

TERMS AND CONDITIONS OF INSURANCE FOR SICKNESS BENEFIT AND SICKNESS BENEFIT DAILY ALLOWANCE COVER OF THE EXPAT® SERIES PART I

**A - GENERAL PROVISIONS
VALID FOR ALL THE INSURANCE POLICIES
LISTED IN PART B**

§ 1 SCOPE OF INSURANCE COVER

So far as has not been agreed to the contrary, the following shall apply:

The scope of insurance cover shall be based on the terms and conditions of insurance for sickness benefit and sickness benefit daily allowance insurance cover of the Expat series part I and part II (tariff), on the statutory prescriptions, and on any additional agreements that may have been made in writing between the insurance company, the policy holder and the parties entitled to insurance.

§ 2 ELIGIBILITY FOR INSURANCE COVER

So far as has not been agreed to the contrary, the following shall apply:

1. Those entitled to insurance are juridical and natural persons.
2. Natural persons may be insured.
3. Persons who at the start of the policy are in need of constant care or mentally ill may not be insured and are not insured, even if premiums have been paid. A person is in need of care if he/she for the most part needs external help in order to manage the tasks of daily life.

§ 3 CONCLUSION AND DURATION OF THE INSURANCE CONTRACT

So far as has not been agreed to the contrary, the following shall apply:

1. The framework insurance contract will be concluded in writing between the insurance company and the policy holder, on the basis of these terms and conditions of insurance. The policy holder is entitled, in the context of the insurance contract, to make possible the registration of persons insured in the form of lists as persons liable for premiums with parties entitled to insurance.
2. The framework insurance contract is concluded for an indefinite period, and will be tacitly extended from year to year if notice of termination is not given at the end of a year of insurance, with a term of notice of three months.
3. The policy holder shall be obliged to notify the parties entitled to insurance of the termination of the framework insurance contract within the term of one month after it becomes known.
4. If the business of the policy holder or the party entitled to insurance should fail, the insurance coverage in respect of the person insured remains unaffected by this.

§ 4 START OF INSURANCE COVER

So far as has not been agreed to the contrary, the following shall apply:

1. Insurance cover commences at the time stated in the confirmation document (start of insurance cover), not however before payment of the premium and not before expiry of the waiting period.
2. No benefit will be paid for claims occasioned before the start of insurance.
3. No benefit will be paid for claims occasioned during the waiting period.

§ 5 END OF INSURANCE COVER

1. The maximum duration of insurance cover is defined in terms of the relevant tariff.
2. Insurance cover for individual persons insured comes to an end, even in connection with pending claims, with
 - a) the end of the insurance relationship
 - b) the expiry agreed upon
 - c) deregistration from the group of persons insured by the party entitled to

insurance, taking into account the terms of notice and conditions defined in the tariff

d) the death of the person insured

e) the ending of the framework insurance agreement between the insurance company and the policy holder

Note: please be aware of the additional stipulations on the end of insurance cover in Part B, II. Sickness benefit daily allowance insurance, § 4.

§ 6 GENERAL EXCLUSIONS

So far as has not been agreed to the contrary, the following shall apply:

There shall be no obligation to pay benefit

1. on account of such illnesses, including their consequences, or consequences of such accidents as are occasioned by active participation in events of war or civil disturbance, or through professional participation in sporting competitions organised by sporting federations and associations or preparatory measures related to these, or such as are recognised as war injuries and are not explicitly included in the insurance cover.
2. on account of illnesses and accidents caused by deliberate intent, including their consequences, or on account of withdrawal measures including courses of withdrawal treatment.
3. during health resort or sanatorium treatment, or during a course of rehabilitation organised by the party legally responsible for rehabilitation.
4. in consequence of accommodation occasioned by the need of care or custody.
5. for benefits consequent on illnesses, complaints or conditions resulting from accidents which existed at the time of the start of the insurance cover.
6. for the treatment of mental or emotional disturbances, or for hypnosis or psychotherapy.
7. on account of such illnesses, including their consequences, which arise as a result of the person's having neglected to obtain the protective inoculations prescribed by statute, unless there should be medical reasons why protective inoculation cannot be carried out. In this case the medical reasons are to be proved to the insurance company by the submission of a doctor's certificate.

Note: please be aware of the special exclusions in Part B, I. Coverage of medical expenses, § 3.

§ 7 WAITING PERIOD

The waiting periods agreed upon in the relevant tariff shall apply.

§ 8 PAYMENT OF PREMIUMS

So far as has not been agreed to the contrary, the following shall apply:

1. The premium is an annual premium, which will be made out in equal monthly instalments. It is determined by the relevant tariff, and is to be paid in advance on conclusion of the insurance contract, at latest by the end of the insurance year.
2. The given tariff may allow for payment of premiums by direct debit or by credit card payment. The premium shall then be considered to have been paid when a legally valid authorisation to debit the insured party's account has been issued, so long as it proves possible thereafter to debit the amount effectively.

§ 9 PAYMENT OF INSURANCE BENEFITS

1. The insurance company shall be obliged to pay out benefits only if the original invoices are presented and the required documentary proofs supplied. These then become the property of the insurance company. If the original papers have been presented to another insurance company for reimbursement, duplicates of the invoices will be considered sufficient,

provided that the other insurance company has made a note on the document of the benefit paid.

- All receipts must carry the name of the physician treating the patient, the first name, surname and date of birth of the patient treated, as well as a description of the illness and the dates of treatment. Benefits paid by other insurance companies, or other companies' refusal to pay such benefits, must be shown.
- Costs that have been incurred in a foreign currency will be converted into euros at the exchange rate of the day on which the receipts are received by the insurance company. The exchange rate for the day is taken to be that defined by "Währungen der Welt" ["World currencies"], publications of the Deutsche Bundesbank [German Federal Bank], Frankfurt, in accordance with the most recent level, unless the party insured can prove on the basis of a bank slip that he obtained the foreign currency required for payment of the invoice at a less favourable rate, and that this was caused by a change in the currency valuation.
- Costs incurred for the payment of insurance benefit by banker's draft to a foreign country, or for special forms of fund transfer which have been selected at the request of the insured party, will be deducted from the benefit paid.
- Claims to insurance benefit cannot either be assigned or given in pledge.
- The insurance company shall be entitled to pay out benefit to the party who submits or sends regular documentary proofs, unless the insurance company has any good reason to doubt the bona fides of the party submitting or sending.

Note: please have regard as well to the special conditions for payment of insurance benefit in Part B, I. Insurance for the cost of medical treatment, § 4.

§ 10 GENERAL OBLIGATIONS

- On being requested to do so by the insurance company, the person insured and the party entitled to insurance are to supply any information which may be required in order to establish the facts of the claim or of the insurance company's obligation to pay benefit, as well as the scope of this obligation. The information requested should also be supplied to a person appointed by the insurance company.
- The person insured is to see to it, as far as possible, that damages shall be minimised, and to refrain from any activities which are prejudicial to recovery.
- The person insured and the party entitled to insurance shall be obliged to authorise any reasonable investigations into the occasion and extent of the obligation to pay benefit, in particular and in addition to submit to examination by a doctor appointed by the insurance company, as also to release physicians treating the illness and other insurance companies from their obligation of confidentiality, if required, and in a case of death to submit the death certificate.
- The person insured and the party entitled to insurance are to inform the insurance company without delay of any changes of address (domestic residence, place of business or place of commercial operations). Otherwise written declarations which are sent by the insurance company in the form of a registered letter to the last known address shall be considered as having been effectively delivered.
- In so far as in the given country of residence particular stipulations, proceedings or legal regulations apply to the processing of insured damages, these may be incorporated by the insurance company (on receiving the relevant information) or by the party entitled to insurance so as to form an integral part of these terms and conditions of insurance.
- The insurance company is to be informed of a case of pregnancy within four weeks after the existence of a pregnancy has been established, unless defined otherwise in terms of the relevant tariff.

Note: please have regard as well to the Special Obligations in Part B, I. Coverage of medical expenses, § 5 and II. Sickness benefit daily allowance cover, § 5.

§ 11 CONSEQUENCES OF FAILURE TO ADHERE TO OBLIGATIONS

- If there should be a failure to adhere to an obligation incumbent on the person insured after the occurrence of a claim, the insurance company shall be released from the obligation to pay benefit, unless it should be the case that the failure to adhere to the obligation was not the result either of deliberate intent or of gross negligence. In a case where an obligation has been breached out of gross negligence, the insurance company shall remain obliged to pay benefit to the extent that the breach shall have had no implications either for the establishment or for the scope of the obligation incumbent on the insurance company.
- Knowledge and responsibility on the part of the person insured are to be taken as equivalent to knowledge and responsibility on the part of the

party entitled to insurance.

§ 12 CLAIMS AGAINST THIRD PARTIES

- If the party entitled to insurance or a person insured should have indemnification claims against third parties, the nature of which have nothing to do with the legal conditions of the insurance policy, then an obligation shall exist, without regard to the statutory transference of claims as defined by § 67 of the VVG, to assign these claims in writing to the insurance company up to the amount of benefit that is to be paid on the basis of the insurance contract.
- If the party entitled to insurance or a person insured resigns such a claim or a right that serves to ensure the claim without the consent of the insurance company, the latter shall be released from the obligation to pay benefit to the extent that it would have been able to obtain compensation on the basis of the right or claim surrendered.

§ 13 ADJUSTMENT OF PREMIUM AND BENEFIT RATES / INSURANCE YEAR

- The insurance company shall be entitled to make changes in the premium level or the extent of the benefits at the beginning of a new insurance year, provided that it notifies the policy holder of this with a term of notice of three months.
- The insurance year will be defined in the terms and conditions for sickness benefit and sickness benefit daily allowance cover of the EXPAT series, part II (tariff).
- The policy holder shall be obliged to give the party entitled to insurance written notice of an adjustment of the premium level or of the level of benefits paid within a term of three weeks from the time it is made known.

§ 14 OFFSET CHARGES

The policy holder, party entitled to insurance and person insured may only set off amounts to which they are entitled against claims of the insurance company to the extent that the counter-claim is either uncontested or has been established as valid at law.

§ 15 DUE DATE OF BENEFIT PAYMENT / TERM FOR SUIT TO BE BROUGHT

- Once the obligation to pay benefit on the part of the insurance company has been proved, with reference both to the grounds and the amount, the insurance benefits must be paid out within one month.
- If the insurance company has rejected a claim, either with reference to the grounds or to the amount, it shall be released from the obligation to pay benefit, if the claim of the policy holder has not been upheld as valid at law within a period of six months. The term shall not be considered to have begun until the insurance company has refused to acknowledge the claim in writing, giving notice of the associated legal consequences that will follow from the expiry of the term.

§ 16 RIGHTS AND OBLIGATIONS IN CASE OF DAMAGES OCCURRING

The person insured has an intrinsic right to assert claims based on the contract against the insurance company.

§ 17 DECLARATIONS OF INTENTION AND NOTIFICATIONS

Declarations of intention and notifications to the insurance company require to be expressed in writing. Intermediate insurance agents are not authorised to receive these.

§ 18 RESPONSIBLE COURT

Suit may be brought against the insurance company at the main place of business of the policy holder.

§ 19 APPLICABLE LAW / RESPONSIBLE SUPERVISORY AUTHORITY

The insurance relationship shall be subject to the laws of the Federal Republic of Germany. The responsible supervisory authority for complaints is the Bundesaufsichtsamt für das Versicherungswesen [Federal Supervisory Office for Insurance Matters], Gaurheindorfer Strasse 108, 53117 Bonn.

B - SPECIAL PROVISIONS

THE RELEVANT SECTION APPLIES IN DEPENDENCE ON THE INSURANCE COVER SELECTED

SECTION I. COVERAGE OF MEDICAL EXPENSES

§1 OBJECT OF INSURANCE

So far as has not been agreed to the contrary, the following shall apply:

- The insurance company shall offer insurance cover for illnesses, sicknesses, accidents and other events mentioned in the contract either within Germany or abroad. In case of a claim occurring, it will reimburse expenses in connection with medical treatment and other benefits agreed upon.
- Grounds of a claim shall be the medically necessitated treatment of a person insured on account of illness or in consequence of an accident.

The claim shall be considered to begin with the treatment, and shall end when medical findings indicate that there is no further need of treatment.

3. In so far as the tariff defines the relevant benefits, further grounds for a claim shall also be:
 - a) Examination and medically necessitated treatment in connection with pregnancy and childbirth
 - b) Examination as an outpatient, with a view to the early recognition of illness in accordance with statutory programmes that have been introduced (targeted prophylactic examinations)
 - c) Death
4. Insurance cover shall extend to medical treatment in the country of residence.

§ 2 SCOPE OF INSURANCE BENEFITS

So far as has not been agreed to the contrary, the following shall apply:

1. The nature and amount of the insurance benefits shall be derived from the terms and conditions of insurance for sickness benefit and sickness benefit insurance cover of the Expat series, Part II (tariff).
2. The person insured has the liberty to choose from among the approved doctors practising, or from among the doctors, dentists and medical practitioners who are qualified to give treatment in terms of the law that applies to the country of residence covered by the terms of the insurance policy.
3. Pharmaceuticals, bandages, medicines and medical aids must be prescribed by the qualified practitioners mentioned in section 2. Pharmaceuticals may also be obtained from a pharmacy.
4. In case of medically necessitated hospital treatment, the person insured has free choice from among those public and private hospitals that are under constant medical supervision, possess sufficient diagnostic equipment and conduct case histories.
5. In case of medically necessitated hospital treatment in licensed hospitals which also carry out health resort or sanatorium or convalescent treatments but which in other respects conform to the conditions of § 2, section 4, benefits at the agreed rate will only be paid if the insurance company has given written consent to this before the start of the treatment. In case of a TB condition, benefit will be paid to the extent defined by the contract for hospital treatment in TB treatment centres and sanatoria as well.
6. The insurance company will pay benefit to the extent defined by the contract for examination and treatment methods and pharmaceuticals that are generally recognised by school medicine. It will in addition pay benefit for methods and pharmaceuticals which have proved themselves in practice to be equally likely to achieve success; the insurance company may however reduce the level of benefit to the amount that would have been paid if existing school medicine methods or pharmaceuticals had been used.

§ 3 SPECIAL EXCLUSIONS

So far as has not been agreed to the contrary, the following shall apply:

1. There shall be no obligation to pay benefit
 - a) for treatments by doctors, dentists, medical practitioners or in licensed hospitals the invoices for which the insurance company has excluded from reimbursement on good grounds, if the claim occurs after the party entitled to insurance has been notified of this exclusion of benefit. In so far as at the time of notification a claim should be pending, no obligation to pay benefit shall exist for expenses incurred after the expiry of three months from the time of notification being given.
 - b) during a stay in a spa or health resort, even if this involves a stay in hospital. This limitation shall no longer apply if the person insured has his/her constant place of residence there or if he/she becomes unable to work as a result of a sickness independent of the purpose of his/her visit or as a result of an accident that has occurred there, so long as this results, on medical testimony, in his/her being unable to journey home. This limitation also shall no longer apply if and to the extent that the insurance company has given written consent to benefit being paid before the start of residence abroad.
 - c) for treatments by spouses, parents, children or persons living together in the immediate domestic circle. Costs of materials will be reimbursed in keeping with the given tariff.
2. If the medical treatment or other measure for which benefit has been agreed upon should exceed the medically necessary limits, or if the remuneration claimed is out of proportion, the insurance company may reduce benefit to an acceptable level.
3. If there should also be a claim on third party benefit providers, the insurance company shall only be obliged to pay benefit for expenses which

are necessary in spite of the benefits paid by third parties and which are insured.

§ 4 SPECIAL CONDITIONS FOR THE PAYMENT OF INSURANCE BENEFIT / DOCUMENTARY EVIDENCE TO BE SUBMITTED

1. To prove the medical necessity of return transport, a doctor's certificate, which should clearly demonstrate the medical necessity, must be submitted.
2. For the assertion of claims in connection with conveyance of the body or funeral costs, an official or medical certificate giving the cause of death must be submitted.

§ 5 SPECIAL OBLIGATIONS

1. The insurance company is to be notified of any hospital treatment within ten days from its starting.
2. The person insured must submit the relevant documentary evidence to the insurance company within three months from the time of each individual course of treatment.
3. If a person insured has concluded a contract for the insurance of medical expenses with another insurance company, if such exists or a person insured avails himself/herself of the entitlement to insurance in connection with statutory health insurance cover, the party entitled to insurance or the person insured shall be obliged to notify the insurance company without delay of the other insurance cover arranged.

SECTION II. SICKNESS BENEFIT DAILY ALLOWANCE INSURANCE COVER

§ 1 OBJECT OF THE INSURANCE

So far as has not been agreed to the contrary, the following shall apply:

1. The insurance company offers insurance cover against loss of income in consequence of illness or accidents and other such occurrences mentioned in the contract, either within Germany or abroad. In case of a claim arising based on inability to work, it will provide a daily sickness benefit allowance.
2. A claim shall exist in case of a proven inability to work in the course of medically necessitated treatment by a doctor. The claim shall be considered to begin with the treatment, and shall end when medical findings indicate that the patient is no longer incapable of working and that there is no further need of treatment.
3. It shall be seen as a case of inability to work in the sense of these conditions if the person insured, on the strength of medical evidence, cannot in any way exercise his or her profession, does not practise it and has no other means of gainful employment. If the medical treatment must be extended to an illness or the consequences of an accident which is unconnected, in terms of origin, with the condition treated hitherto, to that extent it shall be considered to be a new claim.
4. Insurance cover extends to a case of inability to work in the country of residence defined by the insurance agreement.

§ 2 SCOPE OF INSURANCE BENEFITS

So far as has not been agreed to the contrary, the following shall apply:

1. The insurance company's obligation to pay benefit shall begin with the first day of inability to work, with the addition of any days without benefit that form part of the terms of the agreement (waiting period). The obligation to pay benefit ends when the person insured is able to resume work or with the end of the insurance cover as defined in A, General Provisions, § 5 and B, Special Provisions, section II - Sickness Benefit Daily Allowance Insurance Cover, § 4, but at latest with the end of the duration of benefit as defined in the given tariff.
2. The insurance company hereby undertakes to adjust the insurance cover with effect from the first of the following month after application has been made by the party entitled to insurance and the person insured, if and to the extent that
 - a) through a change in the regular net income derived from professional activity an increase in the sickness benefit daily allowance agreed upon is necessary, so as to maintain the previous percentage ratio between sickness benefit daily allowance and net income. This obligation is also incumbent on the insurance company in case of a reduction in the level of a sickness benefit claim on a statutory benefit provider.
 - b) through a change in the duration of continued payment of salary, in case of inability to work, a switch to a different tariff level with a different waiting period should be called for.

This adjustment must be applied for within two months from the occurrence of the reasons for the change. The reasons for the change must be presented in a convincing way, and should be supported by documentary evidence at the request of the insurance company. In the case of current claims, the increased level of cover shall be allowed from the time when the change becomes effective.

3. If it should come to the knowledge of the insurance company that the net income of the chief party insured has sunk below the level of the income on which the insurance agreement is based, it shall be entitled, without distinction as to whether an insurance claim has already occurred or not, to reduce the sickness benefit daily allowance and the premium correspondingly, with retrospective effect from the onset of the reduction, or call for the reimbursement of benefit paid in excess.
4. The payment of sickness benefit daily allowance is based on the assumption that the person insured will be treated by a doctor or in hospital for the duration of the period that he/she is unable to work.
5. In case of medically necessitated hospital treatment, the person insured has free choice from among those public and private hospitals that are under constant medical supervision, possess sufficient diagnostic equipment and conduct case histories.
6. In case of medically necessitated hospital treatment in licensed hospitals which also carry out health resort or sanatorium or convalescent treatments but which in other respects conform to the conditions of § 2, section 4, benefits in terms of the given tariff will only be paid if the insurance company has given written consent to this before the start of the treatment. In case of a TB condition, benefit will be paid to the extent defined by the contract for hospital treatment in TB treatment centres and sanatoria as well.

§ 3 SPECIAL EXCLUSIONS

So far as it has not been agreed otherwise, no benefit will be paid:

1. in a case of inability to work resulting exclusively from pregnancy, also from termination of pregnancy, miscarriage or childbirth. As an exception to this, benefit will be paid to individuals in a position of employment who are insured for the payment of sickness benefit daily allowance with a waiting period (period without benefit) of at least 42 days, outside the statutory prohibitions on working in accordance with § 3, section 2.
2. in case of inability to work during a period of statutory prohibition on working for expecting mothers in a position of employment and women in childbirth (maternity protection).

§ 4 ADDITIONAL STIPULATIONS ON THE END OF INSURANCE COVER

1. The insurance cover comes to an end, in addition to the circumstances mentioned in A - General Provisions, § 5, with the person insured's giving up gainful employment, with the onset of occupational disability or earning incapacity or a partial reduction of earning ability or when the person insured starts to draw an old age pension or pension for occupational disability or earning incapacity or for reduced earning capacity.
2. The insurance company will decide on the question whether, to what degree and starting from what time occupational disability or earning incapacity or reduced earning capacity, as defined by these terms and conditions of insurance, has set in, on the basis of the documentary evidence submitted to or obtained by the company, and will communicate its decision on the matter in a registered letter.

§ 5 SPECIAL OBLIGATIONS

1. The insurance company should be notified immediately of a medically attested inability to work, at latest, however, within the term set in the given tariff, through presentation of the appropriate documents. The doctor's certificate may be sent in advance by fax. The originals must be sent by post without delay. Certification by spouses or life partners, parents or children are not sufficient as a proof of inability to work. If notification is received late, the sickness benefit daily allowance will be paid only from the day of receipt, not however before the time prescribed in terms of the tariff. Documentary proof of continuing inability to work should be regularly supplied to the insurance company, in so far as the insurance company does not request it on a different basis, at two-weekly intervals at most.
2. If a sickness benefit daily allowance policy is concluded for a person insured with another insurance company, or if a person insured has recourse to the insurance entitlement included in statutory health insurance, the party entitled to insurance or the person insured shall be obliged to inform the insurance company forthwith of the other insurance policy.
3. The insurance company is to be notified without delay of any change of career by the person insured.
4. A new insurance policy with a third party insurer that includes a claim to sickness benefit daily allowance may be taken out, or an existing one increased, only with the consent of the insurance company.
5. Persons insured are obliged to notify the insurance company immediately of a reduction in their net income derived from professional activity, if this is not just a temporary condition, or of a change in the duration of continued salary payment by their employer.

GENERAL NOTE: EXTRACT FROM THE VVG

§ 6 FAILURE TO ADHERE TO AN OBLIGATION

1. If the contract stipulates that, in case of a breach of an obligation which is owed by the person insured to the insurance company before the occurrence of a claim, the insurance company shall be released from the obligation to pay benefit, the legal consequence agreed to shall not be effective if the breach was to be seen as one for which the party could not be held responsible. The insurance company may give notice of termination of the contract within one month from the time when the breach comes to its knowledge, without observing a term of notice, unless the breach is to be seen as one for which the party could not be held responsible. If the insurance company does not give notice of termination of the contract within one month, it may not avail itself of the release from obligation to pay benefit that has been agreed upon.
2. If there has been a failure to adhere to an obligation which the policy holder owes to the insurance company with a view to the reduction of the risk or to guard against any possible increase in the risk, the insurance company may not avail itself of the release from obligation to pay benefit which has been agreed upon if it be the case that the breach of obligation has not had any effect on the occurrence of a claim or on the scope of the associated benefit due.
3. If the contract stipulates a release from the obligation to pay benefit in a case where the person insured fails to adhere to an obligation which is owed to the insurance company after the occurrence of the claim, the legal consequence agreed upon shall not be effective if the breach in question was not the result of either deliberate intent or gross negligence. In a case of gross negligence the insurance company shall remain obliged to pay benefit to the extent that the breach involved shall have had no effect either on the establishment of the claim or on the establishment of the scope of the benefit which it is incumbent on the insurance company to pay.
4. Any agreement according to which the insurance company shall be entitled in case of a breach of obligation to withdraw from the contract is invalid.

§ 11 DUE DATE OF PAYMENT

1. Cash payments are to be made by the insurance company with the ending of the enquiries that are needed for the establishment of the claim and the scope of the benefit payable by the insurance company.
2. If these enquiries are not completed after the expiry of one month from the time of notification of the claim, the policy holder shall be entitled to request advance payment on the total claim in the form of instalment payments to the amount of the sum which would be the minimum that the insurance company would have to pay in the given circumstances.
3. This term shall not apply so long as the conclusion of the enquiries has been held up in consequence of actions for which the policy holder can be held responsible.
4. Any agreement by which the insurance company is released from the obligation to pay interest on arrears is invalid.

§ 12 EXPIRY BY LIMITATION

1. The claims based on the insurance contract shall be subject to expiry by limitation after two years, or in the case of life insurance after five years. The period of limitation shall begin with the close of the year in which payment of the benefit may be requested.
2. If the insurance company has been notified of a claim by the policy holder, expiry by limitation shall be blocked until the receipt of the written decision of the insurance company.
3. The insurance company shall be released from the obligation to pay benefit if the claim to benefit has not been successfully asserted at law within six months. This term does not begin until the time when the insurance company has declined in writing to recognise the claim that has been asserted by the policy holder, stating the legal consequences that will follow from the expiry of the term.

§ 38 DELAYED PAYMENT OF THE FIRST OR UNIQUE PREMIUM

1. If the first or unique premium is not paid on time, the insurance company shall be entitled, so long as payment has not been effected, to withdraw from the contract. It shall count as grounds for withdrawal if the claim to the premium has not been successfully asserted at law within three months from the due date of payment.
2. If the premium has not yet been paid at the time of the occurrence of a claim, the insurance company shall be released from the obligation to pay benefit.

§ 39 DELAYED PAYMENT OF A SUBSEQUENT PREMIUM

1. If a subsequent premium is not paid on time, the insurance company may at the cost of the policy holder appoint to the latter in writing a term of payment of at least two weeks; for signature purposes, a reproduction of the autograph signature shall be taken as sufficient. In this connection the legal consequences are to be stated which will ensue with the expiry of the term, in keeping with sections 2 and 3. Any appointment of a term

that fails to take these prescriptions into account is invalid.

2. If a claim should occur after the expiry of the term, and if the policy holder should be in arrears with the payment of the premium or the interest or costs owing on it, the insurance company shall be released from the obligation to pay benefit.
3. After the expiry of the term, if the policy holder is in arrears with the payment, the insurance company may give notice of termination of the insurance contract without observance of any term of notice. Termination may be effected already at the time of the appointment of a term for payment, in such a way that it becomes effective on the expiry of the term, if the policy holder at this point is in arrears with the payment; the policy holder must be expressly informed of this when notice of termination is given. The effects of the notice of termination lapse if the policy holder makes good the payment within one month after notice of termination has been given, or, if notice of termination has been associated with the appointment of a term for payment, within one month after the expiry of the term set for payment, provided that a claim has not arisen by this time.
4. In so far as the legal consequences indicated in sections 2 and 3 relate to the fact that interest or costs have not been paid, they shall only become effective if the notification of the term set for payment states the rate of interest or the amount of the costs.

§ 67 ASSIGNMENT OF INDEMNIFICATION CLAIMS

1. If the policy holder has an indemnification claim against a third party, the claim shall be assigned to the insurance company, provided that the latter indemnifies the policy holder. The transfer may not be claimed to the disadvantage of the policy holder. If the policy holder surrenders his claim on the third party or a right that serves to ensure the claim, the insurance company shall be released from its obligation to indemnify the policy holder to the extent that it could have obtained compensation from the claim or right in question.
2. If the policy holder's claim to indemnification is directed to a family member living with him/her in a domestic context, such an assignment is excluded; the claim shall however be assigned if the family member should have occasioned the damage by acting with deliberate intent.