2022 edition

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Compulsory health insurance with a free choice of doctor

Terms and Conditions of Insurance (TC)
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Terms and Conditions of Insurance (TC)
Compulsory health insurance with a free choice of doctor in accordance with the Federal Law on Sickness Insurance (KVG)

Purpose of the insurance

Compulsory health insurance covers the costs of diagnosis and treatment in the case of illness, accident and maternity under the Federal Law on Sickness Insurance (KVG). Policyholders can take out health insurance with a standard or optional franchise. They can take out compulsory health insurance with a free choice of doctor or as an alternative insurance model in the form of a special type of insurance with a limited choice of service providers.

1 Basic information about the insurance

1.1 Statutory provisions and cantonal law

This insurance policy is based on the provisions of the Federal Act on General Aspects of Social Security Law of 6 October 2000 (ATSG), the Federal Law on the Supervision of Social Health Insurance of 26 September 2014 (KVAG), the Federal Law on Sickness Insurance of 18 March 1994 (KVG) and the implementing provisions belonging thereto as well as these Terms and Conditions of Insurance (TC). Swiss law and cantonal law take precedence over these Terms and Conditions of Insurance (TC).

1.2 Residents of the EU, Iceland or Norway

In addition, with the entry into force of the Agreement on the Freedom of Movement of Persons between Switzerland and the European Union (EU), deviating provisions must be respected, which relate in particular to the group of insured persons, their rights and obligations, the insurance relationship, benefits, premiums and cost contribution.

1.3 Application to insurance companies in the Sympany Group

As the health insurer, the legal entity named in the policy provides the insurance benefits and is here inafter referred to as the ”insurer”.

2 Subject of the insurance

The people specified in the policy are insured against the economic consequences of illness, maternity and accident. The accident risk is covered if it is specified on the insurance policy.

3 General obligations

The insured person must follow the doctor’s instructions, do everything to aid recovery and refrain from anything that might delay it.

4 Liability resulting from medical treatment

Liability for diagnostic and therapeutic services lies solely with the service providers treating the insured person.

5 End of the insurance

The insurance ends:

a) when cancelled,
b) when the policyholder moves abroad, except when the insurance obligation continues to apply,
c) in the event of death.

6 Accident cover

The accident cover against work-related and non-work-related accidents can be excluded if evidence of full compulsory accident cover under the Federal Law on Accident Insurance (AIL) is produced. The exclusion takes place as of the first day of the month following the application. Accident cover is included as soon as the accident cover under AIL ends. The insured person must inform the insurance company immediately when the insurance cover under AIL lapses.

7 Obligation to report to and notify the insurance company

7.1 Reporting an accident

If accident benefits are claimed, the accident notification form must also be completed and submitted. The accident notification must be sent to the insurer no later than ten days after the accident occurred.

7.2 Cooperation of the insured person

The insured person must provide the insurer with all the information needed to evaluate a claim for benefits, free of charge. This also includes the decisions of other social insurance organisations and supporting documents from any private insurance companies.

7.3 Authorisation to share information

The insured person must authorise all people and organisations, i.e. employers, doctors, hospitals, therapists, insurance companies and public authorities, to provide the information needed to evaluate a claim for benefits.

7.4 Failure to uphold the obligation to notify the insurance company

The insured person is responsible for any negative consequences arising as a result of breaching the reporting and notification obligations.

8 Rights and obligations relating to third-party benefits

The insured person is obliged to inform the insurer immediately about any third-party benefits (e.g. accident, third-party liability, military or disabi-

lity insurance) and settlement agreements if it must pay benefits in the same insurance case. The insured person may not waive third-party benefits wholly or partially without the insurer's express permission. If another health, accident or social insurance provider reduces its benefits for reasons which also entitle the insurer to reduce benefits, it will not reimburse the shortfall caused by the reduction.

9 Payment details

The insurer pays out benefits to the insured person's specified post office or bank account. If the insured person fails to specify an account, the insurer may invoice them for a flat rate charge to cover expenses per benefit statement.

10 Fees

10.1 Reminder and debt collection fees

In addition to the costs involved in debt collection proceedings, the insurer may also invoice insured persons who default on payments for appropriate processing costs, handling costs, reminder costs and interest on arrears.

10.2 Payment in instalments

If payment in instalments is agreed during debt collection proceedings, the insurer may invoice the insured person an instalment fee for the additional administration involved.

11 Duty of confidentiality

The insurer's employees are bound by a legal duty of confidentiality.

12 Administration of justice

12.1 Order

If an insured person does not agree with a decision made by the insurer, the insurer shall issue a written substantiated order including instructions for the right to appeal within 30 days of being requested to do so.

12.2 Objection

An objection to the order issued by the insurer can be raised within 30 days of its delivery. The insurer shall review the objection and issue a written substantiated decision on the objection including instructions for the right to appeal.

12.3 Appeal procedure

An appeal against the decision on the objection issued by the insurer can be filed with the cantonal insurance court within 30 days of its delivery. Appeals can be filed by parties who are affected by the contested order or the decision on the objection and who have a legitimate interest in them being overturned or changed.

The responsible insurance court is the one for the canton in which the insured person or third party filing the appeal resides. The insurance court can also be called upon if the insurer does not issue an order or decision on the objection within the allocated time.

If the insured person or third party filing the appeal lives abroad, the responsible insurance court is the one for the canton in which their last place of residence in Switzerland was located or the canton in which their last Swiss employer resides. If it is not possible to determine a responsible court in either of these ways, the insurance court for the canton of Basel-Stadt shall be the responsible court.

13 Legal force

The order or decision on the objection issued by the insurer shall become legally valid if no appeal is filed within the allocated time. Legally binding orders regarding monetary payments are equivalent to enforceable court judgements according to Art. 80 of the Swiss Debt Enforcement and Bankruptcy Act (SchKG).

14 Legal protection

In disputes about fees between the insured person and service providers according to the KVG, the insurer may, at the insured person's request, take over representation of the insured person in the responsible courts at its own expense insofar as the legal request does not seem futile.

15 Data protection

In particular, insured persons' data is processed in accordance with the applicable legal data protection provisions of the Federal Act on Data Protection of 19 June 1992 (DSG, SR 235.1), Art. 33 of the Federal Act of 6 October 2000 on General Aspects of Social Security Law (ATSG, SR 830.1) and Art. 84, 84a and 84b of the Federal Law on Sickness Insurance of 18 March 1994 (KVG, SR 832.10). As regards insurance relationships with international relevance, data is processed in accordance with the applicable provisions (e.g. GDPR [EU] 2016/679 of 27 April 2016).

The data collected from the insured person is used for the purpose of processing the insurance contract (e.g. claims processing, debt collection or document management). Only the data used for this purpose is collected.

Detailed information on data protection can be found on the insurer's website.

16 Interpretation

The German version of these Terms and Conditions of Insurance is the original. The versions in English, French and Italian are translations. In case of discrepancies, the German version shall prevail.

17 Entry into force

These rules come into force on 1 January 2022 and replace all previous rules and terms and conditions regarding mandatory health insurance under statutory law.

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