You can also use our online calculation or online application!

The Loss of Occupation - Insurance for flight attendants – the Highlight´s

Your flight permission and the associated medical fitness secure your regular income and thus your standard of living for you.

Our offer convinces by first-class special conditions:

- Cover for Accidental Death, Accident & Illness Loss of Sight, Limb, Speech or Hearing and/or Accident & Illness Permanent Total Disablement.
- Cover is also available without accidental death or as a temporary total disablement cover.
- Potential coverage until the age of 67. The contract is renewed from year to year and can be adjusted from both sides due to the main renewal date.
- We have waived the option of requesting that you seek other work. This means that you can work in any other occupation after losing your profession without this affecting your entitlement to the one-off lump-sum payment.
- One-off lump-sum payment – no risk of your monthly annuity being cut or stopped
- Same premiums for men and women. As a risk premium that is fixed in each age-dependent.
- With our NCB tariff, you can reduce your premium by 20% from the 2nd year of insurance!

In addition, the following benefits apply:

- Insurance coverage world-wide.
- Extended war risk clause (deployment of German armed forces, police or UN).
- No surprise clauses.
- Customer-friendly application questions.
- Annual query of the sum insured and medical conditions to avoid over- or under-insurance.
- Sum insured of up to five times your annual income, maximum CHF 5,000,000.
- The policy can be issued in the German or English language.
- The insurance currency can be EUR, CHF, USD or GBP.
- You can contribute annually, semi-, quarterly or monthly pay. For the latter, however, with a Rate surcharge.

Please note:

- You can live and work in Switzerland or Great Britain, the insurance coverage is provided worldwide.

Restrictions

- Your airline must not be on the "black list".

☞ Office address
Wunderlich Financial Consulting GmbH
Erlenstr. 27
CH – 2555 Brügg

☞ Contact details
Tel. +41 32 5520570
Fax. +41 32 5520571
Email. office@wunderlich-consulting.net
https://www.wunderlich-consulting.net

☞ Board
Claus Wunderlich
Filip Apostolov

WUNDERLICH
FINANCIAL CONSULTING

Premium table

Entrance Age	Annual premium Accidental Death per 1.000 € Insurance sum	Annual premium Permanent total disablement PTD per 1.000 € Insurance sum	Annual premium Daily benefit TTD after 43rd day* per 1 /day Insurance sum
till 35	3.20	4.00	4.81
36 - 45	3.20	5.60	6.73
46 - 50	3.20	7.90	9.43
51 - 55	3.20	11.80	14.18
from 56	3.20	18.60	22.64

* You can also insure other waiting periods. Calculation basis is always the premium rate from the 43rd day

Daily benefit from the 29th day with a surcharge of 20%
Daily benefit from the 75th day with a discount of 45%
Daily benefit from the 180th day with a discount of 69%

Daily benefit from the 60th day with a discount of 30%
Daily benefit from the 90th day with a discount of 60%
Daily benefit from the 365th day with a discount of 84%

In a cover period of 730 days, the premium will increase by 20%. A benefit period up to the 1095th Day is possible for an additional fee of 31%.

Maximum Insurance Sum:

• PTD	five-time gross annual salary, maximum 5,000,000
• TTD	80% of gross annual salary, maximum 13,699 per day
• Accidental Death	maximum 5,000,000

but all together not more than CHF 5,000,000!

Example:
• Annual salary: 40,000 (gross income liable to social security)
• Entrance age 30 years

• Complete Incapacity PTD:
5 x 40,000 = 200,000 x 4.00 / 1,000 = **800.00 annuity**
or 71.33 monthly

• Daily TTD after the 43rd day for max. 365 days:
75% von 40,000 = 30,000 / 365 = 82 per day x 4.81 = **394.42 annuity**
or 35.17 monthly

• Accidental death:
200,000 x 3.2 / 1,000 = **640.00 annuity**
or 57.07 monthly

Please note that in some countries or product combinations insurance tax incurred. This is also still to be paid.

All premiums and sums insured are given in CHF. Other currencies are possible.

Specials:

- Contrary to the exclusion under section 3, flying in the course of your occupational duties is covered.

The above descriptions are only summaries. The General Terms and Conditions of Insurance (model terms and conditions, tariffs with tariff conditions, etc.) are authoritative.

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Application form for professional disability insurance – CH/GB

Wunderlich Financial Consulting GmbH
Erlenstr. 27
CH-2555 Brügg
office@wunderlich-consulting.net
www.wunderlich-consulting.net

Broker:

Notice on behalf of potential insurers:
Please note that we ask the following questions on behalf of the insurers named in the general customer information, who might cover your risks. The insurers will make a decision to accept or decline the contract based on your answers.

Policyholder (PH):	Surname Forename
Date of birth/tax id. number:	/
Email*/Cell phone*:	/
Address:	
Insured person (IP):	Surname Forename
Date of birth/tax id. number:	/
Email IP*/Cell phone*:	/
Address:	
Marital status:	❑ Married ❑ Divorced ❑ Widowed ❑ Single Gender: Number of children:
Profession / Other income:	
Employer:	Annual income in requested currency:
Endowment Beneficiary	❑ PH ❑ IP ❑ Other: Date of birth:
Death Beneficiary	❑ PH ❑ IP ❑ Other: Date of birth:

* Is absolutely necessary

Start of coverage (1): _____, 00.00 a.m. Annual premium*: _____

* + current insurance tax, if applicable

Currency: ❑ EUR ❑ CHF ❑ USD ❑ GBP ❑ Provisional coverage (1

Payment: ❑ annual ❑ biannual + 3% ❑ quarterly + 5% ❑ monthly + 7% (Minimum payment 50.00)

The contract period is 1 year and is tacit extended by one more year, if not cancelled at least 60 days before the main due date.

(1) Start of coverage: upon our receipt of the insurance application, duly completed and signed, on the condition that the insurer or his representative accepts and that the premium is paid by the insured person or the policyholder. Should you apply for provisional coverage, you shall waive any right to withdrawal or objection. The provisional coverage shall be granted, however, subject to medical assessment of the risk and on the condition that the premium has been paid. The policyholder shall be bound to the application for 4 weeks.

Type of coverage		Minimum sum	Insurance sum	Coverage	Term in days
DEATH:	**Accident**	50,000			
DISABILITY:	**Accident and illness**	50,000			
DAILY BENEFIT:	**Accident and illness**	30		from day _____.	❑ for max. 365 days ❑ for max. 730 days ❑ for max. 1095 days

❑ I would also like to apply the terror cover. The premium increases by 10%.

Direct debit authorization and SEPA direct debit mandate in EUR

☒ Mandate for recurring payments Mandate reference number and Creditor ID will be communicated separately.

I/We hereby grant "Wunderlich Financial Consulting GmbH" permission to collect premiums from my/our bank account by direct debit. At the same time I/we shall instruct my/our bank to clear the direct debits drawn from my/our account. Note: I/We may demand a refund of the amount debited at my/our bank within eight weeks from the debit date. The direct debit conditions agreed with my/our bank shall apply.

IBAN _____ BIC_____

Name of bank	Place	Date	Signature of account holder
_____	_____	_____	X _____

Please fill in only if policyholder/applicant is different from account holder/payer.

_____
Name, street, house number, zip code, city and country

Was the insured person already insured for the same risk? ❑Yes ❑ No

If yes, reason for termination: _____ Insurance company: _____

Do you already have a similar insurance contract? ❑ Yes ❑ No

If yes, with which company(ies)? _____

Insurance amounts: Death _____ Invalidity _____

Incapacity _____ Daily benefit _____

Confidential medical questionnaire

For questions with several possible answers, please circle the appropriate answer

Please always state the beginning and the end as well as the type of treatment for all answers. Also if you are now treatment and complaint free. If you have answered yes to the questions, please provide details on a supplementary sheet.

Height:_____ Weight:_____

				If, give data (Kind, reason, duration, consequences,…)	Date
1	Do you currently suffer from a disability or illness that makes you fully or partially incapacitated for work?	Yes	No		
2	Do you receive a disability benefit?	Yes	No		
3	For women: Are you pregnant?	Yes	No		
4	Are you receiving medical treatment? If yes, since when?	Yes	No		
5	Have you already had a test for AIDS (with a positive result)? If so, when?	Yes	No		

In the last 10 years:

6	Do you suffer from, or have you ever suffered from, depression, neuropathy or paralysis?	Yes	No		
7	Do you suffer from, or have you ever suffered from, a rheumatic illness or a medical condition affecting your bones, joints or ligaments?	Yes	No		
8	Do you suffer from, or have you ever suffered from, a chronic or hereditary condition such as asthma, malaria, allergy etc?	Yes	No		
9	Have you ever been fully or partially incapacitated for work for longer than 14 days as a result of accident or illness, or under medical treatment for longer than 14 days?	Yes	No		

In the last 5 years:

10	Do you suffer or have you suffered from any other illnesses, disorders or complaints (even if they have not been treated by a doctor)?	Yes	No		
11	Have you suffered an accident?	Yes	No		
12	Have you stayed in a convalescent home or rehabilitation centre?	Yes	No		
13	Have you undergone any surgery?	Yes	No		
14	Have blood, urine, x-ray or other tests been carried out on you?	Yes	No		

Instructions pursuant to section 4-6 of the Insurance Contract Act (VVG) regarding the consequences of a breach of the statutory duty of disclosure

Dear customer,
In order for us to properly assess your application or non-binding request for an insurance proposal, you are obliged to answer the enclosed questions fully and truthfully. You must disclose even the circumstances you consider to be of little or no importance.

Information which you do not want to provide to the insurance broker must be provided in writing directly to Wunderlich Financial Consulting GmbH, Erlenstr. 27, CH-2555 Brügg, office@wunderlich-consulting.net, Fax +41 32 5520571.

Should a person other than the policyholder be insured, you and this person shall be responsible for answering these questions fully and truthfully.
Please note that your cover may be jeopardised should you provide incorrect or incomplete information. The following information contains further details about the consequences of a breach of the duty of disclosure. Should you send us a non-binding request for an insurance proposal, we require your complete and true information in order to be able to provide you with an offer for the conclusion of the desired insurance contract. In this case, please note that our proposal is only valid provided that, until your "declaration as to the conclusion of a contract"[1] (declaration of intent to conclude a contract; contractual agreement) which may be found in the declaration of acceptance, there have been no changes to the information provided by you previously and – if not the same person – by the insured person.
Should your situation change before the declaration of acceptance, with the result that the questions asked by us would be answered differently than before, you and the insured person shall be obliged to notify us of these changes. When you submit the contractual agreement, we shall expressly ask you and the insured person to give us a binding confirmation that the questions asked by us regarding the insurance contract have been answered fully and truthfully and that you have notified us of any changes.

What is the precontractual duty of disclosure?
By the time of submission of your contractual agreement, you are obliged to fully and truthfully disclose all risk-relevant circumstances about which we asked in writing. You are also obliged to answer should we make a written request for information regarding risk-relevant circumstances after your contractual agreement but prior to acceptance of the contract.

What are the consequences of a breach of precontractual duty of disclosure?

1. Cancellation and loss of insurance cover
Should you breach the precontractual duty of disclosure, we shall have the right to cancel the contract. This shall not apply if you establish that this breach was neither wilful intent nor gross negligence.
In the case of gross negligence our right to cancellation shall be excluded if we would have concluded the contract, even under different conditions, in full knowledge of the undisclosed circumstances.
In the case of cancellation, there shall be no insurance coverage. Should we declare cancellation after an insurance claim arises, we shall still be obliged to honour valid insurance claims[2], provided that you establish that the circumstances which were not mentioned or mentioned incorrectly did not cause
–the occurrence or determination of the insurance claim
– nor the determination or the scope of our "duty to perform" (e.g. duty to indemnify or honour valid insurance claims).
However, our obligation to pay shall lapse, if you have maliciously breached the duty of disclosure.
In the case of cancellation, we shall be entitled to the part of the premium which would have been due from the start of the contract until the declaration of cancellation entered into force.

2. Termination
Should you breach the precontractual duty of disclosure without fault or only by simple negligence, we shall have the right to terminate the contract after giving one month's notice.
Our right to terminate shall be excluded if we would have concluded the contract, even under different conditions, in full knowledge of the undisclosed circumstances.

3. Contractual amendments
If we are unable to cancel or terminate because we would have concluded the contract, even under different conditions, if we had been in full knowledge of the undisclosed circumstances, the other conditions shall become a contract component upon our request. If you have breached the duty of disclosure without fault, the other conditions shall become a component of the contract only starting from the current insurance period.
If the premium increases by more than 10% as a result of the amendment to the contract or should we exclude risks for the undisclosed circumstances, you may terminate the contract without notice within one month after you have received notification of the amendment to the contract. We shall advise you of this right in our notification.

4. Exercising our rights
We may exercise our right of cancellation, termination or amendment in writing only within a period of one month. This period starts the moment we become aware of the breach of the duty of disclosure which justifies us exercising our rights. When exercising our rights, we must state the circumstances on which we have based our decision. As justification we may also subsequently state other circumstances as long as the period according to sentence 1 above has not expired.
We cannot invoke our right of cancellation, termination or amendment if we were aware of the undisclosed circumstance or the inaccuracy of the disclosure.
Our right of cancellation, termination or amendment shall lapse upon expiration of five years after conclusion of the contract. This shall not apply to insurance claims which were made before the expiration of this period. If you have intentionally or maliciously breached the duty of disclosure, the period shall be ten years.

5. Representation by another person
Should you be represented by someone else when concluding the contract, the knowledge and malice of your representative as well as your own knowledge and malice shall be taken into account with regard to the duty of disclosure, the right of cancellation, termination, amendment and expiration period for exercising our rights. You may assert the defence that the breach of the duty of disclosure was neither by intent nor by gross negligence, as long as you and your representative are not guilty of wilful intent or gross negligence.

[1] according to the wording in the official translation of the Swiss Civil Code.
[2] according to the wording in the official translation of the Swiss Civil Code.

Instructions regarding withdrawal[3] / revocation (for customers only)

1. Right of revocation

You may revoke your contractual agreement in writing (e.g. letter, fax, email) without given reason within a period of 30 days. The period begins after you have received the insurance policy, the contractual provisions including the contractual documents, the information pursuant to Art. 3 of the Federal Insurance Contract Act (VVG) and these instructions, each in text form. Timely dispatch of the revocation is sufficient to comply with the revocation period. The withdrawal is to be sent to:

Wunderlich Financial Consulting GmbH, Erlenstr. 27, CH-2555 Brügg, office@wunderlich-consulting.net, Fax +41 32 5520571.

2. Consequences of revocation

Insurance coverage shall be terminated in the event of an effective revocation, and we shall be obligated to repay the share of the premiums paid for the period after receipt of the revocation, if you had agreed that the insurance cover commences prior to the end of the revocation period. In this case, we may retain the share of the premiums paid until receipt of revocation; this is the amount of the relevant portion of the annual premium which is calculated as follows: number of days on which insurance cover existed multiplied by 1/360 of the annual premium. The duty to reimburse shall be fulfilled without undue delay, at the latest 30 days after receipt of the revocation. If the insurance cover does not commence prior to the end of the revocation period, we shall reimburse the insurance premiums paid and any claimed benefits (e.g. interest) upon effective revocation.

3. Special instructions

Your right of revocation shall cease to apply if the contract has been wholly fulfilled by both sides at your explicit request before you have exercised your right of revocation. You shall have no right of revocation for contracts with a duration of less than two months or for contracts with provisional coverage. If you revoke an insurance contract replacing or modifying an already existing contract with the insurer, your original insurance contract shall remain in force.

Declaration of consent to data protection (data storage, transfer and request)

Data protection notice

As of 25.05.2018, the EU General Data Protection Regulation (GDPR) is effective in all member states of the European Union. The reversed Federal Act on Data Protection of Switzerland applies from 01.01.2022.
The GDPR standardises the rules for processing personal data. This ensures the protection of personal data overall, and guarantees the free movement of data within the European Union. The new provisions of the GDPR place particularly high emphasis on transparency in data processing and extensive rights of the data subjects.
Information on data protection is also available on the internet at https://www.wunderlich-consulting.net/en/privacy-policy
With this notice, we hereby inform you of the processing of your personal data by us and the insurers and the rights you are entitled to according to data protection law.

Persons responsible for the data processing (controllers)

Wunderlich Financial Consulting GmbH, Erlenstr. 27, 2555 Brügg, Switzerland
Managing directors: Claus Wunderlich, Filip Apostolov
Tel. + 41 32 5520570, Fax +41 32 5520571, office@wunderlich-consulting.net, www.wunderlich-consulting.net

as well as the respective insurers.

Purposes and legal bases of the data processing

We (Wunderlich Financial Consulting GmbH and the respective insurers) process your personal data in compliance with the EU General Data Protection Regulation (GDPR), Federal Act on Data Protection (DSG), the provisions of the Insurance Contract Act (VVG) relevant to data protection law as well as all further applicable laws.

When you make an application for insurance coverage or request a quote, we require the information provided by you here to conclude the contract or provide the quote and to estimate the risk to be assumed by us. If the insurance contract comes into effect, we process these data for the performance of the contractual relationship, e.g. to issue policies or invoices. We require details in the event of a claim, for example, in order to verify whether an insured event has occurred and what the extent of the payout is.

The conclusion i.e. the performance of the insurance contract is not possible without the processing of your personal data.

Beyond this, we require your personal data in order to create insurance-specific statistics, such as to develop new tariffs or to fulfil regulatory requirements. We may use the data of all contracts concluded with us for an observation of the overall customer relation, for example for consultation regarding an adjustment or supplement to the contract, for making decisions on goodwill gestures, or for the comprehensive provision of information. The legal basis for this processing of personal data for pre-contractual and contractual purposes is Art. 6 Para. 1b GDPR. If special categories of personal data (e.g. your health data upon concluding an insurance contract) are necessary for this purpose, we seek your consent in accordance with Art. 9 Para. 2a in connection with Art. 7 GDPR. If we create statistics using these data categories, this occurs on the basis of Art. 9 Para. 2j GDPR in connection with DSG.
We also process your data in order to preserve our interests or those of third parties (Art. 6 Para. 1f GDPR). This can be necessary in particular:

- to ensure IT security and IT operations,
- to advertise our own insurance products and their cooperation partners as well as to carry out market and opinion surveys,
- to prevent and clear up offences, we use data analyses in particular to detect signs that may point to insurance fraud.

In addition to this, we process your personal data in order to fulfil legal obligations such as regulatory requirements, commercial and fiscal obligations to retain data, or our duty to give advice. In this case, the legal basis for the processing is formed by the respective legal regulations in connection with Art. 6 Para. 1c GDPR. If we wish to process your data for a purpose that has not been mentioned, we will inform you of this beforehand in the context of the legal provisions.

Categories of recipients of personal data

Reinsurers:
Risks assumed by the insurers can be insured with special insurance companies (reinsurers). For this, it may be necessary to transmit the data of your contract and potentially of your claim event to a reinsurer so that the reinsurer can form a more complete picture of the risk or the claim event.
Intermediaries:
If you are attended to by an intermediary with regard to your insurance contracts, your intermediary processes the application, quote, contract and claim data required for the conclusion and performance of the contract. Our company also transmits these data to the intermediaries who serve you if they require this information to serve and advise you in your insurance and financial service matters.
External service providers:
We partially make use of external service providers in order to fulfil our contractual and legal obligations. You can request the currently valid list of the contractors and service providers used by us with whom we have more than just temporary business relations at any time.
Further recipients:

[3] according to the official translation of the German Civil Code for *Widerruf*.

Beyond this, we may transmit your personal data to further recipients, such as to authorities in order to fulfil legal reporting obligations (e.g. social insurance agencies, financial authorities or law enforcement authorities).

Duration of the data storage
We delete your personal data as soon as they are no longer required for the purposes stated. What may occur here is that personal data are stored for the period in which claims can be asserted against our company or the respective insurers (legal limitation period of three or up to thirty years). In addition, we also store your personal data insofar as we are legally obliged to do so. Corresponding obligations to provide evidence and to retain data arise from, among other things, the Commercial Code, the Fiscal Code and the Money Laundering Act. In accordance with these, the storage periods amount to up to ten years after termination of the contract.

Data subject rights
You can request information on the data stored on your person at the stated address. In addition, you can request the rectification or deletion of your data under certain circumstances. Furthermore, you may have a right to restriction of the processing of your data as well as a right to issuance of the data provided by you in a structured, common and machine-readable format.

Right of objection
You have the right to object to the processing of your personal data for the purposes of direct advertising. If we process your data in order to preserve legitimate interests, you may object to this processing if your particular situation provides reasons against the processing of the data.

Right of appeal
You have the possibility to lodge a complaint with a data protection supervisory authority in your country of residence.

Automated individual decisions
Based on your statements on risk, which we ask you about when you make an application or request a quotation, we can make fully automated decisions, for example regarding the conclusion of the contract, potential risk exclusions or the amount of the premiums to be paid by you.

Consent to the Elicitation and Use of Health Data and Authorisation to Release from the Obligation to Secrecy

The provisions of the Insurance Contract Act, the Data Protection Act and other data protection regulations do not contain sufficient legal foundations for the elicitation, processing and use of health data by insurance companies. In order to be allowed to elicit and use your health data for this application and the contract, pursuant to data protection legislation **Wunderlich Financial Consulting GmbH** (hereinafter referred to as WFC GmbH) and the **insurance company with which the insurance contract was concluded** therefore requires your consent(s). In addition, the insurance company with which your insurance contract was concluded, requires your authorisations to release bodies from the obligation to secrecy in order to be allowed to elicit your health data at points subject to secrecy like, e.g. medical practitioners. Being a life insurance (health insurance) undertaking, the insurance company requires such release from the obligation to secrecy in order to be allowed to forward your health data or other data protected under the Criminal Code, like, e.g. the fact that a contract with you exists, to other agencies, e.g. IT providers.

The following declarations of consent and release from the obligation to secrecy are indispensable for assessing your application as well as for establishing, performing or terminating your insurance contract. Should you not provide them, as a general rule conclusion of the contract would not be possible.

The declarations concern the handling of your health data and other data protected under the Criminal Code
- by WFC GmbH and by the insurance company itself (under 1.),
- in connection with making enquiries at third parties' (under 2.),
- when forwarding to agencies external to the insurance company (under 3.) and
- if the contract does not come into being (under 4.).

The declarations also apply to any persons legally represented and to be co-insured by you, like your children, to the extent the latter fail to recognise the consequences of such consent and are therefore unable to submit their own declarations of consent.

1. Elicitation, Storage and Utilisation by the Insurance Company of Health Data Communicated by You
I consent to WFC GmbH's and the insurance company's eliciting, storing and using the health data communicated by me in this application and in future to the extent this is necessary for review of the application and for establishing, performing or terminating this insurance contract.

2. Queries About Health Data at Third Parties'

2.1. Making Enquiries About Health Data at Third Parties' for the Purpose of Risk Assessment and for the Purpose of <u>Review of the Duty to Provide Benefits</u>

For the assessment of the risks to be insured, it may be necessary to obtain information from bodies that are in possession of your health data. In addition, it may be necessary for the purpose of reviewing duty to provide benefits that the insurance company must subject to scrutiny the data on your health circumstances that you provided in order to establish claims or that ensues from the submitted documents (e.g. invoices, statutory instruments, expert opinions) or communications e.g. of a medical practitioner or of other parties belonging to a healing profession.
Such review will only take place if necessary. For this, the insurance company needs your consent, including a release from the obligation to secrecy for itself and for these bodies, if health data or other information protected has to be passed on within the framework of this query. You may grant these declarations already at his point (Option 1) or later in the individual case (Option II). You may change your decision at any time. Please select one of the two following options:

<u>Option I:</u>
❑ I give my consent – if required for the risk assessment or for review of the insured event – to the insurance company's eliciting my health data from medical practitioners, care personnel and employees of clinics, other hospitals, care homes, health insurers, statutory health insurance companies, trade associations and authorities, and using it for these purposes. I release the stipulated persons and employees of the stipulated facilities from their obligation to secrecy to the extent my admissibly stored health data from examinations, consultations, treatments and insurance applications and contracts from a period of up to ten years prior to application are transmitted to the insurance company. I furthermore agree in this connection – if required – to the passing on of my health data to these bodies and in this respect also release the persons employed by the insurance company from their obligation to secrecy.
Prior to each elicitation of data pursuant to the above paragraphs, I will be informed as to who the data is to be elicited from and for what purpose and it will be pointed out to me that I may object and provide the necessary documents myself.

<u>Option II</u>:
❑ I wish the insurance company to notify me in each individual case about what persons or organisations require the information and for what purpose. I will then decide in each case:
Whether I agree to such elicitation and use of my health data by the insurance company, whether I release the person or organisation, and his/her/its employees from their obligation to secrecy and whether

- I consent to the transfer of my health data to the insurance company
- or whether I provide the required details myself.

I am aware that this may lead to a delay in the processing of the application, or in the review of the duty to provide benefits.
To the extent the above statements refer to the details provided by me when applying for insurance, they will be effective for a period of five years subsequent to conclusion of contract. If there are specific indications that incorrect or incomplete details were intentionally provided when insurance was applied for, the period will be ten years and for this reason the assessment of risk was influenced, the statements will be effective for a period of up to ten years subsequent to conclusion of the contract.

2.2. Statements in the Event of Your Death
For the purpose of reviewing the duty to provide benefits, it may be necessary to review your health data even after your death. A review may also be necessary if up to ten years subsequent to conclusion of contract, for the insurance company concrete clues reveal that when the application for insurance was made incorrect or incomplete details were provided and for this reason the assessment of risk was influenced. The insurance company requires consent and release from the obligation to secrecy also for this purpose. Please select one of the two following options:

Option I:
❑ In the event of my death, I give my consent that my health data may be elicited by third persons for review of liability or necessary new review of application as described in the first tick box (see 2.1. above – First Option).

Option II:
❑ If – for the purpose of reviewing the duty to provide benefits or of necessary new review of application – it should be necessary to collect health data after my death, decision-making authority in respect of declarations of consent and release from the obligation to secrecy will pass to my heirs or – if this is deviatingly provided for – to the beneficiaries of the contract.

3. Disclosure of your health data and other data protected under the Criminal Code to bodies external to the insurance company
The insurance company will contractually oblige the following bodies to observe the regulations on data protection and data security.

3.1 Disclosure of Data for Medical Examination
For the assessment of the risks to be insured and for review of the duty to provide benefits, it may be necessary to call in medical experts. The insurance company needs your consent and release from the duty to maintain secrecy if your health data and other data protected under § 203 of the Criminal Code are transferred in this connection. You will be notified of a transfer of data in each case.
I consent to the insurance company's transferring my health data to medical experts, to the extent this is necessary within the framework of risk review or review of the duty to provide benefits and that my health data is used there in accordance with their designated purpose and that the results are transmitted back to the insurance company. In respect of my health data and other data protected under the Criminal Code, I release the persons working on behalf of the insurance company and the experts from their duty to maintain secrecy.

3.2 Transfer of Tasks to Other Bodies (Companies or Persons)
Particular tasks such as processing insured events or customer assistance by telephone, in connection with which the collection, processing or use of your health data may become necessary, are in some cases not carried out by the insurance company itself but their discharge is transferred to another company of the insurance group, or another body. If your data protected under the Criminal Code are disclosed in this connection, the insurance company needs your release from the duty to maintain secrecy for itself and, if required, for the other bodies.
For the disclosure of your health data and their use by the bodies mentioned above, the insurance company needs your consent.
I consent to the insurance company' transferring of my health data to the bodies specified in the list mentioned above and to my health data being collected, processed and used there for the specified purposes to the same extent as the insurance company would be allowed to. To the extent required, I release the employees of the insurance company, and of the insurance company's group of undertakings, and of other bodies from their duty to maintain secrecy in respect of the disclosure of health data and other data protected under the Criminal Code.

3.3 Disclosure of Data to Reinsurance Companies
To insure satisfaction of your claims, the insurance company may conclude contracts with reinsurance companies who assume the risk insured in whole or in part. In some cases, these reinsurance companies use for this purpose other reinsurance companies to whom they likewise transmit your data. The insurance company may submit your application for insurance or request for payment to the reinsurance company so that the reinsurance company can gain its own impression of the risk or the insured event. This would be the case, in particular, if the cover sum is extremely high or the risk is difficult to assess.
Furthermore, it is possible that a reinsurance company – on grounds of its special expert knowledge – will assist the insurance company when analysing risks and payments and when evaluating procedures.
If a reinsurance company has assumed insurance against a risk, it can oversee whether the insurance company has correctly assessed the risk or an insured event.
Moreover, data relating to your existing contracts and applications will be disclosed to reinsurance companies to the necessary extent so that they can review whether and to what extent they can participate in the risk. Also data relating to your existing contracts may be disclosed to the reinsurance company for the settlement of premiums and insured events.
For the above purposes, anonymised, or pseudonymised data, respectively, are used if possible. Your personal data will be used by the reinsurance companies only for the purposes specified above. You will be informed by the insurance company when your health data are transferred to reinsurance companies.
I consent to my health data being transferred to reinsurance companies – to the extent necessary – and used there for the purposes mentioned. To the extent necessary, I release the persons working on behalf of the insurance company from their duty to maintain secrecy with respect to the health data and other data.

3.4 Disclosure of Data to Independent Intermediaries/Brokers
The insurance company generally does not disclose any details relating to your health to independent intermediaries. However, in the following cases it may be possible that data allowing conclusions to be drawn on your health, or information protected under the Criminal Code relating to your contract are made known to the intermediary.
To the extent it is required for consulting purposes related to the contract the intermediary supporting you may obtain information on whether and, where appropriate, under what circumstances (e.g. acceptance with a risk surcharge, exclusions of certain risks) your contract can be accepted.
The intermediary of your contract learns that your contract was concluded and with what content. At the same time, the intermediary also learns whether surcharges for risks or exclusions of particular risks have been agreed.
In the event of a change from the intermediary supporting you, to another intermediary, transmission of contractual data including the information on existing risk surcharges and exclusions of certain risks may occur. In the event of a change the intermediary supporting you to a different intermediary you will be informed prior to the passing on of health data and also your objection options will be pointed out to you.
I consent to the insurance company's transmitting my health data and other data protected under the Criminal Code in the above-mentioned cases – if necessary – to the independent insurance intermediary and to such data's being elicited, stored and allowed to be used for consulting purposes.

4. Storage and Use of Your Health Data if the Contract Fails to Come About

If the contract with you fails to come about, WFC GmbH and the insurance company may store the health data elicited in the context of the risk assessment in case you re-apply for insurance cover. The insurance company stores your data also so as to be able to answer possible enquiries of other insurance companies. Your data will be stored with the insurance company until the end of the third calendar year after the year the application was made.

I consent to WFC GmbH's and the insurance company's storing and being allowed to use my health data – if the contract fails to come about – for a period of three years from the end of the calendar year of making the application for the above-mentioned purposes.

Closing declaration by the policyholder and person to be insured

1. Miscellaneous

This insurance application serves as the basis for processing the insurance contract. If the person required to provide information conceals or incorrectly states an important fact which they knew or should have known when concluding the contract (concealment), the insurer shall not be bound by the contract if it is cancelled within 4 weeks after the insurer becomes aware of the breach of the duty of disclosure.

2. Responsibility for the application

Your broker shall advise you during the conclusion of the contract. Please check the information which you have provided, or which the broker has provided on your behalf, in this application or other documents, for accuracy and completeness, otherwise you may put your insurance cover at risk.

3. Declaration by the person to be insured for the benefit of a third party

I hereby agree that the applicant is authorised to conclude this insurance in my name in their favour and thus to be beneficiary. I am aware that my heirs and I shall not be entitled to any claim for indemnity.

4. Additional closing joint declaration

I shall be bound by this application for one month. I am aware that the insurance cover shall not commence until I have paid the agreed premium and that any provisional insurance commitments shall lapse retroactively if the initial premium is not paid within two weeks after presentation of the insurance certificate.

5. Remuneration

If an insurance contract between me and an insurer is concluded on the basis of this application, WFC is entitled to remuneration. If I pay the owed single or term premium (hereinafter "premium") to the insurer, WFC's claim for remuneration against me is settled. The amount of the premium owed is determined by the Certificate of Insurance or the Cover Note to this application, even if the premium stated in the application is lower. If I do not pay the premium owed, WFC's claim for compensation will be equal to the lost insurance commission - usually at least 25% of the premium owed. WFC will claim this immediately after termination, unless I prove a lower damage. The assertion of actually higher claims for damages remains reserved. A partial payment will be charged to the damage compensation. WFC is entitled to assign claims for damages.

With my signature I confirm that I have provided the above information to the best of my knowledge and ability. Verbal agreements shall be invalid. I am aware that the insurer may withdraw from the contract or refuse to indemnify should the information be incorrect or incomplete. All notices and declarations of intent for the insurer must be made in writing. I have been provided with a copy of the application.

WFS is authorised to conclude the insurance contract on behalf of the insurers. WFS is in particular granted power of cancellation and collection. I have taken note of this before submitting my application and acknowledge that this power of attorney exists.

Place / Date	X Signature of policyholder
Place / Date	X Signature of insured person
Place / Date	X Signature of legal representative
Place / Date	X Signature of legally represented person (in the case of the required ability to reason, at the earliest from completion of the 16th year of age)
Place / Date	X Signature of broker/broker number

I hereby confirm that before submitting my contractual declaration I have received clear and legible contract documents, including the Insurance Conditions for professional insurance BUB 2024* and the information according to the Insurance Contract Act Information Regulation (*VVG-Informationspflichtenverordnung*), the insurance claim information, the premium table and also the terms and conditions of WFC GmbH in writing. They are therefore a component of the contract. * as at: 01.2024

I hereby grant permission to WFC to select or change the insurer at the beginning of or during the contract as long as the original conditions remain the same or are changed for the better (insurance premium table, conditions, medical decisions).

Place / Date	X Signature of policyholder

Please do not print out this application, but complete it and return it to us on the computer.

Record of consultation

General

Policyholder:

Consultation with:

Date of consultation: _____ from _____ am/pm to _____ am/pm

Place: _____

Participants: _____

Reason for consultation - customer's request

_____

_____

_____

Content of consultation - advice/rationale - customer's decision

_____

_____

_____

_____

_____

_____

_____

_____

❑ **further record in addendum**

Please see our basic/customer information regarding the data required by law.
Insurance coverage starts only after acceptance of the contract (issuing of policy) by the insurance company and payment of the first premium.

_____ _____

(Date, signature of policy holder) (Date, signature of insurance agent)

This English translation may be used for information purpose only, the German wording prevails in case of litigation.

Contract documents from your coverholder (contract manager)

for professional disability insurance
BUB 2024
Stand 01.2024

The contract documents organise into six sections:

I. GENERAL CUSTOMER INFORMATION

Company information
Below is an overview of the possible companies for your contract. Please refer to your application or offer for the company which particularly matches your contract.

Lloyd´s Insurer London

1. Identity and address of the insurer:
Lloyd´s London, Branch Zurich
Seefeldstr. 7, 8008 Zürich, Switzerland
Phone: +41 44 266 6070
Internet: www.lloyds.com
Legal form: Union of Insurance companys
Location: London, UK

2. Main business activity of the insurer / Name and address of the competent supervisory authority
The insurer provides property, casualty and accident insurance.
The supervisory authority is the Financial Conduct Authority (FCA), 25 The North Colonade, Canary Wharf, London E14 5HS, UK. The Prudential Regulation Authority (PRA), 20 Moorgate, London EC2R 6DA, United Kingdom
Lloyd's Underwriters London is authorised by The Prudential Regulation Authority (PRA), 20 Moorgate, London, EC2R 6DA, United Kingdom.
The supervisory authority of the Swiss branch is the Swiss Financial Market Supervisory Authority FINMA, Laupenstrasse 27, 3003 Berne, tel. +41 31 327 91 00, fax +41 31 327 91 01, info@finma.ch.

The principal business activity of Lloyd's Underwriters is non-life insurance, life insurance and reinsurance.

and other syndicates / insurance companies / underwriters on behalf of Lloyd's London, as the case may be, and other insurance companies or underwriters of similar credit standing.

Switching to a different insurer
On the possibility of the change according to § 2 of the powers of the Wunderlich Financial Consulting GmbH we indicate.

Your contract manager (coverholder) is:

Wunderlich Financial Consulting GmbH
Erlenstr. 27, 2555 Brügg, Switzerland
Director: Claus Wunderlich, Filip Apostolov
T. + 41 32 5520570, F. +41 32 5520571
office@wunderlich-consulting.net, www.wunderlich-consulting.net

For the aforementioned insurance company, Wunderlich Financial Consulting GmbH act as underwriter/contract manager (authorised representative of insurer for payment and insurance certificate).

This power of attorney can be transferred to branches, subsidiaries or sister companies of Wunderlich Financial Consulting GmbH. The same applies in reverse order, provided that these companies are authorised representatives.

In addition, Wunderlich Financial Consulting GmbH may use other intermediaries to handle the transaction:
The client (policyholder) authorises Wunderlich Financial Consulting GmbH, its vicarious agents and any legal successor to represent it in the commissioned insurance matters. This power of attorney includes in particular the granting and revocation of sub-authorisations to other insurance intermediaries.

Main features of the insurance contract
The main features of the insurance contract are based on the insurance conditions, including the explanatory notes and clauses. An overview can be found on your application form. For the remainder, the statutory provisions and the law of the Swiss Confederation shall apply.

All of the documentation for your contract can be found attached to this customer information.

These govern the nature, scope, timing and performance of the insurer’s performance.

Total price of the insurance
Please refer to the offer or the application for the total price of insurance in accordance with your preferred payment method. This amount includes the statutory insurance tax.

Additional costs
No other fees and charges are levied for the conclusion of the insurance contract.

In the event of default, we may demand a reminder fee of CHF 30. Should this come to a court order for payment, other fees will be incurred, the amount of which depends on the amount due.

You may be charged for processing fees charged by the banks for a failed direct debit.

In addition, the following flat rate administration costs charges are incurred:

- Issue of a replacement insurance policy or sending the insurance certificate by post CHF 25.
- Issue a tax certificate CHF 25.

When using our service numbers, the normal telephone charges apply.

Payment and performance
The one-off payment is to be made immediately after the date of the start of the insurance period as agreed and specified in the insurance policy, regardless of the existence of a right of withdrawal.

If the agreed date of commencement is prior to the conclusion of the contract, the one-off payment is to be made immediately upon conclusion of contract.

Should the insurance policy differ from the request of the policyholder or from agreements reached, the first or one-off premium is to be paid at the latest one month after receipt of the insurance policy.

In agreements relating to payment by instalments, the first instalment is the first premium payment.

A subsequent contribution will be due on the agreed date of the relevant period of insurance. The payment shall be considered timely if it is initiated within the period specified in the insurance policy or in the premium calculation.

Validity of the information
Unless otherwise agreed, our offers are valid for one month.

If a premium adjustment is performed in the time between the application and the start of the insurance, the premium applicable on the day of the start shall apply.

Formation of contract
The insurance can only be requested through our online application or application form. In the application, please answer the questions truthfully and completely. Please allow sufficient time to do this. Do not make presumptive statements. If you are unsure or have doubts, or can you only vaguely remember, please use all your available opportunities to inform yourself before answering the questions on the respective health situation properly, for example with the help of your doctor.

After receiving an application, we examine if the application can be accepted at normal conditions, using the risk and health information provided.

If the risk assessment shows that an application cannot be accepted on the proposed terms, we examine whether an individual risk exclusion could be created to compensate for the increased risk. If this is not the case, we will defer acceptance of an application for a certain time or refuse to undertake the insurance cover entirely.

An individual risk exclusion always requires your consent, either in the form of a separate consent form to be delivered by you (e.g. when first applying for the insurance) or by way of a marked change in the policy.

The contract is then created upon your receipt of the insurance policy. You are not bound by your application until the end of the withdrawal period (see below). Coverage starts on the agreed commencement date of the insurance, at the earliest from date of receipt of the application by the insurer.

If the first premium has not yet been paid when the risk materialises, we are not required to pay. However, our obligation continues to apply if it can be proved to us that you are not responsible for the non-payment.
Alternatively to the aforementioned process and upon acceptance by us or underwriters, you can also have immediate coverage, if you should expressly request this. This is to be noted on the application. In this case, there will be no medical risk assessment, as all existing illness and their consequences and the consequences of accidents are excluded here.

The insurance coverage begins on the date specified in the policy. This does not apply if you become in arrears with the payment of the first premium (see item 6).

Right of withdrawal
You may revoke your contractual agreement in writing (e.g. letter, fax, email) without given reason within a period of 30 days. The period begins after you have received the insurance policy, the contractual provisions including the contractual documents, the information pursuant to Art. 3 of the Federal Insurance Contract Act (VVG) and these instructions, each in text form. Timely dispatch of the revocation is sufficient to comply with the revocation period. The withdrawal is to be sent to:

Wunderlich Financial Consulting GmbH
Erlenstr. 27
2555 Brügg
Phone: +41 32 5520570
Fax: +41 32 5520571
Email: office@wunderlich-consulting.net

Consequences of withdrawal
Insurance protection will be terminated in the event of effective withdrawal, and we will refund to you the share of the premiums incurred for the period subsequent to receipt of the withdrawal if you have agreed to insurance protection commencing prior to the end of the withdrawal period. We may retain the share of the premium accounted for by the period until receipt of withdrawal in this case; this is the amount of the relevant portion of the annual contribution which is calculated as follows: Number of day on which insurance cover existed multiplied by 1/360 of the annual premium. The refund of repayable amounts will take place promptly, at the latest 30 days after receipt of the withdrawal. If insurance protection does not commence prior to the end of the withdrawal period, effective withdrawal will cause payments received to be refunded and benefits drawn (e.g. interest) to be surrendered.

Special notes
Your right of withdrawal ceases to apply if, at your explicit request, the contract has been fully performed both by you and by ourselves prior to your exercising your right of withdrawal. Upon settlement of contracts for temporary coverage and contracts with a maturity of less than two months you do not have right of withdrawal.
If you withdraw from an insurance contract, which has caused an already existing contract with the insurer to be replaced or modified, your original insurance contract continues to run.

Duration
The contract has been concluded for the agreed duration and shall be renewed automatically for another year if it is not cancelled by the insurer or the policyholder 60 days prior to the respective main due date whereby the wording of § 9 of the insurance conditions must be observed.

Termination of the contract
The insurance contract shall terminate on the expiry of the agreed duration.
For the remainder, a statutory right of termination applies in the following cases:
- for the insurer for non-payment of the subsequent premium

- for the insured party in the case of fee increases
- for the insurer and the insured party after the insurance claim

The details can be found in the stated provisions and the corresponding regulations in the respective terms and conditions.

Applicable law and jurisdiction
All disputes regarding the contractual relationship, including those from prior agreements, are subject to the law of the Swiss Confederation.

Furthermore, the local or regional court in whose district you have your place of residence or, in the absence of such, your usual place of residence at the time the action is brought shall have jurisdiction for claims or actions arising from the insurance contract or insurance mediation. This jurisdiction shall only cease to apply if you move your place of residence or habitual abode outside the area of application of the Insurance Contract Act after conclusion of the contract.

Language

The contract terms and the present information are communicated in German. The communication during the term of the contract is to be in German language.

Out of court complaint and redress procedure
Complaint handling arrangements
Any complaint should be addressed in the first instance to your broker.

The Lloyd's managing agent or the party named above that it has appointed to adjudicate on your complaint on its behalf, will acknowledge your complaint, by text, as soon as possible.
The Lloyd's managing agent or the party named above that it has appointed to adjudicate on your complaint on its behalf, will aim to provide you with its decision on your complaint, by text, within six weeks of the complaint being made.

Should you remain dissatisfied with the final response from the above or if you have not received a final response within six weeks of the complaint being made, you may be eligible to refer your complaint to the following organisation. The contact details are as follows:

Eidgenössische Finanzmarktaufsicht FINMA
Laupenstr. 27
3003 Bern
Phone: +41 31 327 91 00
Fax: +41 31 327 91 01
Email: info@finma.ch

The complaints handling arrangements above are without prejudice to your rights in law.

Several Liability Notice (only Lloyd´s London)
The subscribing insurers' obligations under contracts of insurance to which they subscribe are several and not joint and are limited solely to the extent of their individual subscriptions. The subscribing insurers are not responsible for the subscription of any co-subscribing insurer who for any reason does not satisfy all or part of its obligations.

By the way Lloyds 'chain of security' provides the financial strength that ultimately backs all insurance policies written at Lloyd's. Each Syndicate, like all insurers has its own solvency and financial assets. However, should this prove insufficient, Lloyds provides additional financial protection to its Syndicates via its Members Funds and further through its Mutual Assets including the Central Fund.
For more information and details of the substantial funds that underpin Lloyd's, please click the link below:
https://www.lloyds.com/lloyds/investor-relations/lloyds-capital-structure

Financial Services Compensation Scheme (only Lloyd´s London)
You may be entitled to compensation from the Financial Services Compensation Scheme (FSCS) if We are unable to meet Our liabilities.
This depends on the type of business and the circumstances of the claim. 90% of the claim will be met. For compulsory classes of insurance the claim will be met in full.

Further information about the compensation scheme arrangements is available from the FSCS Information can be obtained on request or by visiting the FSCS website at www.fscs.org.uk.

II. POWERS OF WUNDERLICH FINANCIAL CONSULTING GMBH

§ 1 Notices and declarations of intent

1. **Wunderlich Financial Consulting GmbH** (in the following "WFC") shall be the company in charge of managing all insurance contracts of the insurers.
2. WFC is entitled to receive notices, declarations of intent, notices of claim and premiums as well as to recover outstanding premiums, conduct correspondence and make declarations of intent of any kind in connection with the insurance contract (e.g. withdrawal, termination, rescission). Premiums shall be deemed to have been received at the time of receipt by WFC.
3. The insurer has commissioned WFC to accept or reject applications from policyholders and intermediaries.
4. If the policyholder has changed his/her street or e-mail address but has not informed WFC, a message sent to the last address known by WFC shall be sufficient for any declaration of intent to the policyholder. The declaration becomes effective on the date it would have been delivered under normal conditions if the address had not been changed.

§ 2 Switching to a different insurer

WFC may at any time switch to another company in the name of the policyholder for coverage of the risk covered under this contract and/or have further insurers involved. Should WFC exercise this right, the policyholder shall be informed immediately about the company against which he/she might effectively exercise his/her contractual rights from then on. Any switch to a different insurer does not grant any special right of termination.

This power of attorney can be transferred to branches, subsidiaries or sister companies. The same applies in reverse order, provided that these companies are authorised representatives.

In addition, **Wunderlich Financial Consulting GmbH** may use other intermediaries to handle the transaction:
The client (policyholder) authorises **Wunderlich Financial Consulting GmbH**, its vicarious agents and any legal successor to represent it in the commissioned insurance matters. This power of attorney includes in particular the granting and revocation of sub-authorisations to other insurance intermediaries.

Disablement Insurance
Insurance Product Information Document

WUNDERLICH FINANCIAL CONSULTING

The respective insurer — **Disablement Insurance**

This document provides a summary of the key information relating to this Professional Personal Accident and Illness Insurance Policy. Complete pre-contractual and contractual information on the product is provided in the full policy documentation which contains the full terms, conditions, limitations and exclusions, which you should read and check that it meets your Professional Personal Accident and Illness Insurance requirements. If you have any questions about your coverage or special requirements, please contact your insurance agent or the insurer.

What is this type of insurance?
It is a private professional disability insurance. It protects against risks due to accidental and illness injuries.

What is insured?

Up to the sum insured as shown in the schedule for:

- ✓ **Full profession disability**: Permanent profession disability exists when the insured person is permanently (expected to last longer than 3 years) and completely incapable of actively pursuing the profession activity referred to in the insurance policy due to an accident or illness
- ✓ **Temporary profession disability**: If the insured person's ability to work is affected by an accident or an illness and is receiving medical treatment, we pay a daily allowance for the duration of the medical treatment, up to a maximum is written in the policy. We pay the amount which you are entitled after the treatment. If desired, a 4-week payment schedule may be agreed.
- ✓ **Death Benefit**: A benefit in the event death is paid if the insured person dies within one year because of the accident.

What is not insured?

Unfortunately, we are unable to insure you against all risks and losses. The following cover and risk exclusions are not exhaustive; Further information can be found in within the Policy Document or in the insurance certificate

- ✗ Suicide or attempted suicide, intentional self-harm.
- ✗ war, whether war be declared or not, hostilities or any act of war or civil war.
- ✗ Fly or drive any vehicle (including aircraft) without the corresponding certificate of capacity, driving licence or the appropriate certificate.
- ✗ Alcoholism, obvious intoxication or blood alcohol level that was 1.1‰ at the time of the accident.
- ✗ Drug addiction, excessive intake of non-prescribed drugs or non-compliance with prescription.
- ✗ Nuclear fission or nuclear radiation, unless they are medically prescribed.
- ✗ Terrorist act from nuclear, biological and chemical weapons.
- ✗ Psychiatric illnesses such as psychoses, psychoneuroses, psychogenic reaction or functional disorder of psychological origin according to the classification of the illnesses according to ICD, unless these were caused by an accident or an insured illness insured under this insurance contract.
- ✗ Aesthetic treatments, slimming, rejuvenation treatments, rehabilitation or exercise therapy without function.

Are there any restrictions on cover?
! Individual cover restrictions may underlie your contract.

Where am I covered?
✓ You have worldwide insurance coverage.

What are my obligations?
- You must take reasonable care to give us complete and accurate answers to any questions we ask.
- You must tell us about any changes to the information on the schedule or change which may affect your cover.
- The insured person or the policyholder is to notify the insurer of any accidents or illnesses which result in more than 30 consecutive days of incapacity. Notification is to be given within 90 days following the event giving rise to the incapacity. In the event of death, the beneficiary is responsible for this obligation. The notification must be made no later than submission of the subsequent year information, otherwise the claim will be invalid. (Please note the different notification period for accidental death and temporary sport disability.
- You must pay your premium on time.

When and how do I pay?
The first contribution must be paid no later than two weeks after receipt of the insurance policy. When you have to pay the other contributions, we will inform you. You can transfer the contributions to us or authorize us to withdraw them from your account.

When does the cover start and end?
When the insurance begins, is indicated in the insurance certificate. The prerequisite is that you have paid the first insurance premium on time and in full.

The insurance is valid for the initially agreed duration. Unless otherwise agreed, it automatically renews for another year if you or we do not cancel it.

How do I cancel the contract?
You or we can terminate the contract at the end of the agreed period (this must be done no later than 60 days before). You or we may terminate the contract even if we have provided a service, or if you have brought action against us for performance. Then the insurance ends before the end of the agreed duration.

IV. INSURANCE CONDITIONS FOR PROFESSIONAL DISABILITY INSURANCE BUB 2024

§ 1 Scope of insurance - What is covered?

1.1 The insurer provides coverage for the case of accident (Section 1.4) or illness (Section 1.5), suffered by the insured person during the validity of the contract. The activities that can be insured are found in § 2; the insurance policy shows which types of payment are agreed under the contract.

1.2 An **incident** is an accident or illness that results in an Insured Person being unable to carry out their usual occupational duties.

1.3 The insurance cover is provided around the clock and around the world in carrying out all activities except those that are explicitly excluded under § 3.

1.4 An accident occurs when the insured person suffers a physical health impairment due to sudden external event acting on their body (accident). An accident is also a single, excessive exertion, by which the insured person suffers a bodily injury in particular:

- Dislocations, sprains, bruises, Pubic bone inflammation, burns, scalds, burns (caustic, acid), frostbite, heat stroke, sunstroke and physical injuries which are caused by ultraviolet radiation, with the exception of sunburns.
- Drowning and drowning due to loss of consciousness in cold water.
- Poisoning, burns or poisoning by gases or vapours, toxic or corrosive substances or caused by spoiled food, which were taken by mistake or by the action of third persons.
- Sprains and ruptures of muscles, tendons and ligaments, menisci, vessels, nerves, soft tissues (skin appendages), ligament lesions, Groin breaks, consequences of a soft groin (see athlete's groin).
- Cartilage injuries, fractures, injuries of the central nervous system (SHT, spinal cord).
- Infringements of the internal organs, the sensory organs (eye, ear, nose), eardrum injury, injuries to the teeth and sexual organs (e.g. testicles).

1.5 An illness is an abnormal physical condition which is associated with a disturbance of physical function (physical health damage) and is not attributable to an accident or due to a number of accidents, for example:

- Myocardial infarction.
- Cerebral haemorrhage and aneurysm.
- Dermatitis and varicose veins.
- Syncope and epileptic seizures.
- Low back pain, acute or chronic impairment of the lumbar back, sciatica, sprains and lumbago.
- Effects of air pollution.

1.6 Complete insurance cover is valid when the origin of the accident (Section 1.4) or illness (Section 1.5) or their consequences indicated in the insurance application and existing damage to health before the effectiveness of the contract were involved and policy no individual risk exclusions have been agreed this in the insurance (Section 1.8). Please refer to the pre-contractual obligations (§ 11).

1.7 Please refer to the exclusions (§ 3) and the individual risk exclusions listed in the insurance policy (Section 1.8).

1.8 In the context of the risk assessment, the insurance company reserves the right to refuse acceptance of the application or to make this acceptance contingent on individual risk exclusions. The individual risk exclusions for insured persons are precisely defined in the insurance policy and apply in addition to the exclusions as outlined in § 3.

1.9 Cyber Risks

Any benefits for Bodily Injury caused by or arising out of a Cyber Act or a Cyber Incident are payable, subject to the terms, conditions, limitations and exclusions of this policy.

Cyber Act means an unauthorised, malicious or criminal act or series of related unauthorised, malicious or criminal acts, regardless of time and place, or the threat or hoax thereof involving access to, processing of, use of or operation of any Computer System.

Cyber Incident means:

1.1 any error or omission or series of related errors or omissions involving access to, processing of, use of or operation of any Computer System; or

1.2 any partial or total unavailability or failure or series of related partial or total unavailability or failures to access, process, use or operate any Computer System.

Computer System means any computer, hardware, software, communications system, electronic device (including, but not limited to, smart phone, laptop, tablet, wearable device), server, cloud or microcontroller including any similar system or any configuration of the aforementioned and including any associated input, output, data storage device, networking equipment or back up facility, owned or operated by the Insured or any other party.

§ 2 Types of payment - What types of payment can be agreed?

2.1 The specific types of insurance cover and their amount (sum insured) are taken from the insurance policy. The following provisions apply for the origination of the claim:

2.2 Payment in the event of permanent professional disability:

Permanent professional disability exists when the insured person is permanently and completely incapable of actively pursuing the professional activity referred to in the insurance policy due to an accident (Section 1.4) or illness (Section 1.5). This must be confirmed by an established general doctor.

If an insured person dies within 18 months of an accident or diagnosis of an illness the insured person will be deemed not to have suffered a permanent professional disability.

The permanent professional disability must have arisen within 24 months from the day of the accident or within 24 months from the first occurrence of the illness (onset) and determined in writing by a doctor chosen by the insurer at the latest before the expiry of a further six months and asserted at the insurance company in writing by the policyholder or the insured party.

If an initially lasting (= current) professional incapacity is determined by the physician within the period for the onset of permanent professional disability stated above, and is not clear whether there is any prospect of resuming work, the policyholder may demand that the

insurer agrees to an extension of these deadlines by one month, up to a maximum of three months. The policyholder must request the extension of the period before the above deadlines or before the expiration of the extended deadline from the insurer in writing. If the insured person resumes work before the deadline, the period shall end at this time. Any extension requires the written consent of the insurer.

Level of payment: The insurance payment case of permanent professional disability is paid in the amount of the agreed sum insured in the insurance policy.

If the insured person start the professional activity again after receiving the payment of the sum insured, then the insurer has a right to withdraw the last annual premium.

2.2.1 Payment in the event of loss of limb:

Loss of Limb is
- In the case of a leg permanent physical severance at or above the ankle or permanent and total loss of use of a complete foot or leg.
- In the case of an arm permanent physical severance at or above the wrist or permanent and total loss of use of a complete hand or arm.

2.2.2 Payment in the event of loss of sight:

Permanent and irrecoverable loss of sight is
- In both eyes if the Insured's name is added to the Register of Blind Persons within their usual country of domicile.
- In one eye if the degree of sight remaining after correction is 3/60 or less on the Snellen Scale (which means seeing at 3 feet what the Insured should see at 60 feet).

2.2.3 Payment in the event of loss of speech or hearing:

The permanent total and irrecoverable loss of speech or hearing is given.

2.3 Payment in the case of temporary professional disability:

Temporary professional disability applies when a doctor, declares the insured person temporarily unfit for professional due to accident (Section 1.4) or illness (Section 1.5). The insured person is unable to carry out their professional duties.

The insurance company shall pay the amount specified in the insurance policy for each day of temporary professional disability. The compensation is payable for the maximum number of days specified in the insurance policy. The payments are due on the first day after the expiry of the waiting period stated in the insurance policy and end with even partial accommodation of the profession, but no later than the end of incapacity to work. Payment is made when the end of incapacity has been proven. If desired, a 4-week payment schedule may be agreed.

All interruptions of professional activities, which are attributable to the same cause and occur less than 180 days thereafter, will be considered as a single **incident**. Any other interruption of the activity is considered as a new claim, which leads to a new compensation period and a new waiting period.

Should the annual income increase, the policyholder may request an increase of the daily cash benefit within two months of change of income for an additional premium without any further medical examination. Coverage increases with salary increase. This does not apply for a disability of the insured person, which already existed before the increase was applied for. For this, the insured daily sickness benefit shall be paid in the same amount within the contractual scope.

2.4 Payment in the case of death:

The insured person has died within 18 months following an accident (Section 1.4). A payment in the case of death will be made even if the insured person dies as a result of overexertion or physical breakdown (e.g. heart failure) which is caused by an accident or suspected accident.

The death benefit is paid in the amount of the agreed sum insured in the insurance policy. Amounts already paid within the scope of Sections 2.2 and 2.3 will be deducted from the amount payable in the case of death.

For the avoidance of doubt, this policy does not pay death benefit in respect of illness.

2.5 Multiple Compensation

The payment of temporary professional disability (daily benefit) is not cumulative with the capital payment in the event of permanent professional disability. This means: If the policy provides cover for both a daily benefit and a professional disability benefit, no daily benefit is paid from the day (midnight) of payment of the capital sum for professional disability.

§ 3 Exclusions – In which cases is the insurance coverage excluded?

The following facts and events are not covered:

- Intent of the policyholder or the insured person, suicide or attempted suicide within three years from the effective date, intentional self-mutilation.
- war, whether war be declared or not, hostilities or any act of war or civil war.
- Fly or drive any vehicle (including aircraft) without the corresponding certificate of capacity, driving licence or the appropriate certificate.
- Alcoholism, obvious intoxication or blood alcohol level that was above 1,1‰ at the time of the accident.
- Drug addiction, excessive intake of non-prescribed drugs or non-compliance with prescription.
- Nuclear fission or nuclear radiation, unless they are medically prescribed.
- Terrorist act from nuclear, biological and chemical weapons.
- Psychiatric illnesses such as psychoses, psychoneuroses, psychogenic reaction or functional disorder of psychological origin according to the classification of the illnesses according to ICD, unless these were caused by an accident or an insured illness insured under this insurance contract.
- Aesthetic treatments, slimming, rejuvenation treatments, rehabilitation or exercise therapy without function.

§ 4 Special conditions for coinsurance of passive war risk

The insurance covers illnesses or accidents suffered by the insured person in the war, without being an active participant in the war or civil war (passive war risk). Any person who delivers, removes or otherwise handles certain equipment, facilities, devices, vehicles, weapons or other material on behalf of a warring party is also an active participant.

The following remain excluded from the insurance coverage:

- Accidents caused by NBC weapons (nuclear, biological or chemical weapons).
- Accidents or illnesses caused by war or a warlike situation between world powers (China, France, Great Britain, Japan, Russia, United States).
- Accidents or illnesses associated with war or civil war if the state in which the insured person resides or is ordinarily resident, is involved as a warring party or if the war events take place in the territory of that state.

§ 5 Obligations following the occurrence of an accident or illness

5.1 After an accident (Section 1.4) or illness (Section 1.5) the insured person, who/which can be expected to bring a claim, a doctor must be consulted immediately. The policyholder or the insured person must comply with the doctor's directions and apply other consequences of the accident or to reduce possible illness consequences.

5.2 The insured person or the policyholder is to notify the insurer of any accidents or illnesses which result in more than 30 consecutive days of incapacity.

Notification is to be given within 90 days following the event giving rise to the incapacity. In the event of death, the beneficiary is responsible for this obligation.

The notification must be provided at the latest with the submitted annual information before the respective due date, otherwise the entitlement to benefits expires.

Please note the different notification period for accidental death (5.7.) and temporary professional disability (5.10.).

5.3 The claim report must be in writing, addressed to the insurer or its representative and must contain the following information:

- First and last name, age and residence of the sick, injured or deceased person, as well as a hospital admission note and the name and address of the hospital facility.
- In the event of an illness: its nature and the name and address of the attending physician.
- In the event of an accident: date, place, circumstances; where appropriate, name and address of the person liable for the accident and if possible the witnesses; Name and address of the first attending physician.
- In the event of death: death certificate, and the documents, which identify the beneficiary as such.

5.4 If the insurer provides an alternative claim form, the insured is to fill out the form truthfully and promptly and return it promptly to the insurer. Any additionally required relevant information is to be provided immediately.

5.5 In addition, the insured or, if necessary, the policyholder must:

- Submit as soon as possible without request a detailed medical certificate, which contains precise information about the type of illness or injury as well as its likely consequences.
- Any supplementary information requested concerning the illness being treated or the accident.

5.6 The insurer may collect personal health information from doctors, hospitals and other health centres, nursing homes, other health insurers and public health insurance as well as trade associations and government agencies as may be necessary to assess its payment obligation and the insured person has given their consent to this. The insurer shall notify the insured person about a proposed data collection and at the same time inform them of their right to object. In addition, the insured person may request that any data collection takes place only when the individual has consented to the specific collection of information.

5.7 If the accident (Section 1.4) or illness (Section 1.5) results in death, this shall be reported within 7 days, even if the previous injury or previous illness has already been reported. The insurer has the right to authorise an autopsy by a doctor appointed to be by them.

5.8 The insured person is to undergo tests to determine if the benefits payment and subsequent check-ups by doctors of their choice or, in the event of inconsistencies in the diagnosis, of the insurer’s choice; In the event of an unjustified refusal, the policyholder may lose all entitlement to insurance benefits. If the insurer commissions a medical examination, they shall bear the cost.

5.9 Should the insured person have become incapable of practicing profession be due to an accident (Section 1.4) or an illness (Section 1.5) and have reported this to the insurer, regardless of whether it is a temporary or permanent disability at this time, the insurer has the right to make the resumption of profession contingent on the consent of a doctor appointed by him. In the event of a disagreement, between the doctor appointed by the insurer and the doctor attending to the insured person, sections 7.3 and 7.4 shall apply accordingly.

5.10 In the event if insurance benefits for temporary professional disability, the following special provisions shall apply in addition:

- The policyholder must submit the medical certificate (the certificate of incapacity for work) to the insurer within the waiting period on which the contract is based. This must clearly state Start and end of the incapacity for work with ICD code, % degree of temporary incapacity for work and date of issue. If he does this later, the daily allowance will only be paid from the date of receipt of the medical certificate by the insurer or its representative. Previous days are no longer taken into account.

  Unless otherwise agreed, the medical certificate must always be renewed after 15 days. The cost of these certificates shall be borne by the insured person.

§ 6 Consequences of breach of responsibilities - What are the consequences of a failure to meet obligations?

6.1 In the event of the policyholder or insured person failure to comply with these obligations, the insurer is entitled to decline the claims or a reduction of the claim payment, unless the policyholder or the insured person can prove that the failure to comply with the contractual obligations did not affect the consequences and the assessment of the claim.

6.2 However, the aforementioned declinature or reduction will only apply if the circumstances show that the policyholder, the insured person or the beneficiary is guilty of failure to comply.

6.3 If the insured person fails to comply with 5.2 the insurer shall have the right to limit cover.

§ 7 Requests for payment of benefits and medical review

7.1 In the event of a payment during temporary professional disability (Section 2.3) and a benefit in the event of death (Section 2.4), the payment is automatically requested in the claim report.

7.2 In the event of a payment in the event of permanent professional disability (Section 2.2), the payment must be requested by the insured party within the period of 2.2. This is done through an assessment by a doctor chosen by the policyholder. The insurer has the right to make have the result of this assessment checked by a doctor of their choice at their own expense.

7.3 If there is no agreement between the policyholder, on the one hand, and the insurer, on the other hand, with regard to the causes and consequences of a claim, the policyholder has the right to the request that the Province Medical Association *(Landesärztekammer)* at the last German residence of the insured person appoint an expert arbitrator (specialist) who will make the decision. If the insured party does not have or has not had a German residence, the Province Medical Association in Stuttgart is to be appointed.

7.4 Each party shall pay the professional fees for their expert and possibly half of the fee for the arbitrator. The judgment of the arbitrator shall be binding on both sides.

§ 8 Due date for benefits payments

8.1 Once the insurer has received the documents, which the policyholder is to provide to establish the origin, onset and consequences of the accident or Illness, the insurer is required to declare within three months whether they acknowledge a claim. When applying for an insurance benefit payment for temporary professional disability (Section 2.3), this period is shortened to 14 days.

8.2 If the insurer acknowledges the claim, or if the insurer and the policyholder agreed on the basis and amount, the insurer makes the payment within 14 days.

8.3 The insurer is entitled to the full annual premium in the event of a claim. If there are any outstanding collection claims, these will be offset against any claim payments.

§ 9 Commencement, duration and termination of insurance coverage

9.1 The insurance coverage begins on the date specified in the policy, but not before the insurer accepts in writing the signed application from the policyholder and not before payment of the first premium.

The insurance policy stipulates otherwise. It is extended by another year without a new medical examination if it has not terminated by the insurer or the policyholder by giving notice of 60 days.
Depending on the type of benefit, the contract ends automatically upon retirement, the onset of permanent occupational disability or the death of the insured person.

9.2 In addition, a dissolution of contract is possible under the following circumstances:

A. By the policyholder and/or the insured person: (the insured person is itself entitled to terminate in connection with its insurance coverage if it pays the premiums):

- with a period of notice of 30 days after each **incident**, for which compensation is due, but no later than 14 days after notice of the payment made by the insurer. In the event of a liability claim in the current insurance year, the insurer is entitled to the full annual premium.
- in the event of a change of profession for which no alternative tariff is available, within 3 months of the occurrence of the event. The termination shall take effect upon receipt of the notification. After the expiry of the 3 months, the regular notice period applies.
- The policyholder or the insured person may determine that the termination does not take effect with a period of 30 days, but should become effective at a later date, not later than the end of the current period of insurance.

B. By the insurer

- with a period of notice of 60 days after each claim payment (but not before the first main due date). The contract can be altered (e.g. exclusion of cover, risk surcharge) or cancelled.
- with a period of notice of 60 days to each premium renewal date.
- following any **incident** that lasts for 30 continuous days or more to the end of the contract or the renewal date prior to 60 days before expiry of the Term. The contract can be altered or cancelled. The obligation to pay shall continue unaffected.

  If an insured person fails to notify the insurer of an **incident** which occurs more than 60 days before expiry, any renewal of this contract can be cancelled and/or amended by the insurer with a period of notice of 60 days to each renewal date.

C. As a matter of law, if the insurer's authorisation is revoked.

9.3 In covering against temporary disability (Section 2.2), a partial contract alteration is possible within 2 months (retroactive as of the occurrence of the change), provided that the duration of continued pay changes due to a transfer between clubs. Evidence of this must be provided.

In the event of a later receipt, the right to change only comes into effect as of the receipt of the notice by the contract manager.

Should the waiting period to be changed be 365 days, the duration of benefits is limited to a maximum of 365 days. A normal cancellation is possible as of the main renewal date, provided that the periods stipulated in 9.2 are adhered to.

9.4 The party who terminates the contract must inform the other party in written. The notice of termination results in the waiver of insurance coverage from the termination date. In the case of termination, this can also be textual by fax or e-mail, but always with a signature of the policyholder. However, in the event of discrepancies, the receipt by the other party must be proven.

§ 10 Premium and premium payment – insurance tax – Consequences of late payment of contributions

10.1 The premium is calculated on the basis of the statements made upon conclusion of contract, the concluded insurance coverage, and for certain types of coverage, calculated according to the age of the insured person.

10.2 Depending on the contract, you may pay the premium annually, bi-annually or quarterly. A pro rata payment for single premium contracts is not possible. Please note that the premium is calculated according to the risk incurred. This means that premiums increase with increasing age, as the probability of occurrence of an insured event within the meaning of these terms also increases. For details, see the premium table in the general information provided with your contract. This increase does not trigger any special right of termination.

10.3 The premium, including any surcharges, fees and insurance tax is immediately due and payable at the head office and the registered office of the insurer or its representative. The due dates are specified in the insurance policy.

10.4 Timeliness of payments in the case of payment on account:

Should the policyholder not pay the premium on time, but at a later date, coverage will not begin until after that date if the insured party has been advised by separate notice in writing or through a prominent notice on the insurance policy to this effect. This does not apply if the policyholder can prove that he was not responsible for the non-payment.

If the policyholder does not pay the premium on time, the insurer may cancel the contract where the premium has not been paid. The insurer may not withdraw from the contract if the policyholder can prove that he was not responsible for the non-payment.

10.5 Timeliness of payment by direct debit authorisation:

If the recovery of the premium from an account is agreed, the payment shall be considered timely if the premium can be debited on the due date and the policyholder does not object to an authorised debit.

Should the insurer be unable to collect the overdue premium through no fault of the policyholder, the payment is still on time if it is made immediately after a payment request submitted in writing by the insurer.

If the due premium cannot be collected because the policyholder has revoked the direct debit authorisation, or the policyholder is in another way responsible for the fact that the premium is again unable to be collected, the insurer is entitled to request future payment without direct debit. The policyholder is only required to transfer the first premium payment, when he has been prompted to do so by the insurer in writing.

10.6 Partial payment and consequences of late payment

If payment of the annual premium in instalments has been agreed, the outstanding instalments are due immediately if the policyholder is in arrears with the payment of an instalment. We can also ask for annual contributions in the future.

§ 11 Pre-contractual duty of disclosure – Rights of withdrawal

11.1 Until acceptance of the contract by the insurer, the policyholder must notify the insurer in text form of all material circumstances of risk of which he is aware and which the insurer has asked about in text form and which are material to the insurer's decision to conclude the contract with the agreed content.

11.2 The risk factors that are likely to influence the decision of the insurer to conclude the contract at all or with the agreed contents are significant. In the case of doubt, a fact which the insurer has asked about expressly and in writing is regarded as significant for the risk.

11.3 If a person other than the policyholder is to be insured, that person is responsible in addition to the policyholder for the accurate and complete disclosure of the material facts and answering the questions put to that person.

11.4 Incomplete or inaccurate information on risk-relevant circumstances, entitle the insurer to withdraw from the insurance contract. The withdrawal is made by notice to the policyholder.

11.5 The insurer has no right to withdraw if the policyholder can prove that he or his agent has provided incorrect or incomplete information neither deliberately nor through gross negligence.

11.6 If the insurer’s right to withdraw is excluded as the breach of duty was not down to either intent or gross negligence, the insurer may terminate the contract by giving notice of 30 days.

11.7 The insurer's right to withdraw due to a grossly negligent breach of the obligation does not apply if the policyholder can prove that the insurer would have concluded the contract even if they had knowledge the undisclosed circumstances, albeit under other conditions.

11.8 In the event of withdrawal, there is no insurance coverage.

11.9 If the insurer withdraws after the occurrence of an insured event, they cannot deny insurance coverage if the policyholder can prove that the incomplete or incorrectly disclosed fact was not the cause of the occurrence of the insured event or casual for the determination or amount of the payment. There is also no insurance coverage in this case if the policyholder has fraudulently violated the duty of disclosure.

11.10 The insurer is entitled to the portion of the premium that corresponds to the contract period before the effective date of the cancellation notice.

11.11 The termination shall be excluded if the policyholder can prove that the insurer would have concluded the contract even if they had knowledge of the undisclosed circumstances, albeit under different conditions.

11.12 If the insurer cannot withdraw from or terminate the contract because they would have concluded the contract even if they had knowledge of the undisclosed circumstances but under different conditions, the other conditions retroactively become a component of the contract upon request from the insurer. If the policyholder is not responsible for the breach of duty, the other conditions shall become a component of the contract after the current period of insurance.

11.13 If the amount increases by more than 10% due to a contract amendment or if the insurer excludes the risk coverage for the undisclosed fact, the policyholder may terminate the contract within 30 days after receipt of notification by the insurer without notice.

11.14 The insurer must assert the rights available to them under § 11 in writing within 30 days. They are to state the circumstances on which they are basing their declaration. The period begins on the date on which they became aware of the breach of the duty, upon which the asserted right is based.

11.15 The insurer is only entitled to the rights under § 11 if they have not been informed of the consequences of any breach of duty of the policyholder by separate notice in writing.

11.16 The insurer may not invoke the rights referred to in § 11 if they knew of the undisclosed risk factor or the inaccuracy of the disclosure.

11.17 The right of the insurer, to challenge the contract due to fraudulent misrepresentation remains unaffected by this. In the event of dispute, the insurer is entitled to the portion of the premium which corresponds to the contract period before the effective date of such a declaration.

§ 12 Duties of disclosure during the contract period

12.1 The policyholder or the insured party must inform the insurer in writing by fax or e-mail about changes to professional or related risks within 14 days after becoming aware of this if these changes create a situation to which the statements made upon conclusion of contract no longer apply.

12.2 Where these changes represent a new and/or greater risk, which the insurer would have rejected at the time the contract is signed or only through a premium increase or reduction of coverage, the omission of the risks shall result in the penalties stated in Section 11.4.

The insurer has the right to terminate the contract within 10 days or propose a premium increase:

- If the insurer decides to terminate, the termination shall be effective 30 days after its announcement, with the unused portion of the previously paid premium refunded on a pro rata basis.
- Should the insurer propose a premium increase, the policyholder and/or the insured party may reject this within a period of 30 days from the sending of notification by the insurer; otherwise, the premium adjustment is regarded as accepted. Should the policyholder object to the increase of the premium, the insurer shall have the right to terminate the contract with a period of notice of 30 days.

12.3 If these changes represent a reduction of an aggravated risk, which gave rise to an increase in premiums, the policyholder is entitled to a reduction of the premiums. If this reduction is not granted by the insurer, the policyholder may demand the termination of the contract. This termination takes effect after 30 days; the insurer will then refund the unused portion of the previously paid premium on a pro rata basis.

12.4 Section 11.4 is also applicable during the contract period. The deadlines are to be observed in accordance with Section 12.1.

§ 13 Notifications, declarations and payments (underwriter)

13.1 The Underwriter / contract manager stated in the insurance policy shall handle the business dealings between the policyholder and the insurer and is therefore authorised by the insurer to accept notices, declarations and declarations of intent and pledges to immediately forward these to the insurer.

13.2 A change of name or mailing address of the policyholder is to be reported immediately. Otherwise, the delivery address for notifications shall be the address specified on the insurance policy. The declaration shall be deemed received three days after dispatching.

§ 14 Leadership clause in contracts with several insurers involved

14.1 The leading insurer is authorised to accept reports and statements of intent from the policy holder for all insurers involved.

14.2 The participating insurers recognise the decision made by the leading insurer as binding for them.

14.3 Declarations made by the policyholder and/or the insured person are regarded as satisfactory to the participating insurance companies when they are received by the leading insurer.

14.4 In the event of disputes arising from this contract, the policyholder shall only assert claims against the leading insurer.

14.5 The participating insurers recognise the legally effective judgment of the leading insurer as the settlement made by the leading insurer with the policyholder after arbitration as also binding on them.

§ 15 Applicable law / jurisdiction

15.1 The contract is subject to the law of the Swiss Confederation in all its parts, including with respect to all matters concerning the formation, validity or its interpretation. This also applies to risks outside of the Swiss Confederation.

15.2 Furthermore, the local or regional court in whose district you have your place of residence or, in the absence of such, your usual place of residence at the time the action is brought shall have jurisdiction for claims or actions arising from the insurance contract or insurance

mediation. This jurisdiction shall only cease to apply if you move your place of residence or habitual abode outside the area of application of the Insurance Contract Act after conclusion of the contract.

§ 16 Surrender value

The insurance has no cash surrender value.

§ 17 Profit sharing

The insurance is not dependent on the profit of the insurer.

§ 18 Severability clause

If one of the provisions of this agreement is invalid, it shall be replaced by a provision that corresponds to the economic result of the invalid provision as far as possible. The validity of the remainder of the contract remains unaffected by this.

§ 19 Sanction clause

Notwithstanding other provisions of the insurance contract, cover shall be granted only insofar as and as long as not in contradiction to economic, trade or financial sanctions or embargoes enacted by the European Union or the German Republic that are directly applicable to the contracting parties.
This shall also apply to economic, trade or financial sanctions or embargoes enacted by the United States of America with regard of the Islamic Republic of Iran, insofar as those are not in contradiction to European or German legislative provisions.

§ 20 Terrorism clause (if requested)

The following exclusions are deleted in the insurance conditions (§ 3 and 4) by the payment of the additional premium of 10% on the basic premium:

- Nuclear fission or nuclear radiation, unless they are medically prescribed
- Terrorist act from nuclear, biological and chemical weapons
- Accidents caused by NBC weapons (nuclear, biological or chemical weapons)

§ 21 Miscellaneous

21.1. The policyholder must inform the insurer with the annual information about the annual gross income of the insured person.

21.2. When the insured Person is unemployed, the contract can be suspended or revoked for a maximum of 12 months.
The cancellation of the contract can be effected by unemployment decision within 2 months after admission; during subsequent input until that date. Should the contract be paid monthly, the cancellation is done from the next payment due date of receipt.

If the contract revokes, Revoking at the contract exists in this time no contribution and benefit claim.

21.3 No-claims bonus
The "NCB" tariff includes a no-claims bonus of 20% on the premium from the next main due date, provided that no claim has been reported or no benefit claimed in the current insurance period.
In case of a subsequent notification of a damage, claim or benefit, the no-claims bonus will also be cancelled retroactively. This increase does not trigger any special right of termination.
Excluded from this regulation are tariffs which are already discounted.

V. INFORMATION OF DATA PROCESSING

Declaration of consent to data protection (data storage, transfer and request)

Data protection notice
As of 25.05.2018, the EU General Data Protection Regulation (GDPR) is effective in all member states of the European Union. The reversed Federal Act on Data Protection of Switzerland applies from 01.01.2022.
The GDPR standardises the rules for processing personal data. This ensures the protection of personal data overall, and guarantees the free movement of data within the European Union. The new provisions of the GDPR place particularly high emphasis on transparency in data processing and extensive rights of the data subjects.
Information on data protection is also available on the internet at https://www.wunderlich-consulting.net/en/privacy-policy
With this notice, we hereby inform you of the processing of your personal data by us and the insurers and the rights you are entitled to according to data protection law.

Persons responsible for the data processing (controllers)
Wunderlich Financial Consulting GmbH, Erlenstr. 27, 2555 Brügg, Switzerland
Managing directors: Claus Wunderlich, Filip Apostolov
Tel. + 41 32 5520570, Fax +41 32 5520571, office@wunderlich-consulting.net, www.wunderlich-consulting.net

as well as the respective insurers.

Purposes and legal bases of the data processing
We (Wunderlich Financial Consulting GmbH and the respective insurers) process your personal data in compliance with the EU General Data Protection Regulation (GDPR), Federal Act on Data Protection (DSG), the provisions of the Insurance Contract Act (VVG) relevant to data protection law as well as all further applicable laws.

When you make an application for insurance coverage or request a quote, we require the information provided by you here to conclude the contract or provide the quote and to estimate the risk to be assumed by us. If the insurance contract comes into effect, we process these data for the performance of the contractual relationship, e.g. to issue policies or invoices. We require details in the event of a claim, for example, in order to verify whether an insured event has occurred and what the extent of the payout is.

The conclusion i.e. the performance of the insurance contract is not possible without the processing of your personal data.

Beyond this, we require your personal data in order to create insurance-specific statistics, such as to develop new tariffs or to fulfil regulatory requirements. We may use the data of all contracts concluded with us for an observation of the overall customer relation, for example for consultation regarding an adjustment or supplement to the contract, for making decisions on goodwill gestures, or for the comprehensive provision of information. The legal basis for this processing of personal data for pre-contractual and contractual purposes is Art. 6 Para. 1b GDPR. If special categories of personal data (e.g. your health data upon concluding an insurance contract) are necessary for this purpose, we seek your consent in accordance with Art. 9 Para. 2a in connection with Art. 7 GDPR. If we create statistics using these data categories, this occurs on the basis of Art. 9 Para. 2j GDPR in connection with DSG.
We also process your data in order to preserve our interests or those of third parties (Art. 6 Para. 1f GDPR). This can be necessary in particular:

- to ensure IT security and IT operations,
- to advertise our own insurance products and their cooperation partners as well as to carry out market and opinion surveys,
- to prevent and clear up offences, we use data analyses in particular to detect signs that may point to insurance fraud.

In addition to this, we process your personal data in order to fulfil legal obligations such as regulatory requirements, commercial and fiscal obligations to retain data, or our duty to give advice. In this case, the legal basis for the processing is formed by the respective legal regulations in connection with Art. 6 Para. 1c GDPR. If we wish to process your data for a purpose that has not been mentioned, we will inform you of this beforehand in the context of the legal provisions.

Categories of recipients of personal data
Reinsurers:
Risks assumed by the insurers can be insured with special insurance companies (reinsurers). For this, it may be necessary to transmit the data of your contract and potentially of your claim event to a reinsurer so that the reinsurer can form a more complete picture of the risk or the claim event.
Intermediaries:
If you are attended to by an intermediary with regard to your insurance contracts, your intermediary processes the application, quote, contract and claim data required for the conclusion and performance of the contract. Our company also transmits these data to the intermediaries who serve you if they require this information to serve and advise you in your insurance and financial service matters.
External service providers:
We partially make use of external service providers in order to fulfil our contractual and legal obligations. You can request the currently valid list of the contractors and service providers used by us with whom we have more than just temporary business relations at any time.
Further recipients:
Beyond this, we may transmit your personal data to further recipients, such as to authorities in order to fulfil legal reporting obligations (e.g. social insurance agencies, financial authorities or law enforcement authorities).

Duration of the data storage
We delete your personal data as soon as they are no longer required for the purposes stated. What may occur here is that personal data are stored for the period in which claims can be asserted against our company or the respective insurers (legal limitation period of three or up to thirty years). In addition, we also store your personal data insofar as we are legally obliged to do so. Corresponding obligations to provide evidence and to retain data arise from, among other things, the Commercial Code, the Fiscal Code and the Money Laundering Act. In accordance with these, the storage periods amount to up to ten years after termination of the contract.

Data subject rights
You can request information on the data stored on your person at the stated address. In addition, you can request the rectification or deletion of your data under certain circumstances. Furthermore, you may have a right to restriction of the processing of your data as well as a right to issuance of the data provided by you in a structured, common and machine-readable format.

Right of objection
You have the right to object to the processing of your personal data for the purposes of direct advertising. If we process your data in order to preserve legitimate interests, you may object to this processing if your particular situation provides reasons against the processing of the data.

Right of appeal
You have the possibility to lodge a complaint with a data protection supervisory authority in your country of residence.

Automated individual decisions
Based on your statements on risk, which we ask you about when you make an application or request a quotation, we can make fully automated decisions, for example regarding the conclusion of the contract, potential risk exclusions or the amount of the premiums to be paid by you.

Consent to the Elicitation and Use of Health Data and Authorisation to Release from the Obligation to Secrecy

The provisions of the Insurance Contract Act, the Data Protection Act and other data protection regulations do not contain sufficient legal foundations for the elicitation, processing and use of health data by insurance companies. In order to be allowed to elicit and use your health data for this application and the contract, pursuant to data protection legislation **Wunderlich Financial Consulting GmbH** (hereinafter referred to as WFC GmbH) and the **insurance company with which the insurance contract was concluded** therefore requires your consent(s). In addition, the insurance company with which your insurance contract was concluded, requires your authorisations to release bodies from the obligation to secrecy in order to be allowed to elicit your health data at points subject to secrecy like, e.g. medical practitioners. Being a life insurance (health insurance) undertaking, the insurance company requires such release from the obligation to secrecy in order to be allowed to forward your health data or other data protected under the Criminal Code, like, e.g. the fact that a contract with you exists, to other agencies, e.g. IT providers.

The following declarations of consent and release from the obligation to secrecy are indispensable for assessing your application as well as for establishing, performing or terminating your insurance contract. Should you not provide them, as a general rule conclusion of the contract would not be possible.

The declarations concern the handling of your health data and other data protected under the Criminal Code
- by WFC GmbH and by the insurance company itself (under 1.),
- in connection with making enquiries at third parties' (under 2.),
- when forwarding to agencies external to the insurance company (under 3.) and
- if the contract does not come into being (under 4.).

The declarations also apply to any persons legally represented and to be co-insured by you, like your children, to the extent the latter fail to recognise the consequences of such consent and are therefore unable to submit their own declarations of consent.

1. Elicitation, Storage and Utilisation by the Insurance Company of Health Data Communicated by You
I consent to WFC GmbH's and the insurance company's eliciting, storing and using the health data communicated by me in this application and in future to the extent this is necessary for review of the application and for establishing, performing or terminating this insurance contract.

2. Queries About Health Data at Third Parties'

2.1. Making Enquiries About Health Data at Third Parties' for the Purpose of Risk Assessment and for the Purpose of <u>Review of the Duty to Provide Benefits</u>

For the assessment of the risks to be insured, it may be necessary to obtain information from bodies that are in possession of your health data. In addition, it may be necessary for the purpose of reviewing duty to provide benefits that the insurance company must subject to scrutiny the data on your health circumstances that you provided in order to establish claims or that ensues from the submitted documents (e.g. invoices, statutory instruments, expert opinions) or communications e.g. of a medical practitioner or of other parties belonging to a healing profession.
Such review will only take place if necessary. For this, the insurance company needs your consent, including a release from the obligation to secrecy for itself and for these bodies, if health data or other information protected has to be passed on within the framework of this query. You may grant these declarations already at his point (Option 1) or later in the individual case (Option II). You may change your decision at any time. Please select one of the two following options:

<u>Option I:</u>
❑ I give my consent – if required for the risk assessment or for review of the insured event – to the insurance company's eliciting my health data from medical practitioners, care personnel and employees of clinics, other hospitals, care homes, health insurers, statutory health insurance companies, trade associations and authorities, and using it for these purposes. I release the stipulated persons and employees of the stipulated facilities from their obligation to secrecy to the extent my admissibly stored health data from examinations, consultations, treatments and insurance applications and contracts from a period of up to ten years prior to application are transmitted to the insurance company. I furthermore agree in this connection – if required – to the passing on of my health data to these bodies and in this respect also release the persons employed by the insurance company from their obligation to secrecy.
Prior to each elicitation of data pursuant to the above paragraphs, I will be informed as to who the data is to be elicited from and for what purpose and it will be pointed out to me that I may object and provide the necessary documents myself.

<u>Option II</u>:
❑ I wish the insurance company to notify me in each individual case about what persons or organisations require the information and for what purpose. I will then decide in each case:
Whether I agree to such elicitation and use of my health data by the insurance company, whether I release the person or organisation, and his/her/its employees from their obligation to secrecy and whether I consent to the transfer of my health data to the insurance company
or whether I provide the required details myself.
I am aware that this may lead to a delay in the processing of the application, or in the review of the duty to provide benefits.
To the extent the above statements refer to the details provided by me when applying for insurance, they will be effective for a period of five years subsequent to conclusion of contract. If there are specific indications that incorrect or incomplete details were intentionally provided when insurance was applied for, the period will be ten years and for this reason the assessment of risk was influenced, the statements will be effective for a period of up to ten years subsequent to conclusion of the contract.

2.2. Statements in the Event of Your Death
For the purpose of reviewing the duty to provide benefits, it may be necessary to review your health data even after your death. A review may also be necessary if up to ten years subsequent to conclusion of contract, for the insurance company concrete clues reveal that when the application for insurance was made incorrect or incomplete details were provided and for this reason the assessment of risk was influenced. The insurance company requires consent and release from the obligation to secrecy also for this purpose. Please select one of the two following options:

<u>Option I:</u>

❑ In the event of my death, I give my consent that my health data may be elicited by third persons for review of liability or necessary new review of application as described in the first tick box (see 2.1. above – First Option).

Option II:
❑ If – for the purpose of reviewing the duty to provide benefits or of necessary new review of application – it should be necessary to collect health data after my death, decision-making authority in respect of declarations of consent and release from the obligation to secrecy will pass to my heirs or – if this is deviatingly provided for – to the beneficiaries of the contract.

3. Disclosure of your health data and other data protected under the Criminal Code to bodies external to the insurance company
The insurance company will contractually oblige the following bodies to observe the regulations on data protection and data security.

3.1 Disclosure of Data for Medical Examination
For the assessment of the risks to be insured and for review of the duty to provide benefits, it may be necessary to call in medical experts. The insurance company needs your consent and release from the duty to maintain secrecy if your health data and other data protected under § 203 of the Criminal Code are transferred in this connection. You will be notified of a transfer of data in each case.
I consent to the insurance company's transferring my health data to medical experts, to the extent this is necessary within the framework of risk review or review of the duty to provide benefits and that my health data is used there in accordance with their designated purpose and that the results are transmitted back to the insurance company. In respect of my health data and other data protected under the Criminal Code, I release the persons working on behalf of the insurance company and the experts from their duty to maintain secrecy.

3.2 Transfer of Tasks to Other Bodies (Companies or Persons)
Particular tasks such as processing insured events or customer assistance by telephone, in connection with which the collection, processing or use of your health data may become necessary, are in some cases not carried out by the insurance company itself but their discharge is transferred to another company of the insurance group, or another body. If your data protected under the Criminal Code are disclosed in this connection, the insurance company needs your release from the duty to maintain secrecy for itself and, if required, for the other bodies.
For the disclosure of your health data and their use by the bodies mentioned above, the insurance company needs your consent.
I consent to the insurance company' transferring of my health data to the bodies specified in the list mentioned above and to my health data being collected, processed and used there for the specified purposes to the same extent as the insurance company would be allowed to. To the extent required, I release the employees of the insurance company, and of the insurance company's group of undertakings, and of other bodies from their duty to maintain secrecy in respect of the disclosure of health data and other data protected under the Criminal Code.

3.3 Disclosure of Data to Reinsurance Companies
To insure satisfaction of your claims, the insurance company may conclude contracts with reinsurance companies who assume the risk insured in whole or in part. In some cases, these reinsurance companies use for this purpose other reinsurance companies to whom they likewise transmit your data. The insurance company may submit your application for insurance or request for payment to the reinsurance company so that the reinsurance company can gain its own impression of the risk or the insured event. This would be the case, in particular, if the cover sum is extremely high or the risk is difficult to assess.
Furthermore, it is possible that a reinsurance company – on grounds of its special expert knowledge – will assist the insurance company when analysing risks and payments and when evaluating procedures.
If a reinsurance company has assumed insurance against a risk, it can oversee whether the insurance company has correctly assessed the risk or an insured event.
Moreover, data relating to your existing contracts and applications will be disclosed to reinsurance companies to the necessary extent so that they can review whether and to what extent they can participate in the risk. Also data relating to your existing contracts may be disclosed to the reinsurance company for the settlement of premiums and insured events.
For the above purposes, anonymised, or pseudonymised data, respectively, are used if possible. Your personal data will be used by the reinsurance companies only for the purposes specified above. You will be informed by the insurance company when your health data are transferred to reinsurance companies.
I consent to my health data being transferred to reinsurance companies – to the extent necessary – and used there for the purposes mentioned. To the extent necessary, I release the persons working on behalf of the insurance company from their duty to maintain secrecy with respect to the health data and other data.

3.4 Disclosure of Data to Independent Intermediaries/Brokers
The insurance company generally does not disclose any details relating to your health to independent intermediaries. However, in the following cases it may be possible that data allowing conclusions to be drawn on your health, or information protected under the Criminal Code relating to your contract are made known to the intermediary.
To the extent it is required for consulting purposes related to the contract the intermediary supporting you may obtain information on whether and, where appropriate, under what circumstances (e.g. acceptance with a risk surcharge, exclusions of certain risks) your contract can be accepted.
The intermediary of your contract learns that your contract was concluded and with what content. At the same time, the intermediary also learns whether surcharges for risks or exclusions of particular risks have been agreed.
In the event of a change from the intermediary supporting you, to another intermediary, transmission of contractual data including the information on existing risk surcharges and exclusions of certain risks may occur. In the event of a change the intermediary supporting you to a different intermediary you will be informed prior to the passing on of health data and also your objection options will be pointed out to you.
I consent to the insurance company's transmitting my health data and other data protected under the Criminal Code in the above-mentioned cases – if necessary – to the independent insurance intermediary and to such data's being elicited, stored and allowed to be used for consulting purposes.

4. Storage and Use of Your Health Data if the Contract Fails to Come About
If the contract with you fails to come about, WFC GmbH and the insurance company may store the health data elicited in the context of the risk assessment in case you re-apply for insurance cover. The insurance company stores your data also so as to be able to answer possible enquiries of other insurance companies. Your data will be stored with the insurance company until the end of the third calendar year after the year the application was made.
I consent to WFC GmbH's and the insurance company's storing and being allowed to use my health data – if the contract fails to come about – for a period of three years from the end of the calendar year of making the application for the above-mentioned purposes.

VI. GENERAL TERMS AND CONDITIONS WFC GmbH

By signing and sending the PDF application over the internet, I hereby request insurance coverage according to the relevant conditions (as amended).

I also hereby give Wunderlich Financial Consulting GmbH and/or their representatives the power of attorney to manage and take care of the contract(s) as well as to perform all related services in my name.
This also includes issuing of the insurance policy and debt collection.

I am aware that Wunderlich Financial Consulting GmbH in no way carries out insurance mediation activities.

Furthermore, I expressly confirm that I waive any right to advice and documentation, and am aware of the consequences thereof.

I hereby acknowledge and agree that the insurance companies and/or their representatives and WFC GmbH may save data regarding damages and/or contracts in electronic form and destroy the originals. I accept any electronic copy of said documents as evidence/proof of the original documents.

All correspondence shall be carried out via email. Therefore, WFC GmbH must know my current email address. Should this not be the case or should no email address be known, delivery to the agent shall be considered as delivery to me.

The SEPA period of pre-notification shall be reduced to 1 day for German bank accounts. For non-German bank accounts, the period shall be 2 days for recurring debit transfers and 5 days for one and/or first time debit transfers.

The contractual relationship shall be governed by Swiss law. The authority responsible for dealing with complaints is Eidgenössische Finanzmarktaufsicht FINMA, Laupenstrasse 27, 3003 Bern.

Price list for services

As all correspondence shall be carried out via email, no original document shall be issued. However, an original may be issued and sent via post for an additional service fee.

Sending of insurance policy via email	Free of charge
2nd sending of insurance policy via email	Free of charge
Sending of insurance policy document as hard copy via post	CHF 25.00
Issuance of duplicate insurance policy document	CHF 25.00
Issuance of premium paid certificate or premium receipt via email	Free of charge
Issuance of premium paid certificate or premium receipt as hard copy via post	CHF 25.00
Other costs	as incurred

WUNDERLICH
FINANCIAL CONSULTING

Important information about your occupational disability contract in the event of a claim

Dear Sir/Madam

If a claim arises, it is important that you as policyholder follow the proper procedure.

Be sure to follow the steps listed below. Failure to observe these guidelines may result in loss of insurance cover, and will impede the efficient settlement of your claim.

- If an accident or illness occurs, you must **immediately** seek medical treatment and follow your doctor's instructions.
- The insured person or the policyholder is to notify the insurer of any accidents or illnesses which result in more than 30 consecutive days of incapacity.
  Notification is to be given within 90 days following the event giving rise to the incapacity. In the event of death, the beneficiary is responsible for this obligation.
- A doctor's certificate confirming your incapacity for work must be received here **before the end of the excess period** (the number of days stated in your insurance policy before payment of your claim begins). In the event of later receipt, payment will only be made from this day and not for previous days.
- Advise other service providers (e.g. your employer or Employers' Mutual Insurance Association) about the doctor's certificate.
- If you become fully unable to work, your claim must be submitted within a maximum of 24 months following the date of the claim event.
- It is essential that you observe the **deadlines (obligations)** for your insurance contract! These can be found in the relevant terms and conditions.

If the accident was caused by a **third party** (including animals or third-party vehicles), the party that caused the accident should make every effort to advise his/her liability insurance provider and you must make the appropriate **liability claims**.

We will be happy to help you to process your claim correctly. Feel free to ring us if you have any questions.

Please note, however, that the insurance companies process claims directly from their own head offices or commission claims processors.

We make no decisions on claims and make no payments ourselves.

Stand: 03.2024

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