Daily sickness benefit settlement for policyholders

Version 2023-04

This leaflet provides policyholders with information about the settlement of benefits provided by the collective daily sickness benefit insurance of elipsLife. More detailed information is set out in the General Conditions of Insurance (GCI) and the Special Conditions. The basis of the daily sickness benefit insurance is the Swiss Insurance Policies Act (*Bundesgesetz über den Versicherungsvertrag* – VVG).

Insurance company

The insurance company is Elips Life Ltd, headquartered in Ruggell. All administrative aspects of the insurance are processed at the Zurich branch office. Your contact in the event of a claim is:

elipsLife
Claims Management
Thurgauerstrasse 54, 8050 Zurich
T +41 44 215 45 40
claims.ch@elipslife.com

Reporting the illness

The policyholder must inform elipsLife at the latest 30 days after the date of the start of the illness about the insured person's incapacity to work. It is important to ensure that the illness is reported in good time, as elipsLife draws up long-term solutions and continuously assesses the need for damage-limitation measures, such as, for example, the involvement of case management or a medical examination carried out by an independent medical examiner. Thus, your employees will generally be contacted by telephone by our claims management staff after registration. Our aim is to obtain first-hand information relevant to case management in an approach that is as speedy, uncomplicated and as individual as possible, and to clarify any personal questions and concerns. You can support us in the best way in this regard by providing us with your employees' telephone numbers and e-mail addresses on the claims notification.

When an illness is reported, elipsLife requires a (written or electronic) claims report and a medical certificate or control card. In order to simplify the exchange of data and to streamline the recording of reported claims, we make the following tools available to the policyholder free of charge:

- Sunet*plus* for medium-sized and large companies with more than 20 claims reports per year:
  http://www.bbtsoftware.ch/de/support/sunetplus/downloads.html

- BBT*Claims* for small and medium-sized companies with 20 or fewer claims reports per year:
  https://www.elipslifesunet.com/bbtClaims

After the illness report is received, the claims number is confirmed within two working days by means of an e-mail sent directly to the policyholder.

The policyholder will additionally be asked to supply any documents that are lacking or incomplete. The contact details of a contact person responsible for such matters may be reported to elipsLife via claims.ch@elipslife.com or on the claims report.

Medical records

elipsLife forwards a medical questionnaire to the doctor who is treating the patient. If a claim is accepted, elipsLife requests current medical records at regular intervals from the doctor who is treating the patient.

Assessment of the claim

As soon as the medical report has been received by elipsLife, the merits of the claim will be assessed. If a claim is accepted, this will be confirmed through payment of daily benefits. If a claim is rejected, the policyholder will be informed in writing.

If the incapacity for work is not wholly clarified, elipsLife reserves the right to commission targeted measures to assess entitlement to the claim.

Daily benefits

In the event of incapacity for work caused by illness, elipsLife provides daily benefits amounting to 80/90% of the insured salary, once the agreed waiting period has expired. The first payment the daily benefits will be made once elipsLife has received the medical report. Daily benefits will be provided on an ongoing basis in accordance with the medical certificate or control card, as a rule between the 20th and 30th day of the month, and will be paid per insured person to the policyholder.

In order to enable elipsLife to pay out the benefits, it requires the bank account details of the policyholder, which may be reported to the following e-mail address: account.ch@elipslife.com

Reporting to the disability insurance

If incapacity for work lasts longer than four months, the benefits must be assessed by the Swiss disability insurance (IV). elipsLife shall forward the IV registration form to the insured person after the incapacity for work has lasted approximately 120 days, and shall notify the policyholder accordingly.

Ending of a claim by the policyholder

The ending of incapacity for work must be reported to elipsLife by the policyholder without delay. The same applies to the termination of the employment relationship during the incapacity for work, along with the precise date of leaving as well as the bank account details of the insured person.

Ending of a claim by elipsLife

The reaching of the maximum benefit period of 730 days will be reported to the policyholder approximately three to four months in advance.
Any other cessation of benefits by elipsLife will be reported to the policyholder without delay.

Information for the insured person in the event of illness

Leaflets explaining the settlement of daily sickness benefit and the transfer to individual insurance for insured persons can be downloaded from www.elipslife.com.

elipsLife would like to thank you for the trust you have placed in us, and wishes your employees a speedy recovery from any illnesses they may incur.