HanseMerkur

Overview of payments

With this table we would like to give you a quick overview of the tariff benefits. The full description of the insured benefits and events is given in the relevant clauses of Section II – Description of benefits of the insurance conditions VB-KV 2023 (B-AGV-D).

Insured benefits of travel health insurance		Benefit levels
The maximum compensation for all insured events within the contract period per insured person is as follows		**50.000,– EUR**
2.4	**Out-patient medical treatment**	
2.4.1	Out-patient medical treatment	100 %
2.4.2	Ambulance services	100 %
2.5	**In-patient medical treatment**	
2.5.1	Inpatient medical treatment	100 %
2.5.2	Ambulance services	100 %
2.5.3	Alternatively, daily allowance of up to 14 days, per day	75,– EUR
2.6	**Dental treatments**	
2.6.1 2.6.2 2.6.3	Pain-relieving preservative dental treatments Simple fillings Repairs of existing dental prostheses	300,– EUR per contract period
2.7	**Medicines, dressings, remedies or aids**	
2.7.1	Medications and dressing material	100 %
2.7.2	Remedy Radiation therapy, light therapy and other physical treatments Massages, packs, inhalations, physiotherapy, per contract duration	 100 % 300,– EUR
2.7.3	Accident-related aids	100 %
2.8	**Pregnancy**	
2.8	Examinations; treatments for complications, premature birth, miscarriage	100 %
2.9	**Repatriation, transfer, burial**	
2.9.1	Repatriation of the patient	100 %
2.9.2	Repatriation to the home country or burial in Germany up to the amount of the repatriation costs	100 %
2.10	**Extension of the insurance cover**	
2.10	Extension of the insurance cover until the restoration of transportability	max. 3 months

HanseMerkur Reiseversicherung AG Siegfried-Wedells-Platz 1 DE-20354 Hamburg Tel.: +49 40 4119-1000, Fax: -3040 www.hmrv.de

HanseMerkur

Terms and conditions for travel health insurance for foreign guests with visa

VB-KV 2023 (B-AGV-D)

The scope of the insurance cover is set out in the insurance certificate, in any separate written agreements, in these insurance terms and conditions, and in the statutory provisions of the Federal Republic of Germany.

We are HanseMerkur Reiseversicherung AG based in Hamburg. You are our contractual partner, the so-called policyholder, when you conclude the insurance contract with us. An insured person is both you, if you have insured yourself, and other persons who have (co-)insured you. We also refer to any such persons in these insurance terms and conditions as "you". These insurance terms and conditions apply to you as the policyholder and to you as the insured person.

The insurance terms and conditions consist of three sections.
In Section I, you will find, in particular, explanations about the insured persons, time limits for taking out insurance and premium payments.
In Section II, you will find the scope of benefits for the insurance.
In Section III, you will find an excerpt from the German Insurance Contract Act (VVG).

Content

Section I – General provisions ... 3
1 Insurance cover ... 3
1.1 Who is covered by the insurance? ... 3
1.2 When does the insurance cover start? ... 3
1.3 When does the insurance cover end? ... 3
1.4 What trips are covered by the insurance cover? ... 3
2 The insurance policy ... 3
2.1 Conclusion and duration of the insurance contract ... 3
2.2 When does the insurance contract end? ... 3
2.3 Which legislation applies to the insurance policy? ... 3
2.4 When do claims to benefits lapse? ... 3
2.5 What form should a statement that you make to us be in? ... 3
3 What requirements must be met when paying the premiums? ... 4
3.1 Premium amount ... 4
3.2 Payment of the first premium ... 4
3.3 Collection of premiums ... 4
3.4 Offsetting ... 4
4 What you have to consider in case of an insured event (obligations)? ... 4
4.1 To whom can you direct the claim? ... 4
4.2 When is it necessary to contact us immediately? ... 4
4.3 What information are you obligated to provide? ... 4
4.4 What does your duty of disclosure to minimise damage comprise? ... 4
4.5 What are the legal consequences of failures of duty (breaches of obligations)? ... 4
4.6 When do we pay compensation? ... 4
Section II – Description of payments ... 5
1 General rules for insurance coverage ... 5
1.1 What is an insured event? ... 5
1.2 Which doctors and hospitals can you choose between? ... 5
1.3 Which methods do we cover if you need to be examined and treated? ... 5
2 What are the benefits that we pay if an insured event occurs? ... 5
2.4 What do we pay if you are treated as an out-patient? ... 5
2.5 What do we pay if you are treated as an in-patient? ... 5
2.6 What do we pay if you have dental treatment? ... 5
2.7 What do we pay for medications, dressings, therapeutic products and medical aids? ... 6
2.8 What do we pay in the event of pregnancy? ... 6
2.9 What benefits do we do for repatriation, transfer and burial? ... 6
2.10 When do we extend your insurance cover beyond the agreed duration? ... 6
3 What do we not cover or only provide restricted cover for? ... 6
3.1 In which cases can we reduce the scope of benefits? ... 6
3.2 In which cases do we not provide cover? ... 6
Section III – Extract from the Insurance Contract Act (VVG) ... 7

§ 19 Duty of notification 7
§ 20 Representative of the policyholder 7
§ 21 Exercise of the rights of the insurer 7
§ 28 Non-observance of a contractual obligation 7
§ 37 Delayed payment of first insurance premium 7
§ 86 Assignment of claims 8
Arbitration bodies 8

Section I – General provisions

1 Insurance cover

1.1 Who is covered by the insurance?

1.1.1 You are insured if
- you are named in the insurance certificate and
- you require a visa and
- you have not yet reached the age of 75.

1.1.2 For persons who at the time of the application
- practice a professional sport or
- are permanently in need of care or their participation in general life is permanently excluded,

are not eligible for insurance.
The insurance contract is also not concluded by paying the premium.
The mental condition and objective living conditions of the person in question, in particular, shall be taken into account as regards classification of participation in general life. Per-sons in need of care are those persons who largely require external assistance to complete everyday tasks.

1.2 When does the insurance cover start?

The insurance cover begins on the date indicated on the insurance certificate (commencement of insurance). The prerequisite for this is that the policy is valid.

1.3 When does the insurance cover end?

1.3.1 Your insurance coverage also ends for insurance claims that have not yet been completed no later than
- upon termination of the insurance contract,
- in the event of repatriation upon your arrival at the nearest suitable hospital in your home country,
- if the competent authority refuses to issue the visa.

1.4 What trips are covered by the insurance cover?

The insurance cover applies during the temporary stay in Germany and for temporary trips in the countries of the European Union, the Schengen countries, Andorra, Monaco, San Marino and the Vatican City, but not in your home country. For the purposes of these terms and conditions, home country means your permanent place of residence.

2 The insurance policy

2.1 Conclusion and duration of the insurance contract

2.1.1 An insurance contract must be concluded before entry for the entire duration of stay.

2.1.2 The longest possible insurance term is 365 days.

a) If your stay abroad is extended in Germany
- further insurance cover can only be granted by way of a new insurance contract within the maximum insurance period,
- the application for the new insurance contract must be submitted to us before the expiry of the original insurance contract.

The new insurance contract is only concluded if we expressly agree to it! In this case
- any fulfilled waiting periods of the previous contract will be credited in the new contract.
- illnesses, complaints, accidents and their foreseeable consequences, which have newly occurred during the term of the previous contract, are still insured.

b) If your stay is extended for reasons for which you are not responsible, we will also extend your insurance policy beyond the maximum insurance period upon request if
- we receive your application for an extension before the original expiry date with appropriate evidence and
- we expressly agree to this extension.

2.1.3 If the provisions of clauses 2.1.1 or 2.1.2 are not complied with, the insurance contract shall also not be concluded by payment of the premium. In this case, the premium paid is at the disposal of the sender.

2.2 When does the insurance contract end?

The statutory provisions on the extraordinary right of termination remain unaffected by these agreements.
The insurance contract also ends for not yet concluded or pending insured events
- at the agreed time,
- with the death of the policyholder, the insured persons can continue the insurance contract within 2 months after the death by naming the future policyholder,
- in the event of repatriation upon arrival at the nearest suitable hospital in your home country,
- with the end of the trip abroad or if the preconditions for insurability cease to apply.
  In this case, the contract will be terminated at the earliest at the time we become aware of this.

2.3 Which legislation applies to the insurance policy?

In addition to these provisions, the Insurance Contract Act (VVG) and German law shall apply.
Note on data protection: We store your personal data to fulfil our obligations under the contract. Further information on data protection and your rights in this regard can be found at: www.hmrv.de/datenschutz/information or feel free to request them from us.

2.4 When do claims to benefits lapse?

Claims under this insurance policy expire in three years. The expiry is measured from the end of the year in which the claim can be made. If you have made a claim, the expiry period is suspended until our decision is sent to you.

2.5 What form should a statement that you make to us be in?

Declarations of intent and notifications to us must be in writing (letter, fax, email, electronic data carrier, etc.). The language of the policy is German.

3 What requirements must be met when paying the premiums?

3.1 Premium amount

The premium for an insured person is shown by the premium overview.

3.2 Payment of the first premium

3.2.1 The first premium is due as soon as you have received the insurance certificate and the premium invoice.

3.2.2 If you fail to pay the first premium, we will be entitled to withdraw from the contract and will be released from obligations if the premium remains unpaid. In doing so, we observe the provisions of Section 37 of the Insurance Contract Act (VVG). This can be found in Section III.

3.3 Collection of premiums

If you have agreed with us to take a premium from an account, we will collect it as soon as we receive your direct debit mandate. Payment is considered timely if
– we can debit the premium and
– if collection of the correct payment is not disputed.
If we are unable to collect the premium due for a reason beyond your control, the payment shall still be considered to have been made on time if you make said payment immediately after receiving a request from us.

3.4 Offsetting

You may offset against our claims only if the counter-claim is uncontested or legally established.

4 What you have to consider in case of an insured event (obligations)?

4.1 To whom can you direct the claim?

You can send your claims in any form to: HanseMerkur Reiseversicherung AG, Abt. RLK/Leistung, P.O. Box, 20352 Hamburg,
E-Mail: reiseleistung@hansemerkur.de.
You can also use our online form https://mein-hmrv.de/service/schadenmeldung/.
In emergencies, our 24-hour emergency call service is here to help you. You can reach it at any time from anywhere in the world.

4.2 When is it necessary to contact us immediately?

In the case of
– in-patient treatment, please contact our emergency service immediately with regard to any necessary diagnostic and therapeutic measures.
– non-emergency dental prosthetics, please submit a treatment and cost plan or cost estimate before using the services. In the event of a medical emergency, the submission of a medical and cost plan or cost estimate is not required.
– a possible return transport to a hospital in your home country, please contact our emergency service immediately (see also clause 4.4.2).

4.3 What information are you obligated to provide?

4.3.1 You must provide true and complete information concerning the claim. You must provide us with any information and suitable proof that we need to be able to determine
– whether an insured event has occurred; and
– to what extent we shall disburse insurance benefits.
You must complete our claim form in full and return it.
If we consider it necessary, you are obliged to be examined by one of our doctors.

4.3.2 We need the following original evidence from you, which becomes our property:
– Prescriptions along with the treatment bill
– Invoices for medicines and medical aids together with the prescription.
– Official death certificate and a doctor's certificate on the cause of death if costs of repatriation of mortal remains or burial are to be paid.
– Other evidence and receipts requested by us that we need in order to check our duty to provide benefits. This applies only if obtaining this documentation can be reasonably expected of you.
The receipts must
– stipulate the name of the person treated,
– specify the illness and
– the services provided by the professional providing treatment according to
  – type,
  – location and
  – period of treatment.

If other insurance cover for treatment costs is available and if this is used first, then copies of invoices are sufficient as evidence. These must be annotated to show which items have been reimbursed.

4.4 What does your duty of disclosure to minimise damage comprise?

4.4.1 You should make every effort to keep the claim as low as possible and avoid anything that could lead to an unnecessary increase in costs.

4.4.2 You must comply with our instructions and, in particular, agree to return transport to the nearest suitable hospital in your home country if you are fit to be transported, if we consider return transport to be necessary in view of the nature of the illness and the need for treatment.

4.4.3 Compensation claims against third parties shall be transferred to us as per the statutory regulation in Section 86 of the Insurance Contract Act (VVG), up to the amount of the benefit paid. We shall ensure that this does not disadvantage you. You are also obligated to assist, if necessary, in asserting the claim for compensation.

4.5 What are the legal consequences of failures of duty (breaches of obligations)?

If you fail to carry out one of the duties specified above, we will be released from liability either in full or in part. In this, we comply with the regulations of § 28 (2–4) of the Insurance Contract Act (VVG). These can be found in Section III.

4.6 When do we pay compensation?

4.6.1 We will pay within two weeks. This is subject to the following conditions:
– that our duty to provide an insurance benefit is established on the basis and in the amount, and
– that the necessary evidence – which becomes our property – is available.
The time to the deadline is suspended if you are responsible for our being unable to check your claim.

4.6.2 We convert your costs in a foreign currency using the exchange rate to EUR on the day the records are received. The official exchange rate applies, unless you have purchased the foreign currency to pay the bills at a less favourable rate. We may subtract the following costs from your benefit:
– Costs for the transfer of benefits abroad or
– Costs for special forms of referral that you have commissioned.

4.6.3 You may also have travel insurance with other insurers. This may for example be the statutory health insurance or another private insurer. If you consequently have claims against other insurers, these take priority.

You are not entitled to a greater total benefit than the costs actually incurred. If you have a claim to a benefit from several insurers, you can choose the insurer with which you file the claim.

If you file the claim with us first, we will reimburse you the costs insured under this tariff. After that, we will clarify with the other insurers whether they will contribute to the costs. We do not require the sharing of costs with private health insurance if this would disadvantage you, e.g. through loss of the premium refund.
For more information, see clause 4.4.3.

Section II – Description of payments

1 General rules for insurance coverage

We provide compensation for unforeseen acute insurance incidents that occur in the area of validity. The benefits are limited to a total of 50.000,– EUR per insured person for all insured events within the term of the contract.

1.1 What is an insured event?

Your medically necessary treatment due to illness or the consequences of an accident is considered to be an insured event. The insured event starts with the treatment. It ends once it is medically established that no further treatment is needed. The following are also considered insured events:
- Medically necessary treatments for complaints during pregnancy,
- Premature births until the completion of the 36th week of pregnancy,
- Miscarriage,
- Medically necessary abortions and
- Death.

See clause 2 for details of what precise benefit we provide after an insured event. Please read clause 3 carefully as well. This regulates when we do not provide a benefit, even if an insured event has occured.

1.2 Which doctors and hospitals can you choose between?

You can choose freely among the following legally-recognised individuals and bodies authorised to give treatment:
- Doctors,
- Dentists and
- Hospitals.

The precondition is that these
- charge fees based on the relevant official, applicable fee schedule – if available – or
- based on fees generally charged in the local area.

The hospital in the country of destination must
- be recognised and approved,
- be under constant medical supervision,
- have sufficient diagnostic and therapeutic facilities and
- keep medical records.

1.3 Which methods do we cover if you need to be examined and treated?

We cover
- examinations,
- treatments and
- medication,

recognised by conventional medicine. We also cover other methods and medications,
- which have proved equally effective in practice or
- which are only available in the absence of conventional medicine.

These methods include e.g.
- homeopathic treatments
- anthroposophical medicine or
- herbal treatment.

In such cases we can, however, reduce the benefits to the amount that would have been incurred by the use of available conventional medicine.

2 What are the benefits that we pay if an insured event occurs?

2.1 We will reimburse the following benefits if the insured event occurred after the start of the insurance cover.

2.2 During a stay in the Federal Republic of Germany, we reimburse the following costs up to the so-called threshold values of the effective German Scale of Medical Fees (Gebührenordnung für Ärzte, GOÄ) and the German Scale of Fees for Dentists (Gebührenordnung für Zahnärzte, GOZ). The following are deemed to be threshold levels for benefits
- according to the GOZ, the 2.3-fold fee rate,
- according to No. 437 and section M (laboratory services) of the GOÄ, the 1.15-fold fee rate,
- according to sections A, E and O (technical operations) of the GOÄ the 1.8-fold fee rate, as well as
- for all other benefits of the GOÄ, the 2.3-fold fee rate.

For your stay outside Germany, we reimburse you the following costs based on the currently applicable official fee schedule for doctors and dentists – if available – or based on the fees generally charged for similar medical care in the local area.

2.4 What do we pay if you are treated as an out-patient?

We will reimburse the costs for the following services:

2.4.1 Healing treatment.

2.4.2 Transport
- to the nearest suitable hospital and
- return to the respective accommodation.

2.5 What do we pay if you are treated as an in-patient?

Where necessary, we will give the hospital a guarantee to assume the costs through our worldwide emergency call service.

We will reimburse the costs for the following services:

2.5.1 non-postponable in-patient treatment in the general nursing insurance (multiple-bed room) without optional services (treatment by private doctor), including meals and care in the hospital.

2.5.2 Transport
- to the nearest suitable hospital and
- return to the respective accommodation.

2.5.3 In the event of in-patient treatment, you can decide:
- You will receive reimbursement from us for the payments listed above (2.5.1–2.5.2) or
- You will receive a daily allowance of EUR 75 per day from us for a maximum of 14 days from the start of the in-patient treatment.

The decision must, however, be made at the beginning of the in-patient treatment.

2.6 What do we pay if you have dental treatment?

We will reimburse the costs for the following services up to 300,– EUR per insurance year:

2.6.1 Pain-relieving preservative dental treatments.

2.6.2 Simple fillings.

2.6.3 Repairs to an existing dental prosthesis, insofar as the need for repair has arisen only after the start of the insurance cover.

2.7 What do we pay for medications, dressings, therapeutic products and medical aids?

We provide insurance benefits when these
– have been prescribed by one of the practitioners listed under section 1.2 and
– are medically necessary.

2.7.1 Medications and dressing material

You need to obtain medications from the pharmacy. The following are considered medicines, even if they are prescribed:
– neither nutritive and tonic substances, mineral water, disinfectants, dietary and infant foods,
– nor cosmetic preparations.

2.7.2 Remedy

These are radiation, light and other physical treatments. This also includes
– massages,
– medicinal packs,
– inhalations.
We will reimburse the costs of massages, medical packs and inhalations up to 300,– EUR per insurance year.

2.7.3 Resources

The following items count as aids:
– Bandages, broken ligaments, inlays,
– Crutches and compression stockings,
– Hearing aids,
– Corrective splints,
– Artificial limbs/prostheses,
– Seat shells and foam positioners, wheelchairs,
– Breathing monitor devices, infusion pumps, inhalation devices, oxygen devices,
– Surveillance monitors for infants,
– Orthopaedic body, arm and leg braces, as well as
– speech devices.
The insurance covers simple remedies, provided that they
  – become necessary for the first time as a result of an accident, and
  – serve to facilitate the treatment of the consequences of the accident.

2.8 What do we pay in the event of pregnancy?

We reimburse the costs
– for examinations and/or treatments for pregnancy complications,
– in case of miscarriage, as well as
– for delivery before the end of the 36th week of pregnancy.
The precondition for this is that the need for treatment was not yet determined at the beginning of the insurance contract.

2.9 What benefits do we do for repatriation, transfer and burial?

2.9.1 What do we pay in the event of transport home?

Do you require return transport to your place of residence or to the nearest suitable hospital at your place of residence? We will organise this and reimburse the costs if one of the following conditions is met:
– the return journey is medically reasonable and appropriate.
– According to the prognosis of the attending physician, the duration of treatment in the hospital abroad is expected to exceed 14 days.
– Further treatment abroad is likely to cost more than the repatriation.
We reimburse the costs for the cheapest suitable means of return transport.

2.9.2 What do we do if the insured person dies?

We organise the transfer of the deceased person to the permanent place of residence and cover the costs for this.
Alternatively, we will reimburse the costs to bury the deceased person in the country of travel. However, we only reimburse at most the costs that would have been incurred by repatriation of mortal remains.

2.10 When do we extend your insurance cover beyond the agreed duration?

Your treatment will take longer because
– your illness requires medical treatment beyond the original end of the insurance cover and
– you are not fit to be transported.
In this case, we will extend the duration of your insurance cover,
– until you are fit to be transported again (including any return transport that may then become necessary),
– for a maximum of 3 months.

3 What do we not cover or only provide restricted cover for?

3.1 In which cases can we reduce the scope of benefits?

3.1.1 We can reduce the payments to an appropriate amount if
– the medical treatment exceeds the medically necessary level or
– the expenses for medical treatment exceed those generally charged in the local area.

3.1.2 If you do not use conventional medicine, we can reduce the payment. We will reimburse the amount incurred for existing conventional medical methods or medicines (for more details, see section 1.3).

3.2 In which cases do we not provide cover?

In the following cases we do not provide benefit, even if an insured event has occurred:

3.2.1 When you
– try to fraudulently deceive about circumstances that are important for the reason or the amount of the benefit, or
– you have caused the damage intentionally.

3.2.2 For treatments of illnesses and symptoms that exist at the time of conclusion of the contract and are known to the insured person and their foreseeable consequences, as well as for the consequences foreseeable for the insured person of such illnesses and accidents that have been treated in the six months leading before conclusion of the insurance contract.

3.2.3 For treatments that were
– the sole reason, or
– one of the reasons,
for making the trip or the conclusion of the insurance policy.

3.2.4 For treatments,
– whose necessity was evident before departure and
– were due to an illness that had already been medically diagnosed when the trip started.

Exception:
You are taking the trip because of the death of the spouse or a relative of the 1st degree.

3.2.5 For diseases, including their consequences, as well as for the consequences of accidents caused by
– war,
– internal unrest.

3.2.6 For cures and treatments in a sanatorium.

Exception:
These treatments are made following in-patient treatment due to
– a severe stroke,
– a serious myocardial infarction or
– a serious illness of the skeleton (disc operation, hip replacement)
and they serve to reduce the length of stay in the hospital. In these cases, you have insurance cover, if
– you inform us of the planned stay before the treatment and
– we have agreed to the treatments in writing.

3.2.7 For withdrawal measures including withdrawal cures.

3.2.8 For out-patient healing treatments in a spa or health resort.

Exception:
- The healing treatment is necessary due to an accident occurring there, or
- You were only visiting the spa or health resort briefly and were not staying for the purposes of treatment when you fell ill.

3.2.9 For treatments through
- Spouse
- Parents
- Children
- Persons with whom you are living in your own home or a home being visited.

3.2.10 For treatment or accommodation due to
- infirmity,
- need for care or
- dependency.

3.2.11 For psychoanalytical and psychotherapeutic treatments.

3.2.12 For
- pivot teeth,
- inlays,
- crowns,
- orthodontic treatments,
- prophylactic services,
- dental splints and braces,
- function analytical and function therapeutic treatments and
- implant treatment,

insofar as there are no other provisions in the collective agreement.

3.2.13 For immunisation measures.

3.2.14 For treatments for disorders and damage to the reproductive organs, incl. sterility, artificial insemination and associated preventive examinations and follow-up treatments.

3.2.15 For suicide, attempted suicide and the consequences thereof.

3.2.16 For organ donations and consequences.

Section III – Extract from the Insurance Contract Act (VVG)

§ 19 Duty of notification

(1) [1]Up to the submission of his contractual declaration, the policyholder must notify the insurer of the risk circumstances known to him that are relevant for the decision by the insurer to conclude the contract with the agreed content and which the insurer has asked about in text form. [2]If the insurer asks questions pursuant to sentence 1 after the contractual declaration by the policyholder, but before the acceptance of the contract, the policyholder is also obligated to give notification in this regard too.

(2) If the policyholder breaches his duty of notification pursuant to paragraph 1, the insurer can withdraw from the contract.

(3) [1]The insurer's right of withdrawal is excluded if the policyholder has not breached the duty of obligation in a wilful or grossly negligent manner. [2]In this case, the insurer has the right to terminate the contract giving a period of notice of one month.

(4) [1] The insurer's right of withdrawal due to a grossly negligent breach of the duty of obligation and his right of termination pursuant to paragraph 3 clause 2 are excluded if he would have concluded the contract even if he was aware of the undisclosed circumstances, even if under different conditions. [2]The other conditions, at the insurer's request, become part of the contract retrospectively, with a breach of duty for which the policyholder is not responsible from the current insurance period.

(5) [1]The insurer is entitled to the rights pursuant to paragraphs 2 to 4 only if it has pointed out to the policyholder by separate notification in text form the consequences of a breach of the duty of notification. [2]The rights are excluded if the insurer was aware of the circumstance not notified or knew of the incorrectness of the notification.

(6) [1]If in the case of paragraph 4 clause 2 the premium increases by more than 10 per cent or if the insurer excludes the protection against risks for the circumstance that was not notified, the policyholder can terminate the contract within a month after receipt of the notification from the insurer without giving a notice period. [2]The insurer must point out this right to the policyholder in the notification.

§ 20 Representative of the policyholder

[1]If the contract is concluded by a representative of the policyholder, when applying § 19 (1 to 4), and § 21 (2) Sentence 2 as well as (3) Sentence 2 to take into account both the knowledge and the malice of the representative and the knowledge and malice of the policyholder. [2]The policyholder can only rely on the fact that the duty of notification was not violated intentionally or through gross negligence, if neither the representative nor the policyholder is guilty of intent or gross negligence.

§ 21 Exercise of the rights of the insurer

(1) 1The insurer must assert the rights to which it is entitled under § 19 (2 to 4) in writing within one month. [2]The period begins from the moment when the insurer becomes aware of the violation of the duty to notify, which establishes the right asserted by him. [3]When exercising his rights, the insurer must state the circumstances on which he bases his declaration; he may subsequently state further circumstances to substantiate his declaration if the period under sentence 1 has not elapsed for these.

(2) [1]In the event of withdrawal in accordance with Section 19 (2) after the occurrence of the insured event, the insurer shall not be obliged to provide a benefit unless the breach of the duty of notification relates to a circumstance that is not the cause of either the occurrence or the determination of the insured event, or the determination or the scope of the insurer's obligation to indemnify. [2]If the policyholder fraudulently violates the duty of notification, the insurer is not obliged to pay.

(3) [1]The rights of the insurer according to Section 19 (2 to 4) elapse after the expiration of five years after conclusion of the contract; this does not apply to insurance claims that occurred before the expiration of this period. [2]If the policyholder has intentionally or fraudulently violated the obligation to notify, the period is ten years.

§ 28 Non-observance of a contractual obligation

(2) Where the contract provides that the insurer is not obligated to effect payment in the event of the non-observance of a contractual obligation on the part of the policyholder, the insurer shall be released from the liability if the policyholder intentionally breached the obligation. In the event of a grossly negligent failure to honour the obligation, the insurer shall be entitled to reduce any benefits payable commensurate with the severity of the policyholder's fault; the burden of proof that there was no gross negligence shall be on the policyholder.

(3) Notwithstanding subsection (2), the insurer shall be liable for performance insofar as the failure to honour the obligation caused neither the occurrence nor the establishment of the insured event nor the establishment or the extent of the insurer's obligation to effect payment. Sentence 1 shall not apply if the policyholder fraudulently breached the obligation.

(4) The condition on which the insurer's entire or partial release from liability in accordance with subsection (2) is based shall, in the event of a violation of an existing duty to provide information or duty of disclosure after the occurrence of an insured event, be the fact that the insurer instructed the policyholder in separate correspondence and in writing of this legal consequence.

§ 37 Delayed payment of first insurance premium

(1) If the single premium or the first premium is not paid in good time, the insurer shall be entitled to withdraw from the contract as long as the payment has not been made, unless the policyholder is not responsible for the non-payment.

(2) If the single premium or first premium has not been paid when the insured event occurs, the insurer shall not be obligated to effect payment, unless the policyholder is not responsible for the non-payment. The insurer shall only be released from liability if he had informed the policyholder of the legal consequence of non-payment of the premium in writing in a separate communication or by means of a conspicuous note in the insurance policy.

§ 86 Assignment of claims

(1) If the policyholder is entitled to claim damages from a third party, this claim shall be assigned to the insurer insofar as the insurer compensates for the loss. The claim may not be assigned to the detriment of the policyholder.

(2) The policyholder shall safeguard his claim for damages or a right serving to safeguard this claim in accordance with the applicable form and time requirements, and he shall assist the insurer wherever necessary in asserting them. If the policyholder intentionally breaches this obligation, the insurer shall not be obligated to effect payment insofar as he cannot, as a result, claim compensation for it from a third party. In the event of a grossly negligent failure to honour the obligation, the insurer shall be entitled to reduce any benefits payable commensurate with the severity of the policyholder's fault; the burden of proof that there was no gross negligence shall be on the policyholder.

(3) If the policyholder claims compensation from a person with whom he is sharing a common household when the loss occurs, assignment in accordance with subsection (1) cannot be asserted, unless that person intentionally caused the loss.

Arbitration bodies

We would like to draw your attention at this point to the possibility of out-of-court dispute resolution.

For health insurance, the voluntary membership of HanseMerkur in the Verband der Privaten Krankenversicherung e.V (Association of Private Health Insurers) requires, according to the statutes, participation in mediation procedures through a consumer mediation office.

Ombudsman

Private Kranken- und Pflegeversicherung (Private Health & Care Insurance)

Postfach 060222

DE-10052 Berlin

Hotline: +49 1802 550 444