

FUNDAMENTAL PRINCIPLES OF HEALTH INSURANCE CONTRACTS

General Insurance Conditions for Policies Covering Costs of
Illness/Disease and Daily Hospital Allowance (AVBKV 2004)

April 2007

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General Insurance Conditions for Policies Covering Costs of Illness/Disease and Daily Hospital Allowances (AVBKV 2004)

THE INSURANCE COVER

§1

Subject and Scope of the Insurance Cover

- (1) In the case of an event insured, the insured has the right to claim insurance protection within the scope of the rates elected.
- (2) a) An insured event is the medically necessary curative treatment of the insured for a disease (illness) or for consequences of an accident. The insured event commences with the curative treatment and ends when, according to medical evidence, curative treatment is no longer necessary. If the curative treatment must be extended to a disease or consequences of an accident, which are not in causal relationship with the one/those previously treated, then a new insured event ensues in this respect.
b) The following are also considered insured events:
 - deliveries, including the medical examinations required on account of the pregnancy as well as any medically essential curative treatment related to it;
 - other insured events listed in the table of rates.
c) The following are not considered insured events:
 - cosmetic treatment and operations and the consequences thereof, unless such measures serve to correct consequences of accidents; and sex transformation;
 - dental implantations and their consequences, unless they are the consequence of an accident, as well as any preparatory measures that are in causal relationship with them;
 - home nursing not carried out by a physician, as well as measures of geriatrics, rehabilitation and remedial pedagogy;
 - any form of artificial fertilisation (e.g., in vitro fertilisation, insemination);
 - other events listed in the table of rates or in the policy.
- (3) The term 'curative treatment' denotes a medical treatment considered suitable, according to the generally accepted standard of medical science, to recover a person's health, improve his/her condition or prevent its deterioration.
- (4) The term 'disease' or 'illness' denotes, according to the generally accepted standard of medical science, an abnormal physical or mental condition.
- (5) The term 'accident' denotes any event from external sources suddenly acting on the insured person's body (accidental event), through which the insured involuntarily suffers damage to his/her health.
- (6) Insurance cover is restricted to persons in good health having their permanent residence in Austria. Other persons may be insured on special terms.
- (7) Insurance cover extends to insured events throughout the world, unless the territorial scope is defined differently in the table of rates.

§2

Conclusion of the Insurance Contract

- (1) The policy holder may only be a person having his/her permanent residence in Austria.
- (2) The applicant is bound to his/her application for a period of six weeks. This period commences with the date of application or on the date on which the application was mailed.
- (3) The acceptance of the application may also be made dependent on a medical examination or the production of a medical attestation.
- (4) The management of the insurance company decides on the acceptance of the application. Applications may be rejected without any reasons being stated. The applicant must be informed of the decision in writing. The insurance contract is deemed to have been concluded when the policy has been served (handed over), or upon a written declaration of acceptance.
- (5) In the case of new-born children, who are not entitled to benefits from a social health insurance institution and where such entitlement cannot be substantiated, the insurer of the cost-of-illness cover

waives the right of refusal (paragraph (4)) and the exclusion of benefits pursuant to § 6, paragraphs (1) and (2), provided that

- the policy holder (a parent) is himself/herself insured at a rate which corresponds to the insurance cover requested for the child;
- the child's coinsurance must be applied for within two months after his/her birth with effect from the first day of the month of his/her birth;
- in the event of a substandard risk (physical or mental handicap) a reasonable additional premium (risk premium) is paid.

- (6) In the case of new-born children who are entitled to benefits from a social health insurance institution, the insurer of the cost-of-illness cover waives the right of refusal (paragraph (4)), provided that
- the policy holder (a parent) is himself/herself insured at a rate which corresponds to the insurance cover requested for the child;
 - the child's coinsurance must be applied for within two months after his/her birth with effect from the first day of the month of his/her birth;
 - if there are other children, all the children under the age of 18 living in the common household must already have been coinsured subsequent to the parents' insurance.

§ 3

Commencement of the Insurance Cover

Insurance cover commences upon conclusion of the insurance contract, but not before payment of the first premium, not before expiry of the waiting periods, and not before the time and date designated in the policy (commencement of the insurance). If the policy is handed over after that time and date and the premium is paid thereafter within a period of 14 days, insurance protection, except for the provisions regarding the waiting periods, will commence at the time and date named in the policy. From that time and date (original commencement of the insurance) the insurance year will subsequently be counted as well.

§ 4

Waiting Periods

- (1) The waiting periods (qualifying periods) are counted from the commencement date of the policy or, in the event of an increase or extension of the insurance cover, from the date of such alteration.

- (2) The general waiting period is three months.

There will be no waiting period:

- a) in the case of accidents.
Hernias of the upper or lower abdomen, which were caused or worsened as a result of an accident, are not considered consequences of an accident.
- b) in the case of the following acute infectious diseases:
rubella, measles, chicken-pox (varicella), scarlet fever, diphtheria, whooping cough, mumps, spinal poliomyelitis, meningitis, dysentery, paratyphoid fever, epidemic typhus (spotted fever), typhoid fever, relapsing fever, malaria, anthrax, erysipeloid disease, yellow fever, plague, tularaemia, psittacosis.
- c) in the case of coinsurance of new-born children for benefits to the extent of the existing insurance,
 - if such coinsurance has been applied for within two months after the date of birth, with effect from the first day of the respective month of his/her birth
- d) in the case of coinsurance of spouses for benefits to the extent of the existing insurance,
 - if the insurance has been in force for at least three months, and
 - if such coinsurance has been applied for within one month from the date of marriage, with effect from the first day of the month of marriage.

- (3) Special waiting periods

- a) The provisions for the general waiting period apply, unless special waiting periods have been provided for in the rate tables or in the policy.
- b) Deliveries, including the examinations required on account of pregnancies, as well as the medically necessary curative treatment related to the pregnancy (§ 1, paragraph (2)b) are covered after a waiting period of nine months has expired.
There will be no waiting period, if the policy holder furnishes provable evidence that the pregnancy started after the commencement date of the insurance.

An attestation that the date of birth computed by the physician will be nine months after the commencement date of the insurance, will be accepted as proof.

- (4) If evidence can be produced that a cost-of-illness insurance has been taken out within one month immediately subsequent to the termination of a compulsory insurance, the period of such insurance will be credited to the general waiting period; this applies by analogy also to persons previously entitled to benefits from a social health insurance institution. For the curative treatment of inpatients, however, insurance protection within the general waiting period will be granted only up to the maximum extent of the benefits due from the compulsory insurance. The preconditions permitting the compulsory insurance to be credited must be proven to the insurer by suitable documentary evidence.

§ 5

Type and Scope of the Insurance Cover

- (1) The type and scope of insurance protection evince from the table of rates, the supplementary insurance conditions, and the policy. If these provide for benefits for outpatient and/or inpatient curative treatment, the following provisions will apply.

A) Benefits for Outpatient Curative Treatment

- (2) The insured may choose freely among the established physicians and dentists licensed to practise the medical profession independently. If necessary from the medical point of view, the cost of consulting several physicians during one insured event will also be refunded.
- (3) Travelling expenses incurred by the insured when travelling to a physician and from him/her back home will not be reimbursed.
- (4) In the case of treatment by spouses, parents or children of the insured only the proven material costs will be reimbursed.
- (5) Costs of special examinations (e.g., laboratory tests, X-ray diagnoses, ultrasonic examinations) and the costs of medically prescribed special curative treatments (e.g., physical curative treatment, medicinal baths) will be reimbursed, if they had been carried out by a physician or by a person entitled to perform such services on a professional basis. Any additional costs for consulting hours or home visits will not be refunded in this connection.
- (6) The costs of medically prescribed remedial devices (adjuvants) will be reimbursed. Such devices include, i.a., spectacles, contact lenses, hernial trusses, artificial limbs, hearing aids, orthopaedic corsets, orthopaedic arch supports and the orthopaedic fitting of shoes, bandages and abdominal corsets, but they do not include, i.a., irrigators, inhalers, milk pumps, oral douches, ice bags, electric pads clinical thermometers, as well as any other apparatuses and devices for personal hygiene and nursing. Once the insurer has refunded the costs of remedial devices, a further claim for benefits will exist only after the usual service life has expired, unless a new acquisition becomes necessary at an earlier stage for medical reasons.

B) Benefits for Inpatient Curative Treatment

- (7) The term 'curative inpatient treatment' as used in these insurance terms denotes curative treatment within the framework of a medically necessary stay of a patient in hospitals, or departments of hospitals, which are approved by the sanitary authorities, provided that such hospitals or departments provide for the permanent presence of physicians, are equipped with adequate diagnostic and therapeutic facilities, work exclusively in conformity with the generally accepted standard of medical science, are not oriented towards specific methods of treatment, and keep case histories. A patient is considered an inpatient only when the type of his/her curative treatment requires a stay of at least 24 hours.

An inpatient stay for dental treatment as well as dental operations or maxillary surgery is deemed to be necessary from the medical point of view only if outpatient curative treatment is impossible on medical grounds.

In particular, an inpatient stay is not considered medically necessary, if and when it is merely occasioned by lack of home nursing or other personal circumstances of the insured person.

- (8) Benefits for inpatient curative treatment within the meaning of paragraph (7) will be paid in respect of the institutions (or departments of institutions) listed below, only if the insurer has approved them beforehand in writing:
- in institutions not exclusively working according to the generally accepted standard of medical science, or in departments of that kind at all the hospitals;
 - in institutions where rehabilitation measures or cures are carried out apart from the curative treatments of inpatients, or in departments of that kind at all the hospitals;
 - in institutions where long-term treatments are carried out apart from the curative treatments of

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- inpatients, or in departments of that kind at all the hospitals;
 - in institutions where convalescents or persons needing care are also admitted, or in departments of that kind at all the hospitals;
 - in geriatric institutions (e.g., medical, neurological, psychiatric geriatrics), or in departments of that kind at all the hospitals;
 - in private hospitals outside Austria;
 - in institutions for neurotic and/or mental patients and in institutions of psychosomatics (with the exception of independently conducted departments of neurology and neurosurgery) and/or in centres of psychic health;
 - as well as in institutions for patients suffering from lung diseases, or in departments of that kind at all the hospitals.
- (9) There is no insurance protection for stays at the following institutions (including their patient wards) or in departments of hospitals:
- in institutions primarily oriented towards rehabilitation, or in departments of that kind at all the hospitals;
 - in institutions for alcohol and drug addicts, or in departments of that kind at all the hospitals;
 - in health facilities of the Federal armed forces;
 - in institutions (or departments of institutions) for criminals;
 - in institutions for mentally abnormal law-breakers, or in departments of that kind at all the hospitals;
 - in independent outpatients departments (even when the examination or treatment to be carried out necessitates a short-term stay);
 - in sanatoria, recovery, diet and convalescence homes;
 - in institutions for the chronically ill, or in departments of that kind at all the hospitals;
 - in institutions for the care of patients on account of old age, frailty, invalidism, or lack of home care, or
 - in departments of that kind at all the hospitals; and
 - in day and night clinics.
- (10) The insurer cannot plead exemption from paying benefits pursuant to paragraphs (8) and (9) if, and as long as, the urgency of inpatient treatment does not permit admission to a hospital within the meaning of paragraph (7), or the procurement of a written acceptance before commencement of the treatment pursuant to paragraph (8).
- (11) If transfer to a hospital for inpatient curative treatment and transport home is necessary for medical reasons, the cost of the ambulance car, railway, or taxi transport will be reimbursed.

C) Common Provisions

- (12) Operation costs are deemed to include the fee of the operating surgeon, the anaesthetist and the physicians assisting in the operation, as well as the material costs charged separately. If several operations are carried out at the same time, the one graded highest in the table of rates will be refunded in full, each further operation at different operation sites at a maximum rate of 50%, and operations at the same operation site at a maximum rate of 25% of the amount listed in the table of rates.
- (13) Costs of radiotherapy are deemed to include the fees of the attending physician and his/her assistant(s), the costs for the use of the equipment, of radiating material, and any other material expenses, as well as any and all incidental costs.
- (14) The costs of medicinal products (remedies) which have been prescribed by a physician within framework of a curative treatment, which comply with the Medicinal Drugs Act, and which have been acquired at a pharmacy, will be reimbursed. Not refunded are the costs of any medicinal products not registered in Austria. For remedies acquired within the framework of curative treatment abroad the valid local regulations shall apply in respect of their registration. The costs of medicinal and mineral waters, medicated wines, nutriments and restoratives, geriatric products, tonics and cosmetic remedies will not be refunded in any case.

§ 6

Restrictions of the Insurance Cover

- (1) Excluded from the insurance cover are curative treatments that have started before commencement of the insurance.
- (2) Diseases and consequences of accidents, which have occurred prior to the commencement of the insurance but do not require curative treatment until after commencement of the insurance, will be included in the insurance cover only to the extent outlined in paragraph (6) and § 11.
- (3) Diseases and consequences of accidents which had been treated for the first time during the general waiting period (§ 4, paragraph (2)) are not covered until termination of the insured event, up to a

maximum of three years at the latest after the conclusion, modification or revival of the insurance contract; the same applies to any diseases that are in direct causal relationship with them. However, the insurer is obliged to pay benefits, if the policy holder or the insured proves that the disease has not been recognisable for him/her before the conclusion of the contract.

- (4) There is no insurance protection
 - for diseases and accidents and their consequences, which occur or deteriorate on account of alcohol or drug abuse, or whose curative treatment is substantially hampered through alcohol or drug abuse, as well as for withdrawal measures and withdrawal treatments;
 - for detention or institutionalisation on account of endangering oneself or others, as well as for the curative treatment of the consequences of suicide attempts;
 - for diseases and accidents and their consequences, from culpable participation in brawls, or from committing a criminal offence which presupposes premeditation;
 - for diseases and accidents and their consequences, which were premeditated on the part of the policy holder or the insured; if the policy holder has intentionally caused the disease or the accident of another insured person, the insurer will remain obligated to pay benefits to the latter; but the insured person's right to claim damages against the policy holder shall pass to the insurer.
 - for diseases and accidents and their consequences, occurring as a result of any kind of war, including violations of neutrality.
- (5) Diseases and consequences of accidents pursuant to paragraphs (1) to (3) may be included in the insurance cover on special terms (higher premiums, special waiting periods).
- (6) Insurance coverage of diseases and consequences of accidents, which were disclosed by the policyholder or the insured prior to the conclusion of the insurance contract, can be excluded only by way of an explicit written statement on the part of the insurer.
- (7) If curative treatment exceeds the normally required standard, the insurer is entitled to reduce the reimbursement to the appropriate scale.
- (8) In justified cases the insurer may exclude from the insurance cover any treatment by specific physicians or dentists or at specific hospitals or departments or hospitals. This applies to treatments carried out after the corresponding notification has been served.
Current insured events will, however, continue to be covered till the expiry of the third month at the latest after the delivery of such notification.

§ 7

Disbursement of Insurance Benefits

- (1) Insurance benefits are disbursed upon presentation of receipted original bills or confirmation of stays. These documents must mention the first names and surnames, address, policy number, the date of birth of the treated person, as well as the designation of the disease, the performance effected, and the treatment data.
If the insured person is additionally covered by another health insurance institution (legal or private), duplicates accompanied by the relevant accounts, or detailed accounts of the other insurers, may also be submitted.
- (2) Subject to the provisions of paragraph (5), the insurer may regard the bearer of such documents as the person entitled to receive the insurance benefits attributable to him/her.
- (3) The documents become the insurer's property.
- (4) Any costs incurred in foreign currencies will be converted into euros at the mean foreign exchange rate quoted on the official Vienna foreign exchange market on the last day of the treatment abroad.
- (5) Claims to insurance benefits may neither be pledged nor assigned without the insurer's approval. The policy holder may set off his/her claims against those of the insurer only if they constitute counterclaims which are legally connected with his claim, which have been ascertained by a court, or which have been accepted by the insurer.
- (6) Pecuniary benefits payable by the insurer are due upon completion of the investigations carried out in order to ascertain the insured event and the scope of the insurer's benefit payment. Notwithstanding this provision, such benefit falls due for payment, if the policy holder, upon expiration of two months from the date of his/her request for a pecuniary benefit payment, asks the insurer to state the reasons why it has not been possible to complete the investigations, and if the insurer fails to comply with such request within one month.
- (7) The insurer is exempt from the obligation to pay, if the claim for payment is not lodged with a court within a period of one year. This period will not commence until the insurer has refused the policy holder's claim

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in writing. The insurer must substantiate its decision at least by indicating a fact on which the refusal is currently based and by referring to the relevant legal or contractual provision, as well as by stating the legal consequence of the expiration of the stipulated period; the insurer's decision will be suspended pending the outcome of composition negotiations conducted with regard to the claim, as well as for any period during which the policy holder is prevented, through no fault on his/her part, from lodging his/her claim in court in time.

- (8) The limitation period for the claims to insurance benefits is three years. If the claim is due to a third party, the term of limitation starts on the date on which such third party was informed of his/her right to the insurer's benefit payment; if the third party has not been informed of such right, the limitation period will be ten years.

Once a policy holder's claim has been reported to the insurer, the limitation period will be suspended until a written decision on the part of the insurer has been received, indicating at least the fact on which the refusal is currently based as well as the substantiating legal or contractual provision. The term of limitation will in any case be ten years.

§ 8

Suspension of the Insurance Cover

- (1) On application by the policy holder, and in justified cases, a suspension of the rights and obligations under the insurance contract may be agreed for a predetermined period not exceeding twelve months.
- (2) A revival of the insurance, requested by the policy holder, prior to the expiration of the agreed period may be made dependent on a medical health examination.
- (3) Insured events occurring while the insurance contract is suspended are not covered.

Expectancy Insurance

- (4) If, during the suspension period, an expectancy premium has been agreed and paid in advance (expectancy insurance), the continuation of curative treatment of the insured events which occurred during the suspension period will be covered after the revival of the insurance. The term of the expectancy insurance will be credited to the waiting periods (§ 4).

Discontinuation of the Insurance Cover

- (5) If no expectancy premium is paid for the suspension period of the insurance, the continuation of curative treatment of insured events which have occurred during the suspension period will not be covered after the revival of the insurance. An inclusion in the insurance cover may be agreed on special terms (higher premium, special waiting periods).

§ 9

Termination of Insurance Protection

The insurance cover terminates upon expiration of the insurance contract, also in respect of any current insurance cases.

DUTIES OF THE POLICY HOLDER

§ 10

(A) Premiums, Fees and Levies

- (1) The premium is an annual premium and is calculated from the date of commencement of the insurance. It is payable at the beginning of any insurance year, but may also be paid in equal monthly premium instalments, which are considered respited up to the maturity date of the premium instalment. The premium instalments are due for payment on the first day of any month. The first premiums are due for payment at latest on the date on which the policy or the offer has been handed over and the premium payment has been requested.
- (2) If a coinsured child has completed the age of 18, the premium applying to adults will be payable from the first day of the following month.
- (3) The premiums shall be paid to the agency to be designated by the insurer.
- (4) Any levies (taxes) due under the insurance contract shall be borne by the policy holder. Apart from this, the policy holder may be charged only the fees used to cover any extra expenses that are occasioned by the conduct of the policy holder or the insured.

B) Delay in Payment and Its Consequences

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- (5) If the first premium or the first premium instalment has remained unpaid within 14 days from the conclusion of the insurance contract and from the date of the request of payment of the premium, the insurer is entitled, for as long as payment has not been made, to withdraw from the contract. Unless the claim for premium payment has been lodged in court within three months from its due date, the insurer will be deemed to have withdrawn.
- (6) If subsequently a due premium or a due premium instalment is not paid in time, the insurer may request the policy holder in writing – indicating the amount of the premium and the cost owed and the legal consequences a further default may have – to pay the debt to the agency named by the insurer, within a period of 14 days from the date of receipt of such request and without deduction of remittance expenses. Interest on arrears may be charged in the amount of the legal interest payable on arrears, in addition to the postal fees and the cost of reminders.
- (7) If the insured event occurs after the payment deadline has expired, and if at that time the policy holder is in default regarding the premium payments, the insurer is under no obligation to pay benefits, unless the policy holder had been prevented from paying the premium in time through no fault of his/her own. The insurer's obligation to pay will be re-enacted as soon as all the outstanding premiums are paid; however, the policy holder will not be entitled to benefits for insured events that have occurred, or further consequences, after the expiration of the payment deadline and before payment of the outstanding premiums.
- (8) If the policy holder defaults by not more than 10% of the annual premium, but at the most by the maximum amount mentioned in § 39 a of the Insurance Contract Act (at present EUR 60.00), the insurer is not exempted from the payment of benefits as defined in paragraph (7) above.
- (9) The insurer is entitled to terminate the insurance contract without giving a period of notice, if the policy holder is in default of payment after the expiration of the fourteen-day period. The insurer may terminate the insurance contract already when fixing the deadline for payment, so that the termination will take effect upon expiration of the deadline, if the policy holder is in arrears at that date.
- (10) The effects of termination will lapse, if the policy holder subsequently effects payment of the premiums within one month from the date of the notice of termination or, if termination had been linked with the fixing of the deadline, within one month from the expiration of the deadline.
- (11) Failure to pay interest or costs does not entail the legal consequences referred to in paragraphs (7) and (9) above.

§ 11 Obligations

A) Obligation to Disclose Prior to the Conclusion of the Insurance Contract

- (1) Upon applying for insurance cover, and between the date of application and the date when the policy is served (handed over), the policy holder and the insured must disclose any and all substantial hazards. Any hazard for which the insurer has expressly asked in writing by giving a detailed description shall in case of doubt be deemed substantial.

B) Consequences of Violating the Obligation to Disclose Prior to Conclusion of the Insurance Contract

- (2) If the policy holder or an insured person has culpably violated the obligation to disclose substantial hazards, the insurer may withdraw from the contract. The obligation to disclose is deemed to be violated also when questions about hazards are answered incompletely.
- (3) Withdrawal from the insurance contract is permissible within one month from the date on which the insurer has learned about the infringement of the obligation to disclose.
- (4) If the insurer withdraws after an insured event had occurred, insurance protection will nevertheless be upheld, if the circumstances in respect of which the obligation to disclose had been violated has had no impact on the occurrence of the insured event or on the scope of the insurer's benefit payments. However, the insurer may request the refund of any benefits relating to facts that have entailed the withdrawal.
- (5) If the preconditions for the withdrawal apply only to some of the insured persons, it may be restricted to such persons. In such an instance the policy holder will be entitled to terminate the insurance contract in its entirety within one month after having received the notice of withdrawal.
- (6) The insurer may no longer withdraw from the contract, or terminate it, on account of the policy holder's non-compliance with his/her obligation to disclose upon conclusion of the contract, if more than three

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years have passed since its conclusion. However, the insurer's right to rescind the contract is not extinguished if the duty to disclose has been fraudulently violated.

- (7) In the event of a guiltless infringement of the obligation to disclose the insurer may in those cases where its business plan provides a higher premium for hazards previously unknown to it, charge the respective higher premium from the beginning of the current insurance year.
If, in accordance with the principles governing the insurer's business operations, the greater hazard is not accepted even against payment of a higher premium, the insurer may terminate the insurance relationship by giving one month's advance notice.

C) Duties of the Policy Holder and the Insured During the Term of the Insurance Contract

- (8) Upon the insurer's request the policy holder and the insured must provide the insurer with any information that may be required for the ascertainment of the insured event or the type and scope of insurance protection.
This includes the obligation on the part of the insured, at the insurer's request, to undergo an examination by a physician mandated by the insurer.
- (9) In the event of a disease the policy holder and the insured must comply with the reasonable rules of conduct prescribed by the physician or the insurer.
- (10) If a health insurance contract is concluded for an insured person by another insurer, the insurer must be informed of such further insurance contract without delay.

D) Consequences of a Breach of Duties During the Term of the Insurance Contract

- (11) If the policy holder or the insured violates the duty to disclose as defined in paragraph (8), the insurer will be exempt from the obligation to pay benefits, if such violation was committed wilfully or by gross negligence.
If the obligation to disclose is not violated with the intention to influence the insurer's obligation to pay and to impede the ascertainment of such circumstances as are identifiably significant for the insurer's obligation to pay, the insurer will remain obliged to pay benefits, if and when such infringement has affected neither the ascertainment of the insured event nor the ascertainment or the scope of the benefits payable by the insurer.
- (12) If the required conduct referred to in paragraph (9) is violated, intentionally or through gross negligence, the insurer will be exempt from the payment of benefits and will be entitled to terminate the insurance contract without notice.
- (13) Should the duty to disclose the information referred to in paragraph (10) is culpably violated, the insurer will be exempt from the payment of fixed sums, such as the daily hospital allowance, substituted daily hospital allowance, sick pay, or cure subsidies. Moreover, the insurer may terminate the insurance contract in its entirety, or only with respect to the relevant insured person, within one month after having learned about the infringement of the obligation, without giving a period of notice. If the insurer fails to terminate the contract within one month, it may not plead exemption from payment.

§ 12

Claims Against Third Parties

- (1) If, in addition to the claims against the insurer, there are equal claims for the same insured event against third persons or public-law or private insurance institutions, such claims pass to the insurer inasmuch as this insurer refunds the cost. The claimant is obliged to confirm this assignment to the insurer in writing upon the latter's request.
- (2) If and to the extent that the claimant has already received compensation of the costs incurred by him/her from third persons liable in damages on the grounds of other insurance contracts, the insurer is entitled to net such compensation against its payments.
- (3) Paragraphs (1) and (2) do not apply to benefits which are due without any evidence of the costs having to be produced.
- (4) The insurer's obligation to pay costs, part of which the entitled party may claim from a public-law insurance institution, does not ensue until the latter has accorded the benefits due to him/her.
- (5) If the party entitled to claim waives his/her claim, or a right to secure his/her claim, against third persons, without the insurer's approval, the insurer will be exempt from its payment obligation to the extent of the compensation that he could have obtained from such claim or right.

TERMINATION OF THE INSURANCE CONTRACT

§ 13

Cancellation by the Policy Holder

- (1) The insurance contract is concluded for an indefinite period of time. The policy holder has the right to terminate the insurance contract as at the end of any insurance year by giving three months' advance notice, but not earlier than the expiry of an agreed insurance term.
- (2) The insurance year takes its bearings from the original commencement date of the policy.
- (3) Notice of cancellation must be made in writing and addressed to the insurer's management.
- (4) a) If the policy holder terminates the insurance contract with respect to individual persons, the insurer has the right within one month to cancel the insurance contract with regard to the remaining persons as at the same deadline.

b) If the policy holder terminates the insurance contract with regard to individual rates, the insurer has the right within one month to cancel the contract with regard to the other rates of the respective person as at the same deadline. This provision applies only to those rates which were insurable only in combination with other rates at the date of the conclusion of the contract.
In such a case, too, the insurer has in any event the right to counter-termination pursuant to paragraph (4)a.

c) Within one month from such counter-termination by the insurer the policy holder has the right to withdraw the termination originally declared.
- (5) If premiums are increased or benefits decreased (§ 11 B) paragraph (7)), the policy holder has the right to terminate the insurance contract in respect of the affected persons, within one month from receipt of the notification regarding the alteration, as at the date on which such alteration becomes effective.
- (6) If a policy holder or an insured person is admitted to a hospital for chronically ill persons, the policy holder has the right to terminate the insurance contract as at the end of the month in which he/she proves his/her admission to such an institution.

§ 14

Cancellation by the Insurer

- (1) The insurer waives the right to terminate the contract; exceptions to this provision are the cases referred to in § 10 paragraph (9), § 11 paragraphs (12) and (13), § 13 paragraph (4), and § 14 paragraph (2).
- (2) If the policy holder or an insured person obtains an insurance surreptitiously, or attempts to obtain it surreptitiously, by making false statements knowing them to be false, especially by feigning an illness, or if he/she takes part in such acts, the insurer is exempt from its obligation to pay and is entitled to terminate the insurance without notice.
- (3) If the insurer terminates the insurance contract with respect to individual persons as referred to in § 11, paragraph(13), the policy holder has the right within one month to cancel the insurance contract in respect of the remaining persons as at the same deadline.

§ 15

Other Reasons for Termination

- (1) The insurance contract terminates with the policy holder's death. However, the insured persons are entitled to continue the insurance contract by naming the future policy holder. A statement to this effect must be given within two months from the policy holder's death.
- (2) Upon the death of an insured person the insurance contract terminates with regard to such person.
- (3) The insurance contract also terminates when the policy holder or the insured relocates his/her residence abroad, unless another arrangement is made. The provisions of paragraph (1) apply by analogy.

OTHER PROVISIONS

§ 16

Form and Recipients of Declarations of Intent and Notifications

This English translation of the authentic German text serves merely information purposes. In case of disagreement concerning the acceptance of the wording only the authentic German text shall be binding.

- (1) Any notifications and statements destined for the insurer must be made out in writing and should be sent to the insurer's management.
- (2) If the policy holder has changed his domicile without notifying the insurer, any declaration of intent on the part of the insurer towards the policy holder shall be deemed to be legally valid if the corresponding letter is sent to the latest address notified to the insurer.

§ 17

Place of Settlement, Jurisdiction

- (1) The place of settlement for the reciprocal obligations arising from the insurance contract is the insurer's seat.
- (2) Complaints against the insurer may be filed with the court at the insurer's seat, or with the court at the place where the mediating agent had its business headquarters, or in the absence of such a place, his place of residence while acting in this capacity..
- (3) Local jurisdiction for complaints against the policy holder rests with the court which has jurisdiction for the place where the policy holder has his/her residence, his/her usual abode, or where his/her place of employment is situated.

§ 18

Modification of Insurance Conditions and of the Premium

- (1) The insurer is obliged, after the conclusion of the contract, to increase or alter the premium or the insurance cover (the general and supplementary insurance conditions and rates) unilaterally, if at least one of the following circumstances have occurred; in like manner, the insurer shall also be obliged to reduce the premium where the agreed preconditions for a change of the premium exist:
 - a) an agreed index has changed,
 - b) the average expectation of life has changed,
 - c) a change in the frequency of availment of benefits according to the type of those provided for in the contract and the expense they involve, relative to the persons insured at the respective rate,
 - d) a change in the proportion between the contractually agreed benefits and the corresponding cost reimbursements on the part of the legal social insurance institutions,
 - e) a change - by law, ordinance or other act of the authorities or by agreement between the insurer and the public-health facilities listed in the insurance contract - of the fees fixed for the use of such facilities,
 - f) a change in the health system or the legal provisions governing it.
- (2) If the insurer increases the premium pursuant to the provisions of paragraph (1), it must offer the policy holder, upon his/her request, the possibility to carry on with the existing contract, with the premium at best remaining unchanged and with benefits being reasonably altered.
- (3) Any statement as to a retroactive change of the premium or the insurance cover is not effective; such statement will not take effect before the first day of the month following its despatch.
- (4) The policy holder has the right, during the term of the contract, to change over to another rate provided in the business plan for the same type of insurance (§ 178 b of the Insurance Contract Act) and to the existing scope of the cover, while the rights acquired in the course of the contract term and the reserve for increasing age are credited.

§ 19

Profit Participation / Reimbursement of Premiums

The attribution to a specific profit-sharing pool depends on the insured rates.

A. Profit Pool A

Profit Pool A comprises the insurances for the costs of curative treatments, which denotes insurance at one of the rates for outpatients curative treatment in conjunction with a rate of inpatient curative treatment and/or a rate for daily hospital allowance.

B. Profit Pool B

Profit Pool B is made up of the hospital cost insurances, the daily hospital allowance insurances, the daily compensation insurances, the nursing allowance insurances, the cure and rehabilitation cost insurance and health provision insurances.

C. Determination of the Profit

Eighty-five percent of the profit determined as provided in the business plan are allocated to the profit reserve of Profit Pool A and Profit Pool B. From this reserve the profit shares due to the individual policy holder will be disbursed under the following terms:

- (1) In the first place, only those insurances within the profit pool are entitled to participate for which the premiums for the entire calendar year had been fully paid.
Alterations of the insurance cover or the rates in the course of a calendar year do not establish a right to participate. If the premium had changed during the calendar year, the amount of profit participation is determined on the basis of the lowest monthly premium.
Another precondition is that no benefits have been received from the insurer during the entire preceding calendar year.
Excluded are those insurances where periods of relief from liability for payments have occurred during the calendar year ended, or which have existed in the form of expectancy insurances (§ 8, paragraph (4)).
- (2) **Payment of benefits**
In determining the eligibility for participation in the profits, the insurances of adult persons are regarded as one entity; this is to say that insurances are eligible for profit participation only if none of the adults had been paid any benefits in the year ended. Thereby benefits of health provision insurances will be ignored.
- (3) Premiums for children are not eligible for profit participation.
- (4) The share of the profit attributable to an individual insurance is determined under the terms of the business plan. It must at all times constitute an integral multiple of one monthly premium. Any balance remaining in the insured person's profit reserve will be carried forward to the following year.
- (5) In Profit Pool A a profit share of three monthly premiums is guaranteed (premium refund).
- (6) The profit share will be settled after the publication of the balance sheet. There will be no settlement for insurance contracts that had ceased by the date of such settlement.
The insurer will credit the profit share to the premiums for the months following the settlement.
- (7) If claims for insurance benefits for the business year ended are asserted once the profit share has been received, the profit share will be given credit for the payment of the insurer; any profit share (premium refund) wrongfully received must be returned.