
If the →insured person becomes subject to compulsory insurance under the statutory health insurance in system, the →Policyholder is entitled to terminate the rate within 3 months of the individual becoming subject to compulsory insurance with retroactive effect from the point in time at which the individual becomes subject to compulsory insurance.

The termination shall be ineffective if the Policyholder does not provide us with evidence of the compulsory insurance requirement within two months of us asking the Policyholder to do so in written or electronic form (e.g. letter, fax, e-mail). This shall not apply if the Policyholder is not to blame for this deadline being missed.

If the Policyholder exercises their right to termination, we are only entitled to the premium up until the time at which the compulsory insurance requirement arises. The calculation of the daily premium shall be based on Section B item 1.4 paragraph 6.

Later, the Policyholder can terminate the rate taken out for the insured person to the end of the month in which they provide us with evidence of the compulsory insurance requirement. In such cases, we shall be entitled to the premium until the termination of this rate.

The following are deemed equivalent to the compulsory insurance requirement:
- the statutory entitlement to family insurance or
- the entitlement - which must be of a not only temporary nature - to medical assistance for civil servants under an employment relationship under civil service law or a similar employment relationship.

(4) Increase in premium and reduction in our benefits
If we increase the premium pursuant to item 2.1, the →Policyholder is entitled to terminate the rate under this component that is affected by the increase for the →insured person in question at the time at

which the change comes into force. For this to happen, we must have received the notice of termination within 2 months of receipt of the amendment notice.
If we reduce our benefits pursuant to item 2.2 paragraph 1, the Policyholder is entitled to terminate the rate under this component that is affected by the reduction in benefits for the insured person in question at the time at which the change comes into force. For this to happen, we must have received the notice of termination within 2 months of receipt of the amendment notice.

(5) Right to rescission
If we only contest, withdraw from or terminate the policy in respect of individual →insured persons, the →Policyholder is entitled, within 2 weeks of receiving our notice to this effect, request the rescission of all of the insurance policies taken out with us with effect from the end of the month in which the Policyholder received our notice, and in the case of termination, at the time at which the termination becomes effective.

4.2 How is the insurance year determined?

The first insurance year shall begin on the agreed policy inception date. It shall end on December 31 of the calendar year in question. The subsequent insurance years shall correspond to the calendar year in question.

4.3 Subject to what conditions can we terminate the policy?

(1) **Right to termination for convenience**
We shall waive our right to termination for convenience

(2) **Right to extraordinary termination**
The statutory provisions governing the right to extraordinary termination shall remain unaffected. The termination can be limited to individual →insured persons, rates or to subsequent increases to the daily sickness allowance.

4.3 In which other cases does the insurance policy end?

(1) Maximum insurance period
The rate will end after the expiry of the maximum insurance period of 5 years. The maximum insurance period shall start on the agreed policy inception date agreed for the →insured person.

If, prior to this rate being taken out, the insured person already has a fixed-term health insurance policy that has been taken out with another insurer for the stay in Germany pursuant to § 195 (3) of the German Insurance Contract Act (VVG), the period of insurance under that policy shall count towards the maximum insurance period pursuant to sentence 1.

(2) In the event of occupational incapacity
The rate concluded for the →insured person shall end upon the occurrence of occupational incapacity.

Occupational incapacity shall be deemed given if the insured person has, based on medical diagnosis, lost more than 50% of their earnings capacity in the profession exercised thus far for an unforeseeable period of time.

(3) 67th birthday
The rate concluded for the →insured person shall end on the day on which they become 67 years old.

If the insured person continues to fulfil the requirements in order to be →eligible for insurance pursuant to Section A item 1.3. after their 67th birthday, the →Policyholder may request continued insurance cover for this person for a fixed term up to the maximum insurance period pursuant to §196 of the German Insurance Contract Act (VVG).

(4) Drawing old-age pension
The rate concluded for the →insured person shall end when they start drawing an old-age pension.

(5) Death
The rate shall end upon the lapse of the day on which the →insured person dies.

(6) Drawing statutory pension for reduced earnings capacity
The rate concluded for the →insured person shall end upon the lapse of the day on which they first draw a pension due to full reduction in earnings capacity pursuant to § 43 (2) of Book VI German Social Code (SGB VI).

(7) Termination of the group insurance policy
The rate shall end at the time of termination of the →group insurance policy

(8) Individual leaves the group of people eligible for insurance
The rate taken out for the →insured person shall end when the latter no longer belongs to the →group of individuals eligible for insurance pursuant under the group insurance policy.

4.5 When does the insurance cover end?

The insurance cover provided under the Krankentagegeld Inbound rates (group insurance) shall end for the →insured person - also for →pending insured events - at the time at which the rate ends.

For pending insured events, we provide the insured benefits for a further 4 weeks if the rate ends because the →group insurance policy has been terminated.

This is subject to the proviso that there are no claims to further insurance based on the terms and conditions of individual insurance.

5. German law

What law applies to the insurance policy?

German law applies to the insurance policy.

6. Means of complaint

Which means of complaint are available?

The following means of complaint are available to you:

(1) Lodging a complaint with us or your insurance intermediary

If you are not satisfied, please do contact us. You can find further information on this subject matter as well as contact details at: www.allianz.de/service/beschwerde/. You may also address any complaints to your insurance intermediary.

(2) Lodging a complaint with the Ombudsman for Private Health and Long-Term Care Insurance [*Private Kranken- und Pflegeversicherung*]

You may also initiate a complaints procedure with the Ombudsman for Private Health and Long-Term Care Insurance (address: P.O. Box 06 02 22,10052 Berlin, website: www.pkv- ombudsmann.de). We participate in the dispute resolution procedure before this arbitration board. The Policyholder and Insured may contact the Ombudsman with their complaints regarding their private health and long-term care insurance provider, or with complaints regarding the insurance intermediary in connection with the mediation of insurance policies. The Ombudsman responds to every complaint and, where appropriate, provides a resolution proposal.

Should you, as consumer, have concluded the insurance contract electronically (e.g. via a website or email), you may use the online dispute resolution platform set up by the European Commission (website: www.ec-europa.eu/consumers/odr/) to lodge your complaint. Your complaint will then be forwarded to the Ombudsman for Private Health and Long-Term Care Insurance.

(3) Lodging a complaint with the insurance supervisory authorities
As an insurance company, we are subject to supervision by the Federal Financial Supervisory Authority [*Bundesanstalt für Finanzdienst-leistungsaufsicht*] (BaFin), Graurheindorfer Str. 108, 53117 Bonn, email: poststelle@bafin.de, website: www.bafin.de. You can also contact them if you have a complaint.

(4) Legal action
The complaint notwithstanding, the option of taking legal action is open to you at all times.

7. Competent court

Where can the main insured person or we assert claims before a court of law?

(1) Competent court for your claims
You can assert claims under this insurance policy or insurance mediation before the court which has jurisdiction over our registered office or our branch responsible for managing your policy.

Alternatively, you can assert claims before the court in the district in which you have your place of residence or, in the absence of such place of residence, your habitual place of abode at the time the claim is asserted. If the →main insured person is a legal entity (e.g. a stock corporation act or a German limited liability company (GmbH) or a partnership that can be party to legal proceedings (e.g. a general commercial partnership (*offene Handelsgesellschaft*) or a limited partnership (*Kommanditgesellschaft*), the competent German court is determined by its registered office.

If further places of jurisdiction exist by law and cannot be excluded by way of an agreement, you may also bring legal action at such places.

(2) Competent court for our claims
We can assert claims under the insurance policy before the court in the district in which you have your place of residence or, in the absence of such place of residence, your habitual place of abode at the time the claim is asserted. If the →main insured person is a legal entity (e.g. a stock corporation act or a German limited liability company (GmbH) or a partnership that can be party to legal proceedings (e.g. a general commercial partnership (*offene Handelsgesellschaft*) or a limited partnership (*Kornmanditgesell-schaft*), the competent German court is determined by its registered office.

If, at the time the action is brought, neither your place of residence nor your habitual place of abode is known, we can bring action before the court that is responsible for our registered office or branch responsible for managing the insurance policy. This shall apply accordingly if the main insured person is a legal entity or a partnership that can be party to legal proceedings and its registered office is unknown.

(3) Main insured persons outside of the European Community, Iceland, Norway or Switzerland

If you move your place of residence to a country outside of the European Communities, Iceland, Norway or Switzerland, both you and we can only assert claims under this insurance policy or insurance mediation before the court which has jurisdiction over our registered office.

(4) Damaging event abroad
If upon conclusion of the policy, you have your place of residence, habitual place of abode or registered office in Germany and an insured damaging event occurs abroad, legal action in this connection can only be brought before a German court.

If, at the time the action is brought, you have your place of residence, habitual place of abode or registered office in Germany, the competent German courts are those set out in paragraphs 1 and 2.

If, at the time the action is brought, you do not have your place of residence, habitual place of abode or registered office in Germany, action can be brought before the court that has jurisdiction over our registered office.

If further places of jurisdiction in Germany exist by law and cannot be excluded by way of an agreement, you may also bring legal action at such places.

8. Limitation

What limitation period applies by law to claims under the policy?

(1) Limitation period and applicable statutory provisions
Claims arising from the insurance policy are subject to a limitation period of 3 years pursuant to § 195 of the German Civil Code (*Bürgerliches Gesetzbuch — BGB*). Details on the commencement, duration and suspension of the limitation period are based on §§ 195 through 213 of the German Civil Code.

(2) Suspension of the statute of limitations during our assessment of our obligation to perform
If a claim arising from the policy has been reported to us, the limitation period is suspended until you or the claimant have/has received our decision in written or electronic form (e.g. by letter, fax, e-mail).

9. Offsetting

What provisions apply to offsetting vis-à-vis us?

Only undisputed counterclaims that have been established with res judicata effect can be offset against our claims.

10. Transfer of contractual claims to third parties

Can claims to insurance benefits be transferred to third parties?

(1) Exemption from attachment for claims to payment
Claims to pecuniary insurance benefits are, in accordance with the statutory regulations, exempt from attachment.

(2) Obligation to notify us of an assignment
Should claims to insurance benefits be assigned to third parties, you shall notify us thereof without delay

It shall suffice if the assignee presents us with the deed of assignment. The assignee is the person who has received the claim to insurance benefits via the assignment. As a rule, we do not require the original copy of the deed of assignment. In principle, a copy, duplicate, scan or photo of the deed shall suffice.

Insofar as we have not been notified of the assignment in one of these two alternatives, we are not obliged to render benefits to the assignee. In this case, we can continue to satisfy the claim by rendering said benefits to you.

These requirements and legal consequences are based on the law. You have no influence on the legal admissibility or effectiveness of the assignment of claims to insurance benefits to third parties.

Explanation of specialist terms

Here, we provide you with explanations of specialist terms used in the terms and conditions of insurance for the Krankentagegeld Inbound rates (group insurance.

Ageing provision
The premiums for this rate do not contain any shares to set up ageing provisions. For other health insurance policies, however, this requirement applies by law. For these insurance policies, the premiums in the first few years are higher than the current risk premium (savings phase). To the extent that an ageing provision has been set up in the savings phase, the missing amount in subsequent years in which the premium is lower than the required risk premium will be taken from these ageing provisions (payout phase). Premium increases due to the insured person growing older are excluded to this extent.

Group insurance policy
A policy we have taken out with a company or organization (e.g. association, club, society). The group insurance policy sets out, among other things, who can be insured (e.g. a company's employees) and the special policy content, in particular which special conditions apply or based on which conditions additional individuals (e.g. relatives) can be insured.

Main insured person
The person who has a direct entitlement to the insurance benefit under the group insurance policy (e.g. an employee of our Policyholder). This is why the terms and conditions of insurance are aimed at the main insured person under the group insurance policy. The Policyholder also has to observe the terms and conditions of insurance.

Deferred benefit period
The deferred benefit period refers to the period between the time when the inability to work is first ascertained by a doctor and the commencement of benefits as provided for under the respective rate. There shall be no claim to benefits during the deferred benefit period.

Obligation
This is a conduct-related duty incumbent upon the insured person that is contractually agreed. Any breach of this duty has unfavorable consequences that are based on § 28 of the German Insurance Contract Act (VVG) and are described in the terms and conditions of insurance.

In writing
The declaration must be provided in a document or another form suitable for permanent reproduction in written characters. This includes, for example, letter, fax or e-mail. The person making the declaration must be made and the end of the declaration must be marked as such.

Pending insured event
A pending insured event describes an insured event that has occurred but has not yet ended.

Technical basis of calculation
An umbrella term for all documents and data that we use to calculate premiums.

Trustee
The use of a trustee is required by law. Trustees are particularly important when policy amendments have to be made (such as adjustments to terms and conditions of insurance or premiums). Only individuals with suitable professional qualifications who are independent of the insurance company can be appointed as trustees. The supervisory authorities are provided with the name of the trustee.

Insured person
The person directly covered by the insurance cover afforded under the insurance policy as agreed. This person is named in the insurance certificate.

Eligibility for insurance
A characteristic that is specific to a certain individual as set out in Section A. This characteristic must be exhibited by the insured person during the term of the insurance. If it no longer applies, the insured person can no longer remain insured in the rate.

Policyholder
Our partner for the group insurance policy. The Policyholder is the company or organization (e.g. association, club, society) with which we have concluded the group insurance policy. Although the terms and conditions of insurance are aimed at the main insured person under the group insurance policy, as this is the person entitled to the insurance benefits, the Policyholder, as our contractual partner, also has to observe the terms and conditions of insurance.