sumiswalder
ihr partner für gesundheit

Daily allowance regulations as per the HIA

Contents

Art. 1 Purpose/legal basis

1 Sumiswalder offers daily allowance insurance based on its General Terms and Conditions of Insurance (GTC). The Health Insurance Act (HIA) and the Federal Act on General Aspects of Social Security Law (GSSLA) take precedence over these General Terms and Conditions of Insurance (GTC).

2 The daily allowance insurance provides benefits in the event of loss of earnings resulting from incapacity for work due to illness, accident or maternity.

Art. 2 Accession/membership

1 Persons resident or gainfully employed in the Sumiswalder operational area may take out daily allowance insurance, provided they are at least 15 years old and not yet 65. The application is made in writing using a pre-printed form. All questions on the form must be answered truthfully and fully by the applicant.

2 The applicant authorises the insurer to obtain the information required to accept and clarify a subsequent obligation to pay benefits. In addition, the insurer may request a medical certificate or an examination by a medical examiner. The insurer may also appoint a doctor. Any costs shall be borne by the insurer.

3 Persons to be insured may choose a different insurer for this than for compulsory health insurance.

4 Daily allowance cover can be taken out as collective insurance. Collective insurance policies can be concluded by:

a. Employers for themselves and their employees;
b. Employers' and professional organisations for their members and the employees of their members;
c. Employee organisations for their members.

5 Any change of domicile or address must be reported to the insurer within 30 days. A change of domicile is deemed a change of domicile under civil law.

Art. 3 Free movement of persons EU/EFTA

Since the Agreement on the Free Movement of Persons with the European Union (EU) and the European Free Trade Association (EFTA) entered into force, deviating provisions have to be observed in Switzerland with regard to the group of insured persons, their rights and obligations, the insurance relationship and benefits.

Art. 4 Start/end/suspension/adjustment

1 The insurer offers the insurance with a different start date. The insurance inception date is the date of acceptance confirmed by the insurer. Upon acceptance, the insured person shall receive the insurance policy and these daily allowance regulations. The insurance policy shows the insurance option chosen by the insured person, the premium and other important data. If the insurance cover is continued upon reaching the maximum entry age with the consent of the insurer, the insurer shall pay the insured daily allowance for a maximum of 180 days, including the waiting period.

2 The daily allowance insurance expires:

a. by termination
b. moving abroad
c. in the event of definitive exhaustion of the entitlement to benefits
d. upon reaching the age of 65 (subject to Art. 13)
e. in the event of death

The statutory grounds for exclusion in the event of a breach of duty on the part of the insured person remain reserved.

The insured person may cancel with effect from the end of a month subject to a three-month notice period.

In the event of a premium adjustment, the insured person may cancel with effect from the end of the month preceding the validity of the new premium, subject to a one-month notice period.

Apart from any outstanding insurance benefits, there shall be no legal claims against the insurer after termination of the insurance. The insured person is obliged to meet their financial obligations to the insurer.

3 If the behaviour of an insured person proves to be abusive or otherwise inexcusable and the continuation of the daily allowance insurance is no longer a reasonable prospect for the health insurer, the insured person may be excluded following a previously issued warning of sanctions if they,

a. have not completed the insurance application truthfully;
b. repeatedly defy or seriously violate the doctor's instructions;

c. are in arrears with the premium payments and fail to comply with a payment request plus exclusion order if they fail to pay within one month;
d. for other good cause.

4 The insurance may be suspended with the consent of the insurer in the following cases:

a. if the insured person stays abroad for more than three months;
b. if the insured person does military training or civilian service for more than one month, the benefits covered by the military insurance may be suspended;
c. if the insured person stays for more than three months in a penal or custodial institution or reform school.

The insurance can be suspended for a maximum of two years. If the insurance is reactivated, the insured person is entitled to the original insurance cover. In addition, once the suspension is lifted, the insured person is immediately entitled to benefits again without having to accept new insurance restrictions or an age group-related loss.

5 The insured person may request an increase or reduction in the daily allowance, a shortening or extension of the waiting period and the inclusion or exclusion of accident cover at any time. In the event of higher insurance, the conditions of the application shall apply mutatis mutandis; in the event of an insurance reduction, the conditions of termination shall apply. In the event of retroactive inclusion of accident cover, the insurer shall grant the existing insurance to the entry age group. However, the insurer has the right to exclude the consequences of accidents from the insurance cover by means of caveats.

6 If the insured daily allowance is reduced and the existing waiting period is shortened or vice versa, the insurer shall grant this adjustment without changing the entry age group, provided the premium remains unchanged. An insurance increase may be refused in the following cases:

a. if the OASI retirement age is exceeded;
b. if there are illnesses or consequences of accidents, including from the past that present a high risk;
c. if premiums are still outstanding.

The insurer may stipulate additional or different conditions for the benefit of the insured person for insurance adjustments.

Art. 5 Caveats and high risk

1 Sumiswalder may conditionally exclude illnesses and consequences of accidents, which existed at the time of the application or earlier and for which experience has shown that relapses are possible. A caveat with regard to a cover extension is only relevant for the additionally insured benefits.

2 The insured person shall be informed of any caveat in writing. It is only valid if the insured person is notified of it in writing and the notification specifies the illness in question plus the inception and end of the period for which the caveat applies. The caveat is effective from the start of the insurance for five years and then lapses after the expiry of the period without further notice.

3 Before this period expires, the insured person may provide proof that an existing caveat is no longer justified. The insurer shall then decide whether the caveat should be lifted early. Any costs incurred shall be borne by the insured person.

4 If the information provided by the insured person is incorrect or incomplete when submitting the application, the insurance company may apply a retroactive caveat.

Art. 6 Change of insurer

1 The insurer may not impose any new caveats if the insured person switches to it because:

a. the commencement or termination of their employment relationship requires them to do so;
b. they leave the operational area of the previous insurer;
c. the previous insurer no longer provides social health insurance.

2 Sumiswalder may continue with the caveats of the previous insurer until expiry of the original period.

3 The previous insurer shall ensure that the insured person is informed in writing of their entitlement to freedom of movement. If it fails to do so, the insurer remains responsible for the cover. The insured person must assert their right to freedom of movement within three months of receiving corresponding notification.

4 At the request of the insured person, the insurer must continue to insure the daily allowance at the current level. In doing so, it can offset the daily allowances received from the previous insurer against the duration of the right to receive benefits in accordance with Art. 72 HIA.

Art. 7 Collective insurance

1 The insurer may conclude collective policies in accordance with Art. 67 para. 3 HIA for certain groups of people. The insurance terms and conditions may deviate from these daily allowance regulations. The terms of the collective insurance contract take precedence over these daily allowance regulations.

2 If an insured person leaves the collective insurance because they no longer belong to the group of insured persons described in the policy or because the policy is terminated, they have the right to transfer to the individual insurance. Insofar as the insured person does not insure higher benefits under the individual insurance, no new insurance restrictions may be applied. The entry age applicable in the collective policy must be retained.

3 The insurer informs insured persons in writing of their right to transfer to individual insurance. If it fails to do so, the insured person will remain in the collective insurance. They must assert their right of transfer within three months of receipt of the notification.

Art. 8 Insurance offer

1 The amount of the daily allowance shall be agreed between the insured person and the insurer. The value of the insured person's work, which they are unable to perform following the occurrence of an insured event, or the presumed loss may be covered. The insurer may limit the maximum insurable daily allowance.

2 The insured daily allowance is equal to the average, material loss of earnings in a year divided by 365. Any existing daily allowance insurance policies with other insurers must

be declared. If these daily allowance insurance policies are taken out after concluding the daily allowance insurance as per the HIA, they must also be declared.

3 Insured persons with income from employment as an employee may take out insurance up to the amount of their gross salary subject to OASI contributions. Paragraph 1 of this Article remains reserved.

4 Insured persons with income from self-employment may acquire cover to the amount of their income subject to OASI contributions in accordance with the last contribution ruling issued by the OASI office.

5 Persons who are not gainfully employed may take out a daily allowance of up to CHF 50.

Art. 9 Entitlement to benefits

1 There is an entitlement to the insured benefits in accordance with the extent of the concluded insurance and these daily allowance regulations remain in force for the duration of the insurance cover. The total daily allowance benefits provided may not exceed the value of the work rendered impossible plus the additional costs as defined by law or the presumed loss of earnings.

2 The additional agricultural costs (assistance) must be documented by means of the invoices issued by said assistants or by means of regular payroll accounting in accordance with statutory provisions.

3 Upon the onset of entitlement to benefits, the insurer pays the daily allowance benefits for all days on which a medically certified incapacity to work exists after the selected cover inception date. The daily allowance is paid for one or more illnesses and accidents together, for a maximum of 730 days within 900 days. Daily allowances already received under policies concluded previously are offset against the total entitlements.

4 Entitlement to benefits only exists after expiry of the agreed waiting period. This is calculated from the day on which the medically confirmed incapacity for work begins. If a person is unable to work at least 40% for a day, the day in question qualifies as a waiting day. Accordingly, in the event of a waiting period of one day, the benefit is provided from the first working day after the onset of the medically certified incapacity to work. If a longer waiting period has been agreed, the benefits shall be provided from the first day after expiry of the agreed waiting period. Waiting periods of up to 720 days can be agreed for insurance policies with deferred inception of benefits.

5 The agreed waiting period applies once per calendar year. If the incapacity to work exceeds one calendar year, the waiting period shall only be reinstated if the insured person was able to work in the meantime. The waiting period counts towards the maximum duration of benefits insofar as the employer is obliged to continue paying the salary during the waiting period. In the case of daily allowance insurance policies whereby entitlement to benefits is deferred by more than one day from the onset of the incapacity to work, the waiting period counts towards the maximum duration of benefits of 730 days within 900 days, insofar as the employer is obliged to continue paying the salary during the waiting period.

6 In the event of partial incapacity for work, a correspondingly reduced daily allowance is paid. Insurance cover for the remaining ability to work remains in place in accordance with the provisions of the HIA. Entitlement to benefits exists if the incapacity for work is at least 40% or more.

7 If the daily allowance is reduced as a result of overcompensation, the insured person who is unable to work is entitled to the equivalent of 730 full daily allowances. The periods for drawing the daily allowance shall be extended to reflect the reduction.

8 A reduction in the daily allowance due to serious negligence on the part of the person concerned does not extend the duration of benefits.

9 The insured person may not extend the eligibility period by partially waiving daily allowance benefits.

10 The foregoing is without prejudice to mandatory statutory provisions in the event of unemployment in accordance with Art. 10 of these regulations.

11 The daily allowance insurance expires in the event of exhaustion of the benefit entitlement.

Art. 10 Exclusions

1 There is no entitlement to benefits:

a. for illnesses or accidents falling under an effective caveat;
b. for illnesses or consequences of accidents culpably not declared or only declared incompletely by the insured person when submitting the application. The restriction relates to the period during which the insurer would have excluded the illnesses and consequences of an accident had it been aware thereof;
c. during the waiting period;
d. for the consequences of accidents covered by another insurer;
e. if treatment does not serve to remedy a health disorder or the consequences thereof. Measures to prevent the imminent occurrence or worsening of a health disorder are reserved if the patient is already in a morbid condition;
f. if the insurance is suspended;
g. if the insured person participates in acts of war or similar.

2 The following benefits may be temporarily or permanently reduced or withheld in serious cases:

a. in the event of a breach of a statutory obligation to cooperate, such as obligatory notifications (e.g. with other social insurance providers);
b. if the insured person refuses to undergo an examination by a medical examiner at the insurer's request;
c. if the insured person evades or opposes reasonable treatment or integration into working life or purposely fails to make a reasonable contribution to doing so;
d. in the event of the intentional causing of an illness or accident or in the event of illnesses or accidents connected with criminal acts, fights or other acts of violence;
e. for insured persons enforcing penalties or measures.

3 Erroneous or wrongly received benefits may be reclaimed by the insurer.

Art. 11 Unemployed insured persons

1 Unemployed insured persons are paid the full daily allowance in the event of incapacity for work exceeding 50%, and

half of the daily allowance in the event of incapacity for work exceeding 25%, but not more than 50%.

2 In addition, unemployed insured persons can, in return for an appropriate premium adjustment, convert their previous daily sickness allowance insurance into an insurance policy incepting on the 31st day. This is while maintaining the previous daily allowance level and taking into account the previous entry age, but without taking into account the state of health at the time of conversion.

Art. 12 Maternity

1 In the event of pregnancy and childbirth, the insured daily allowance is granted, provided the insured person was covered for the daily allowance under maternity benefits up to the day of childbirth for more than three months or at least 270 days without interruption.

2 The insured person is entitled to a daily maternity allowance of 16 weeks, of which at least eight weeks must be after the birth. Maternity benefits do not count towards the maximum period of entitlement.

Art. 13 OASI age

1 The daily allowance insurance expires on the first day of the month in which an insured person reaches the age of 65.

2 Daily allowance insurance policyholders who are gainfully employed beyond the age of 65 may, upon corresponding written request, be granted the continuation of daily allowance insurance up to a maximum of 50%, subject to a corresponding premium adjustment, provided they earn a corresponding income from employment. A request to this effect must be submitted to the insurer in writing one month before reaching the age of 65. The application must contain information about the person's further employment and state of health. Any continued insurance invariably requires full capacity to work.

3 For those insured under a group policy, the daily allowance remains unchanged and continues to be granted in accordance with the insurance policy.

4 If an insured person is granted the continuation of increased daily allowance cover, this insurance cover lasts until the insured person reaches the age of 69 at the latest. The increased daily allowance is paid for a maximum of 180 days, whereby any deferment periods count towards these 180 days.

Art. 14 Abroad

1 In the case of holidays abroad for private reasons, the insured benefits are only provided for hospital stays.

2 If an insured person who is unable to work and is entitled to benefits travels abroad without the consent of the insurer, the entitlement to benefits expires for the period of the stay abroad.

Art. 15 Accident

1 Unless otherwise stipulated in these regulations, accidents are deemed to be equivalent to illness in terms of the insured benefits, provided that they are also insured against an additional premium.

The definition of an accident is based on the applicable provisions of the Federal Act on General Aspects of Social Security Law (GSSLA).

2 If an applicant or insured person wishes to exclude the risk of accident, this must be expressly noted in the application form and confirmed by signature, or in the case of existing insurance policies, an application must be made in writing. Thereafter, the insured person must pay the premium reduced by the exclusion of the accident risk. Retroactive changes are not possible.

3 In each case, the completed accident report form provided by the insurer must be submitted to the insurer within five days.

Art. 16 Age groups and premiums

1 The premiums for the daily allowance insurance are determined by the Sumiswalder Board according to entry age and region. If the insurance is suspended as per Article 4, paragraph 4 of these Regulations, a reduced premium shall be charged.

2 In the event of higher insurance, the insured person is assigned to the age group corresponding to their age at the time of inception for the higher insurance policy.

3 The premium must be paid in advance. The premium must also be paid without interruption in the event of illness, accident, incapacity for work or if entitlement is suspended.

4 If the premiums and cost contributions due are not paid by the insured person, the insurer shall issue the insured person with a payment demand following at least one written reminder. In this payment demand, the insured person is granted a grace period of 30 days. The insured person shall also be informed of the consequences of late payment. If due premiums, cost contributions and interest on arrears are not paid within the grace period despite a payment demand, the cover for new cases and the entitlement to benefits for ongoing cases expires. If the open items are subsequently paid, the cover for new cases and the entitlement to benefits for ongoing cases come back into effect, albeit not retroactively. In addition, the insurer has the right to withdraw from the contract after expiry of the deadline set in the payment demand, if the outstanding premiums, cost contributions and interest on arrears have not been paid within the deadline set. All expenses arising from issuing reminders and the related administration is always at the insured person’s expense.

5 Claims against the insurer may not be pledged and may only be assigned in the cases provided for by the HIA.

Art. 17 Reporting/reference/procedure in the event of illness or accident

1 The insured person must notify the insurer within five days of their incapacity to work, which could lead to an entitlement to a daily allowance. They must also indicate whether the triggering event is an illness or accident. The certificate issued by the doctor must be sent to the insurer no later than ten days after the start of the incapacity to work. Backdating of medical certificates and sickness or accident reports for the purpose of obtaining daily allowance benefits is not permitted. These documents must also be submitted on time if the duration of the inability to work is fully within the agreed waiting period.

2 In the event of late submission of the confirmation of incapacity for work for which the employee is at fault, the employee shall be entitled to the insured daily allowance at the earliest from the date of receipt of the medical certificate. The waiting period begins as soon as the insurer has received the notification. Reports delayed without fault are reserved. Backdating in order to obtain daily allowance benefits is not permitted.

3 Upon termination of the incapacity for work (including partial), written medical confirmation of the degree and duration of the incapacity for work must be immediately submitted to the insurer. In addition, the insured person must provide evidence of non-covered loss of earnings, including any acquisition costs.

4 The insured person must do everything to advance their recovery and refrain from anything that delays recovery. In particular, the instructions of medical professionals must be followed. The insurance provider may check compliance with medical instructions and take appropriate monitoring measures.

5 The insured person must provide the insurer free of charge with all information required to clarify the entitlement and determine the insurance benefits. In particular, it must inform the insurer of all third-party benefits in the event of illness, accident and disability and provide the insurer with all necessary information about the circumstances of the accident and third parties involved in the accident.

6 If benefits are drawn, the insured person must authorise all persons and bodies such as doctors, employers, insurers and official bodies to provide all information required to clarify entitlement to benefits, unless these persons and bodies are already obliged by law to provide information.

7 The insured person must undergo an examination by another doctor or a medical examiner of the insurer on request. The insurance provider shall bear the costs of this examination.

8 In any case, the insurer is entitled to check the incapacity to work as well as any non-covered loss of earnings, including any acquisition costs, and to take appropriate monitoring measures if necessary.

9 Payment of the daily allowance is made upon regaining the ability to work on the basis of medical certification. If the inability to work lasts longer than one month, the daily allowance is usually paid out on a monthly basis.

10 If the insured person fails in an unacceptable way to fulfil their duties to provide information and cooperate in the event of a claim, the insurer may rule on the claim on the basis of the records or not respond to the claim request.

Art. 18 Overcompensation

Overlapping benefits from different social insurance schemes must not lead to overcompensation. Overcompensation is regulated in accordance with Art. 69 GSSLA.

Art. 19 General provisions and administration of justice

1 If an applicant or insured person does not agree with a decision, the insurer shall, upon request, issue a written, reasoned ruling within 30 days with instructions on rights of appeal. The insured person may lodge an appeal against this ruling with the insurer within 30 days. The insurer shall examine this appeal and issue a decision on the appeal, which shall be substantiated in writing and include instructions on rights of appeal.

2 Appeals against appeal decisions can be lodged with the cantonal insurance court within 30 days of notification. Any person who is affected by the contested decision or the decision on the appeal and who has a legitimate interest in its revocation or amendment is entitled to lodge an appeal. The competent court is the insurance court of the canton in which the insured person or third party making the appeal is domiciled. In addition, the insured person may contact the insurance court if the insurer does not issue a ruling or a decision on the appeal by the deadline. If the insured person or third party lodging the appeal is domiciled abroad, the competent court is the cantonal insurance court of the last relevant Swiss place of residence or in which the last Swiss employer is based. If none of these locations can be determined, the competent court is the insurance court of the canton in which the insurer has its registered office.

3 In the absence of a response to a ruling or an insurer's decision on the appeal within the objection or appeal period, or if the appeal is dismissed with legal effect, the ruling or decision on the appeal is legally binding. The legally binding rulings stipulating monetary payments are equivalent to enforceable court judgements within the meaning of Art. 80 of the Debt Enforcement and Bankruptcy Act (DEBA).

4 The statutory provisions as well as the Articles of Association and/or General Terms and Conditions of Insurance of Sumiswalder shall apply mutatis mutandis to all matters not specifically covered in these regulations.

5 The insured person shall be informed of any changes to these daily allowance regulations in writing, in the journal for insured persons or by means of official publication.

6 These regulations are published on the Sumiswalder Health Insurance website.

7 These regulations were approved by the Board on 19 June 2025 and enter into force on 1 January 2026. All previous provisions on daily allowance insurance are thus null and void. This does not apply to the daily allowances applying when these regulations came into effect, which will be granted for a further two years in accordance with the provisions of the current law on the duration of benefits.