General Terms and Conditions of Insurance for Daily Sickness Benefits

Part I 2009 German standard conditions 2009 of the Association of Private Health Insurance (MB/KT 2009)
Part II tariff conditions (TB/KT 2013)

Version of January 2018

Contents

These General Terms and Conditions of Insurance consist of: Part I (German standard conditions 2009 of the Association of Private Health Insurance [MB/KT 2009]), Part II (Tariff Conditions [TB/KT 2013]) and Part III (Tariffs). The Tariff Conditions shall supplement the German standard conditions and moreover contain variations in favor of the insured persons.

The insurance coverage

§ 1 Subject, scope and scope of application of insurance coverage

I

(1) The insurer offers insurance cover against loss of earnings as a result of illness or accident, insofar as this causes an incapacity to work. In an insured event, the insurer shall pay a daily sickness allowance in the contractual scope for the duration of the incapacity to work.

(2) An "insured event" shall mean the medically necessary treatment of an insured person due to illness or the consequences of an accident during the course of which an incapacity to work is medically established. The insured event shall commence with the treatment and shall cease when, according to medical findings, there is no longer any incapacity to work and no need for treatment. Any illness or consequence of an accident which has newly occurred and been treated during treatment and in the course of which an incapacity to work is medically diagnosed shall only give rise to a new insured event if it has no causal connection to the first illness or consequence of the accident. If an incapacity to work is caused simultaneously by several illnesses or consequences of an accident, the daily sickness allowance shall be paid only once.

(3) An "incapacity to work" in the terms of these conditions shall be deemed to exist if the insured person is temporarily unable to carry out his or her professional activity in any way whatsoever according to medical findings, nor is the person carry out the activity and is not pursue any other gainful activity.

(4) The scope of the insurance coverage shall result from the insurance certificate, later written agreements, these General Terms and Conditions of Insurance (German standard conditions with annexes and tariff conditions) and the provisions of law. The insurance relation shall be subject to German law.

(5) The policyholder may request the transformation of the insurance policy into a similar type of insurance coverage, provided the insured person fulfills the prerequisites for the insurance eligibility. The insurer shall accept an application for transformation within a reasonable period. The acquired rights shall be retained; the provision formed in accordance with the technical bases for calculating the risk accruing as the insured person ages (aging provisions) shall be added in accordance with these bases of calculation. If the new insurance coverage is higher or more comprehensive, a risk premium may be requested (§ 8a, para. 3 and 4) or an exclusion of benefits may be agreed; furthermore, waiting periods must be kept for the added part of the insurance coverage. The conversion right shall not exist in the case of qualifying period and dormancy insurance policies so long as the reason for the qualifying period or the reason for the dormancy has not ceased to exist; with the exception of a temporal limitation in accordance with § 196 of the Insurance Agreements Act (VVG) (see annex), the conversion right shall also not exist in the case of insurance relations with a limited term. The transformation of the insurance coverage from a rate for which the premiums are calculated independently of gender to another rate for which this is not the case shall be excluded hereby.

(6) The insurance cover shall extend to Germany.

(7) During a temporary stay in another European country, the daily sickness allowance for acute illnesses or accidents occurring abroad shall be paid in the contractual scope for the duration of medically necessary inpatient treatment in a public hospital. Special arrangements may be made for a temporary stay in non-European countries.

(8) If an insured person transfers his or her habitual place of residence to another Member State of the European Union or another state party to the Agreement on the European Economic Area, the daily sickness allowance for acute illnesses or accidents occurring in that state shall be paid in the contractually agreed scope for the duration of medically necessary inpatient treatment in a public hospital.

II

(1) If the risk is increased, for example, through prior illnesses, the insurer may make the acceptance of the insurance application contingent on the agreement of special conditions (e.g. risk surcharges).

(2) In extension of § 1 (3) MB/KT 2009, the insurer shall also pay benefits for up to 8 weeks in the event of partial incapacity to work as part of a reintegration into working life. This benefit shall only be provided for employees with a permanent employment relation for whom the insurer has taken out comprehensive health insurance for outpatient and inpatient treatment. A "reintegration into working life" shall exist:

- *if, immediately following a complete incapacity to work pursuant to § 1 (3) MB/KT 2009 of at least 12 weeks' duration, the professional activity is resumed in stages and*
- *provided there is a more than 50% incapacity to work, which must be certified by a doctor. The remuneration paid by the employer shall be deducted from the daily sickness allowance.*

(3) The insurance cover may be extended beyond the scope of § 1 (7) MB/KT 2009. This shall require a prior written agreement, if necessary also about special conditions.

(4) In all provisions, Switzerland shall be equivalent to the states mentioned in § 1 (8) MB/KT 2009 and/or to the other member states of the European Union and the other contracting states of the Agreement on the European Economic Area.

(5) If an insured person relocates his or her habitual place of residence to one of the countries listed under § 1 (8) MB/KT 2009, the insurer undertakes to enter into a special agreement to continue the insurance relation upon request. Upon application, the insurance relation shall also be converted into a vested benefit. The conclusion of this special agreement for the continuation of the insurance relation or the conversion into a vested benefit insurance policy must be applied for at the latest within 6 months after the relocation of the habitual residence.

In the event of a relocation of the habitual place of residence (departure) to a country other than the countries listed in § 1 (8) MB/KT 2009, § 15 (1e) MB/KT 2009 shall apply from the beginning of the stay abroad.

§ 1a Daily sickness allowance during maternity protection periods and on the day of delivery

I

(1) An "insured event" shall also mean the loss of earnings of a female insured person which occurs during the protection periods pursuant to § 3, para. 1 and 2 of the Maternity Protection Act (see annex) and on the day of delivery if the insured person does not work or only works to a limited extent during this period. The provisions of §§ 1 and 2 to 18 shall apply accordingly to such an insured event, provided no deviations arise from the following paragraphs.

(2) For the duration of these periods of protection and on the day of delivery, the insurer shall pay a daily sickness allowance in the contractual scope irrespective of the exclusions of benefits in accordance with § 5. Insofar as the insured person is entitled to maternity benefit in accordance with Title Five of the Social Code or the Maternity Protection Act during this period, to parental benefit in accordance with the Federal Parental Benefits and Parental Leave Act or to any other appropriate compensation for the loss of earnings caused during this period, such benefits shall be credited towards the agreed daily sickness allowance. If the insured person is or becomes unable to work during the statutory maternity protection periods or on the day of delivery with a claim to receive daily sickness allowance, the daily sickness allowance shall only be paid one time up to the agreed amount.

(3) The daily sickness allowance paid during the maternity protection periods and on the day of delivery, together with the maternity allowance pursuant to Title Five of the Social Code and pursuant to the Maternity Protection Act, the parental allowance pursuant to the Federal Parental Benefits and Parental Leave Act and other compensation for loss of earnings caused during this period, may not exceed the net income resulting from professional activity, converted to the calendar day. The average earnings of the last 12 months before the start of the maternity protection period in accordance with § 3 1) of the Maternity Protection Act (see annex) shall be decisive for the calculation of the net income.

(4) The occurrence and duration of the protection periods in accordance with § 3, para. 1 and 2 of the Maternity Protection Act (see annex) and the date

of delivery must be documented by the policyholder. The latter shall bear any costs of the documentation.

(5) The waiting period shall be 8 months from the commencement of the insurance.

II

With regard to net income, the provisions pursuant to § 4 MB/KT 2009 and the related rate conditions shall otherwise apply.

§ 2 Start of insurance coverage

I

The insurance coverage shall commence upon the date specified in the insurance certificate (starting date of insurance), though not before the conclusion of the insurance agreement (particularly receipt of the insurance certificate or a written acceptance declaration) and not before the expiry of the waiting periods. Benefits shall not be rendered for insurance events that occur before the start of the insurance protection. Insurance events occurring after the conclusion of the insurance agreement shall only be excluded for the portion of the duty to render benefits which falls in the period before the starting date of insurance or in waiting periods. In the event of contractual modifications, Sentences 1 to 3 shall apply to the added portion of the insurance coverage.

II

(1) At variance with § 2 (1) MB/KT 2009, insurance events that occurred even before the conclusion of the insurance agreement shall only be excluded for that portion of the duty to render benefits which falls in the period before the start of the insurance coverage. This shall only apply, however, if these insurance events are duly notified to the insurer and no special terms and conditions to the contrary have been agreed. This provision shall apply accordingly to the additional benefit after any change in the existing insurance coverage.

(2) Through the modification in the insurance coverage in the course of the coverage period, the insurance year determined upon the original closing of the agreement shall not change.

§ 3 Waiting periods

I

(1) The waiting periods shall be calculated from the starting date of insurance.

(2) The general waiting period shall be three months. It shall not apply in the event of accidents.

(3) The special waiting periods for psychotherapy, dental treatment, dentures and orthodontics shall amount to 8 months.

(4) If the rate plan so provides, the waiting periods may be waived based on separate agreement provided a medical certificate about the state of health is presented.

(5) Persons who have withdrawn from private or statutory health insurance shall have the period of insurance which can be documented to have been completed without interruption there credited against the waiting periods up to the amount of the previous claim to health care or daily sickness benefits. The insurance must have been requested no more than two months after the cessation of the prior insurance together with health costs and the insurance coverage shall begin at variance with § 2 immediately thereafter. This shall also apply in the event of any withdrawal from a public service agreement with the claim to health benefits.

(6) In the case of contractual modifications, the waiting period rules for the added portion of the insurance coverage shall apply.

II

(1) Notwithstanding § 3 (2) and (3) MB/KT 2009, the insurer waives the observance of waiting periods if, in addition to the daily sickness benefit insurance, there is also a comprehensive insurance for health care costs. Full health care cost insurance shall exist if the insured person is covered by the insurer for outpatient and inpatient treatment as basic insurance.

(2) In the case of contractual modifications, the insurance time accrued to date in rate plans with equivalent benefits shall be credited towards the waiting periods.

(3) The waiver of waiting periods foreseen in § 3 (4) MB/KT 2009 must be requested in connection with any medical examination findings which are to be submitted on the form foreseen for this purpose. The costs of the medical examination for the person to be insured shall be borne by the applicant.

(4) If the prerequisites pursuant to § 3 (5) MB/KT 2009 are fulfilled, the insurance period completed in a statutory or private health insurance scheme shall be credited towards the waiting periods for the total insured daily sickness allowance. This provision shall apply accordingly to persons leaving a public service with a claim to free curative care.

§ 4 Scope of the duty to render benefits

I

(1) The amount and duration of insurance benefits shall arise from the rate plan with the Rate Conditions.

(2) The daily sickness allowance, together with other health care and daily sickness allowances, may not exceed the net income from professional activity, converted to the calendar day. The net income shall be calculated on the basis of the average earnings over the last 12 months before the application was submitted or before the onset of the incapacity to work, unless the rate plan provides for a different period.

(3) The policyholder shall be obliged to inform the insurer immediately of any not merely temporary reduction in net income resulting from the professional activity.

(4) If the average net income of the insured person falls below the level of the net income on which the contract is based over a period of 12 months, the insurer may, even if the insured event has already occurred, reduce the daily sickness allowance and the premium in accordance with the reduced net income.

For an employee, the relevant period shall be the last 12 months before the insurer became aware of the insured event. If an incapacity to work has already occurred when the insurer becomes aware of it, the last 12 months before the beginning of the incapacity to work shall be taken as the relevant period.

For self-employed persons, the relevant period shall be the last completed calendar year before the insurer became aware of the insured event. If an incapacity to work has already occurred when the insurer becomes aware of the insured event, the last calendar year prior to the beginning of the incapacity to work shall be taken as the relevant period.

Periods of incapacity to work or a prohibition of employment due to protective regulations shall not be taken into account. Notwithstanding para. 2, the determination of the net income shall be based on the rate conditions. The reduction of the daily sickness allowance and the premium shall take effect from the start of the second month after receipt of the reduction declaration by the policyholder. Until the time of the reduction, the obligation to render benefits in the previous scope shall not be affected, even for an incapacity to work that already occurred.

(5) The payment of daily sickness benefit shall be subject to the condition that the insured person is treated by a accredited doctor or dentist in private practice or in hospital during the period of the incapacity to work.

(6) The insured person shall have the choice among established and approved physicians and dentists.

(7) The onset and duration of the incapacity to work must be documented by a certificate from the doctor or dentist treating the patient. Any costs of such documentation shall be borne by the policyholder. Certificates from spouses, life partners pursuant to § 1 of the German Civil Partnership Act (see annex), parents or children shall not sufficient to document an incapacity to work.

(8) In the case of medically necessary in-patient medical treatment, the insured person may freely choose among public and private hospitals which are under standing direction by physicians, possess sufficient diagnostic and therapeutic possibilities and keep medical records.

(9) For medically necessary in-patient medical treatment in hospitals which also perform curative or sanatorium treatment or accept reconvalescent patients but which otherwise meet the conditions in para. 8, the benefits according to the rate plan shall only be rendered if the insurer has promised such benefits in writing before the start of treatment. In

the case of TB diseases, benefits shall also be rendered in the contractual scope for in-patient treatment in TB sanitariums.

(10) At the request of the policyholder or the insured person, the insurer shall provide information on and insight into expert opinions or statements which the insurer has obtained in the course of the examination of the obligation to render benefits, for the determination of any incapacity to work or occupational disability (cf. § 15 (1b). If significant therapeutic or other significant grounds oppose the provision of information to or the inspection by the policyholder or the insured person, merely the provision of information to or an inspection by a named physician or attorney may be requested. The claim may only be asserted by the relevant person or the legal representative thereof. If the policyholder has obtained an opinion or assessment at the instigation of the insurer, the insurer shall reimburse the costs incurred.

II

(1.1) "Net income"

a) for workers shall mean:
80% of taxable income from employment (gross wages). Exclusively cash performances paid by the employer are to be taken into account, provided these are contractually agreed and the employee is paid regularly, at least annually,

b) for self-employed persons (e.g. tradespersons and members of the liberal professions, including established doctors and dentists) shall mean:
80% of the taxable profit from this self-employment (determined by comparison of business assets or an earnings statement [Einnahme-Überschuss-Rechnung]).

(1.2) If the policyholder documents that the tax due on the gross wage pursuant to para. 1.1a) or the profit pursuant to para. 1.1b) is less than the lump sum of 20% used as a basis in para. 1.1, the policyholder may demand that this actual tax burden be decisive in calculating the net income.

(1.3) In an insured event, the insurer may demand in accordance with § 9 (2) MB/KT 2009 that suitable documentation of the amount of net income be presented (e.g. salary statements or calculations for determining profits by an accountant certified in Germany).

(2) If the net income from professional activity increases, the daily sickness allowance may, upon application, be insured at a higher rate in proportion to the increase in net income. If the period of the claim to continued payment of remuneration in the event of an incapacity to work is reduced for employees, insurance cover may be applied for at a rate level with a correspondingly shorter waiting period. Such an application is to be accepted without a new risk assessment if it is submitted within two months of the first day of the next month. From the date of the contractual modification onward, the additional benefits shall also be paid for an ongoing insurance event, provided a duty to render benefits exists within the framework of the previously insured daily sickness allowance.

Documentation of the increase in net income must be provided on request (e.g. by means of salary statements or calculations determining profits by an accountant certified in Germany). Documentation of the reduction in the duration of the claim to continued payment of remuneration in the event of an incapacity to work must also be provided on request. In the event of termination of an employment relation and commencement of self-employment, the provision on the reduction of waiting periods in the event of a change in the period during which employees continue to receive remuneration shall apply accordingly.

(3) If the claim to continued payment of the remuneration is extended to a period which exceeds the contractually agreed waiting period, the insurer may adjust the waiting period to the period during which the remuneration continues to be paid. The adjustment shall be made with effect from the beginning of the second month after the insurer becomes aware of the changed claim to continued payment of the remuneration.

(4) The occurrence and continuation of any incapacity to work is to be certified on forms provided by the insurer.

(5) A written commitment to provide benefits in accordance with § 4 (9) MB/KT 2009 shall not be required:

a) if the matter concerns an emergency referral or if the hospital is the only health care institution in the vicinity of the insured person and exclusi-

vely medically necessary medical treatments are to be performed which require in-patient admission and therapy; or

b) if an accident or an acute illness occurs during the stay in the hospital, as long as this event requires medically necessary in-patient treatment, irrespective of the actual purpose of the treatment; or

c) if the in-patient treatment is medically necessary for the purpose of a surgical operation; or

d) for the first three weeks of a medically necessary follow-up treatment beginning within 28 days after acute in-patient treatment that takes place in an institution which is licensed by a statutory rehabilitation agency for the respective follow-up treatment. A further prerequisite shall be that an application for benefits is submitted in writing with a statutory rehabilitation agency, provided the latter is subject to render benefits based on the merits, and the application is submitted in writing and decided before the start of the follow-up treatment.

(6) The contingent premium reimbursement shall be made in accordance with the Bylaws.

§ 5 Restriction of the duty to render benefits

I

(1) There is shall be no obligation to render benefits in the event of any incapacity to work:

a) due to those illnesses and the consequences thereof and for the consequences of accidents caused by events of war or recognized as a military injury which are not expressly included in the insurance coverage;

b) due to illnesses and accidents based on intentional action and the consequences thereof and due to detoxification measures, including detoxification programs;

c) due to illnesses and the consequences of accidents resulting from a loss of consciousness caused by alcohol consumption;

d) exclusively due to pregnancy, further due to abortion, miscarriage and childbirth;

e) during the period when pregnant women and women who have recently given birth are legally prohibited from working (maternity protection). This temporal limitation of the duty to render benefits shall apply accordingly to self-employed persons, unless the incapacity to work is not connected with the events mentioned under Litera d);

f) if the insured person is not at his or her habitual place of residence in Germany, unless - notwithstanding para. 2 - the insured person is undergoing medically necessary inpatient treatment (cf. § 4, para. 8 and 9). If the insured person becomes incapable of working in Germany outside his or her habitual place of residence, the insured person shall also be entitled to the daily sickness allowance, so long as the illness or accident prevents a return to work in accordance with medical findings;

g) during curative and sanatorium treatment and for rehabilitation measures of statutory rehabilitation agencies, unless the rate plan foresees otherwise;

(2) During the stay in a spa or health resort - even during a hospital stay - there shall be no duty to render benefits. This restriction shall not apply if the insured person has his or her habitual place of residence there or becomes incapable of working during a temporary stay due to an acute illness or accident that is independent of the purpose of the stay, so long as the return is ruled out by medical findings as a result.

II

(1) The benefit restriction pursuant to § 5 (1a) MB/KT 2009 shall not apply to events of war abroad if:

a) no travel advisory by the German foreign service exists for the affected territory of stay; or

b) a travel warning for the area of stay is only issued during the stay, and the insured person leaves the area of stay immediately or is prevented from leaving the area of stay for reasons beyond his or her control. Such a ground exists, for example, if leaving the area is only possible at considerable risk to oneself.

Terrorist attacks and the consequences thereof shall not be counted among events of war in the terms of § 5 (1a) MB/KT 2009.

(2) Notwithstanding § 5 (1b) MB/KT 2009, benefits shall be paid during the first inpatient withdrawal measure if and insofar as the insurer has promised the benefit in writing before the start of the measure. The benefit shall be limited to 80% of net income, taking into account other claims to daily sickness allowance and wage replacement benefits. The commitment may be contingent on an opinion about the success prospects issued by a physician determined by the insurer.

(3) The benefit restriction pursuant to § 5 (1c) MB/KT 2009 shall not apply.

(4) The benefit restriction pursuant to § 5 (1d) MB/KT 2009 shall only apply to the period during the statutory prohibitions on employment for expectant mothers and women who have recently given birth in an employment relation (maternity protection). These deadlines shall also apply accordingly to self-employed persons.

(5) The benefit restriction pursuant to § 5 (1f) MB/KT 2009 shall not apply:

a) if and insofar as the insurer has agreed to provide benefits in writing before the start of the stay; or

b) if another stay in Germany and its expected duration is notified to the insurer in advance in text form, the insured person can be reached there by post and no follow-up appointment is scheduled at the time of notification.

(6) The benefit restriction pursuant to § 5 (1g) MB/KT 2009 shall not apply to inpatient treatment in a sanatorium if and so long as the medical findings establish an incapacity to work and the stay in the sanatorium was immediately preceded by at least four weeks of incapacity to work. This shall also apply to rehabilitation measures carried out by a statutory rehabilitation agency. Claims for other daily sickness allowance, sickness benefit and transitional allowance shall be credited towards the daily sickness allowance if these claims together with the daily sickness allowance exceed the net income in accordance with § 4 (2) MB/KT 2009.

(7) The limitation of benefits pursuant to § 5 (2) MB/KT 2009 shall not apply for the duration of medically necessary in-patient hospital treatment in a spa or health resort. The restriction shall also not apply if and insofar as the insurer has promised benefits in writing before the start of the stay and under the prerequisites in No. 5b) of the rate conditions.

§ 6 Disbursement of the insurance benefits

I

(1) The insurer shall only be obliged to render benefits if the documents requested by the insurer have been provided; these shall become the property of the insurer.

(2) Otherwise, the prerequisites for the maturity of the benefits of the insurer shall arise from § 14 of the Insurance Agreement Act (see annex).

(3) The insurer shall be obliged to render benefits to the insured person if the policyholder has named the insured person in text form as entitled to receive his or her insurance benefits. If this prerequisite is not met, only the policyholder may request the benefit.

(4) Costs for the remittance of the insurance benefits and for translation may be deducted from the benefits.

(5) Claims to insurance benefits may not be assigned or pledged.

II

(1) The daily sickness allowance shall be paid retroactively for the duration of the documented incapacity to work.

(2) Remittance costs shall not be deducted if the policyholder names and domestic bank account on which the amounts are to be remitted.

§ 7 End of insurance coverage

I

The insurance cover shall cease, also for pending insured events, upon the cessation of the insurance relation (§§ 13 to 15). If the insurer terminates the insurance relation in accordance with § 14 (1), the insurance cover for pending insured events shall not cease until the 30th day after cessation of the insurance relation. If the insurance relation ends because one of the prerequisites for insurability specified in the rate plan ceases to apply or because occupational disability occurs, the obligation to render

benefits shall be determined in accordance with § 15 (1), Literi a) or b).

Duties of the policyholder

§ 8 Payment of premiums

I

(1) The premium is an annual premium and will be charged from the start of the insurance. The premium shall be payable at the start of each insurance year, but may be paid in equal monthly premium installments, which shall each be considered as deferred until the maturity of the premium installments. The premium installments shall be due on the first of each month. If the annual premium is re-determined during the insurance year, the difference must be subsequently paid or repaid from the modification date until the start of the next insurance year.

(2) If the agreement is concluded for a specific period subject to the condition that the insurance relation shall be tacitly extended by one year after the expiry of a specific period of time unless the policyholder terminates the agreement in due time, the rate plan may foresee monthly premiums in lieu of annual premiums. The shall be due on the first of each month.

(3) Unless stipulated otherwise, the initial premium or the initial premium installments shall be due without delay two weeks after the receipt of the insurance certificate.

(4) If the policyholder is in default with the payment of a premium installments, the deferred premium installments of the current insurance year shall be due. However, they shall be considered as deferred again if the premium portion in arrears and the premium installments for the current month on the payment date and the payment reminder costs are paid.

(5) The untimely payment of the initial premium or a subsequent premium can lead under the prerequisites in §§ 37 and 38 of the Insurance Agreement Act (see annex) to the loss of the insurance coverage. If a premium or premium installments is not paid in due time or if the policyholder is sent a reminder in text form, the policyholder shall be obliged to pay the payment reminder costs, the amount of which shall result from the rate plan.

(6) If the insurance relation ceases before the expiry of the term of contract, the insurer shall only be entitled for this contractual term to that portion of the premium or premium installments corresponding to the period in which the insurance coverage existed. If the insurance relation ceases by a rescission based on § 19 (2) of the Insurance Agreement Act (see annex) or through voidance by the insurer due to fraudulent deception, the insurer shall be entitled to the premium or premium installments up to the effective date of the rescission or voidance declaration. If the insurer rescinds the agreements because the initial premium or initial premium installments have not been paid in due time, the insurer may request a reasonable transaction fee.

(7) Premiums shall be payable to the office designated by the insurer.

II

(1) For the determination of the premiums, the age at entry shall be considered the difference between the year of birth and the calendar year in which the insurance relation begins.

(2) In the case of an annual premium payment, a premium (cash) discount of 3% shall be granted.

(3) If the insurance agreement is concluded before the start of insurance, the first premium or the first premium installment shall be due on the starting date of the insurance. If the starting date of insurance is before the closing of the agreement, the initial premium or initial premium installment shall be due on the closing date of the agreement.

§ 8a Calculation of premiums

I

(1) The premiums shall be calculated in accordance with the provisions of the Insurance Supervision Act as determined in the insurer's technical bases of calculation.

(2) In the event of a change in the premiums, also through a change in the insurance cover, the gender and the rate-related age (age group) of the insured person at the time the change comes into effect shall be taken into account; this shall not apply with regard to gender to rate plans whose premiums are charged irrespective of gender.

In this regard, the age of entry of the insurance person shall be taken into account by crediting an aging provision pursuant to the principles set out in the technical bases of calculation. However, an increase in the premiums or a reduction in the benefits of the insurer due to the aging of the insured person shall be ruled out throughout the insurance relation, provided a provision for aging is to be established.

(3) In the event of changes in premiums, the insurer may also change separately agreed risk surcharges accordingly.

(4) If risk is increased in the case of contractual modifications, the insurer shall be entitled to a reasonable surcharge in addition to the premium for the additional portion of the insurance coverage. This surcharge shall be calculated in accordance with the principles applicable in the insurer's business operations for compensation of the increased risks.

II

The age reached according to the rate plan shall mean the difference between the year of birth and the calendar year in which the change of the premiums occurs.

§ 8b Premium adjustments

I

(1) Within the framework of the contractual commitment to render benefits, the benefits of the insurer may change, for example, due to frequent incapacity to work on the part of the insured persons, due to longer periods of incapacity to work or due to increasing life expectancy. Accordingly, the insurer compares at least on an annual basis for each rate plans the necessary insurance benefits and mortality rates with those calculated in the technical bases of calculation. If this comparison results for a unit under observation of a rate plan in a percentage variance more than that stipulated by law or in the rate plan, all premiums of this unit under observation shall be reviewed by the insurer and, if necessary, adjusted with the approval of the trustee. Under the same prerequisites, an agreed risk premium may also be amended accordingly.

(2) A premium adjustment may be waived if, in the concurrent assessment of the insurer and the trustee, the change in the insurance benefits is to be viewed as temporary.

(3) Premium adjustments and changes in deductibles and then the agreed risk surcharges shall become effective at the start of the second month following the notification of the policyholder.

II

If the comparison pursuant to § 8b (1), Sentence 2 of the MB/KT 2009 results in a change of more than 5% of the insurance benefits calculated in the technical bases of calculation, all premiums according to the rates plan for the unit under observation shall be reviewed by the insurer and adjusted, if necessary, with the approval of the trustee.

Under the same prerequisites, an agreed risk premium may also be modified.

§ 9 Obligations

I

(1) The insurer must be notified of the medically diagnosed incapacity to work without delay, though at the latest within the period stipulated in the rate plan, by providing documentation (§ 4 (7)). If the notification is received late, the daily sickness allowance may be reduced or cancelled altogether up to the day of receipt in accordance with § 10; however, no payment shall be made before the date stipulated in the rate plan. Persistent incapacity to work must be documented to the insurer within the period stipulated in the rate plan. The insurer must be notified of the restoration of working capacity within three days.

(2) The policyholder and the insured person reported as entitled to receive information (cf. § 6 (3)) must provide any information at the request of the insurer which is necessary to determine the insurance event or the duty to render benefits on the part of the insurer and the scope thereof. The requested information must also be given to an agent of the insurer.

(3) At the request of the insurer, the insured person shall be obliged to have him or herself examined by a physician commissioned by the insurer.

(4) The insured person must ensure that he/she is able to work again; in particular, the insured person must conscientiously follow the instructions of the doctor and refrain from all actions that hinder recovery.

(5) Any change of profession of the insured person must be notified immediately.

(6) The conclusion of a further new insurance policy or the increase of an otherwise existing insurance policy with a claim to daily sickness benefits may only be carried out with the consent of the insurer.

II

(1) The insurer must be notified of the occurrence of any total incapacity to work by no later than the date of the specified commencement of benefits. The medical certificate must also contain the name of the illness.

(2) The deadline for providing documentation of a continued incapacity to work shall be notified to the insured person in each insured event.

§ 10 Consequences of breaches of obligations

I

(1) With the restrictions stipulated in § 28, para. 2 to 4 of the Insurance Agreement Act (see annex), the insurer shall be free in whole or in part from the obligation to render benefits if one of the obligations mentioned in § 9, para. 1 to 6 is breached.

(2) If one the obligations set forth in § 9, para. 5 and 6 is breached, the insurer may also terminate the agreement without notice subject to the prerequisite in § 28 (1) of the Insurance Agreement Act (see annex) within one month after obtaining knowledge of the breach of the obligation.

(3) The knowledge and fault of the insured person shall be equivalent to the knowledge and fault of the policyholder.

§ 11 Duty to notify in the event of loss of insurability

I

The insurer must be notified without delay of the elimination of a prerequisite for insurability specified in the rate plan or the occurrence of occupational disability (cf. § 15 (1), Litera b)) of an insured person. If the insurer becomes aware of the occurrence of this event only at a later date, both parties shall be obliged to return to each other the benefits received for the period after the cessation of the insurance relation.

§ 12 Set-off

I

The policyholder may only set off claims of the insurer with counterclaims that are undisputed or declared by non-appealable judgment. A member of the Assurance Association may not set off any claim based on the duty to pay premiums.

End of insurance

§ 13 Termination by the policyholder

I

(1) The policyholder may terminate the insurance relation effective as of the close of any insurance year upon notice of three months.

(2) Termination may be limited to individual insured persons or rate plans.

(3) If an insured person is required to be insured in the statutory health insurance scheme, the policyholder may terminate within three months after the occurrence of the insurance requirement a daily sickness benefit insurance policy or a vested benefit insurance policy existing for daily sickness benefits retroactively effective from the occurrence of the insurance requirement. The termination shall be invalid if the policyholder does not document the occurrence of the insurance requirement within two months after the insurer has requested the policyholder to do so in text form, unless the policyholder is not responsible for the failure to meet this deadline. If the policyholder avails itself of its termination right, the insurer shall be entitled to the premium only until the date of the occurrence of the insurance requirement. The policyholder may later terminate the daily sickness benefit insurance or a vested benefit insurance exist for daily sickness benefits effective only from the end of the month in which the policyholder documents the occurrence of the insurance requirement. The insurer shall be entitled to the premium in this event until the cessation of the insurance agreement. The statutory claim to family insurance or a non-temporary claim to therapeutic care based on civil service law or a similar employment relation shall be equivalent to the insurance requirement.

(4) If the insurer increases the premiums on the basis of the premium adjustment clause or reduces its benefits pursuant to § 18 (1) or exercises its right to a reduction pursuant to § 4 (4), the policyholder may terminate the insurance relation with regard to the affected insured person within two months of receipt of the notification of the change as of the date the change takes effect. In the event of a premium increase, the policyholder may terminate the insurance relation also up to and as of the effective date of the increase.

(5) If the insurer declares the voidance, rescission or termination only with respect to individual insured persons, the policyholder may request within two weeks after receipt of such declaration the rescission of the other portion of the insurance effective as of the close of the month in which the policyholder received the declaration from the insurer; in the event of the termination, as of the date on which such termination becomes effective.

(6) If the policyholder terminates the insurance relation as a whole or for individual insured persons, the insured persons shall have the right to continue the insurance relation by naming the future policyholder. The declaration must be issued within two months after the termination. The termination shall only be valid if the policyholder documents that the affected insured persons have received knowledge of the termination declaration.

II

(1) In the case of a termination in due time pursuant to § 13 (3) MB/KT 2009, the comprehensive healthcare cost insurance shall technically cease in relation to the affected insured persons and the affected insured rate plan at the end of the month in which the insurance requirement has occurred. The premium components attributable to the period as of the occurrence of the insurance requirement until the technical cessation of the agreement shall be repaid or, upon the continuation of health insurance, netted out with future premiums. The insurance coverage shall then cease, also for pending insurance events, upon the date of the occurrence of the insurance requirement; the insurer shall point this out to the policyholder in the confirmation of the termination.

(2) An ended insurance agreements may be put into effect again while maintaining the original age of entry and waving the observance of new waiting periods, if this is requested within 6 months after the cessation thereof and the reanimation becomes effective after this period at the latest. For this purpose, a new insurance application must be submitted.

(3) The insurance requirements in one of the states mentioned in § 1 (8) MB/KT 2009 shall be equivalent to the insurance requirement in § 13 (3) MB/KT 2009.

(4) In the event of a relocation of the habitual place of residence to one of the countries listed under § 1 (8) MB/KT 2009, the policyholder may terminate the insurance relation for the insured person within two months of the relocation of the habitual place of residence.

§ 14 Termination by the insurer

I

(1) The insurer may terminate the insurance relation at the end of each of the first three years of insurance by giving three months' notice, provided there is no legal claim to a premium supplement from the employer.

(2) The provisions of law concerning extraordinary termination shall not be prejudiced hereby.

(3) The termination may be limited to individual insured persons, rates or to subsequent increases in daily sickness allowance.

(4) If the policyholder declares the termination only for individual insured persons or rates, the insurer may, within two weeks of receipt of the termination, demand that the remaining part of the insurance be rescinded on the date on which the notice takes effect. This shall not apply in the event of § 13 (3).

II

(1) The insurer waives the ordinary right of termination pursuant to § 14 (1) MB/KT 2009.

(2) The rights of the insurer pursuant to § 19, para. 2 to 4 of the Insurance Agreement Act in the event of a negligent breach of the contractual notification duty shall expire three years after the closing date of the agreement or the increase of the insurance coverage. This shall not apply to insurance events that occur before the expiry of this period. If the policyholder has intentionally or fraudulently breached the notification duty, the period shall be 10 years.

§ 15 Miscellaneous grounds for termination

I

(1) The insurance relation shall cease with regard to the affected insured persons:

a) in the event of the elimination of a prerequisite for insurability specified in the rate plan as of the end of the month in which the prerequisite ceased to apply. If, however, at that time there is incapacity to work in an insured event which has already occurred, the insurance relation shall not cease before the date on which the insurer must provide the benefits listed in the rate plan for this incapacity to work, but no later than three months after the elimination of the prerequisite;

b) upon occurrence of the occupational disability. "Occupational disability" shall be deemed to exist if the insured person is medically diagnosed as being more than 50% incapacitated for an unforeseeable period of time in his or her previous occupation. However, if at that time there is an incapacity to work in an insured event that has already occurred, the insurance relation shall not end before the date by which the insurer must provide the benefits listed in the rate plan for this incapacity to work, but no later than three months after the occurrence of the incapacity to work;

c) upon the receipt of retirement pension, at the latest, if agreed in the rate plan, at the age of 65. If cessation is agreed upon reaching the age of 65, the insured person shall have the right to demand the conclusion of a new daily sickness benefit insurance policy in accordance with § 196 of the Insurance Agreements Act (VVG) (see annex);

d) upon death. Upon the death of the policyholder, the insured persons shall have the right to continue the insurance relation, naming the future policyholder. The declaration must be issued within two months after the death of the policyholder.

e) in the event of a relocation of the habitual place of residence to a state other than those mentioned in § 1 (8), unless the insurance relation is continued on the basis of another agreement.

(2) The policyholder and the insured persons shall have the right to continue a contract terminated by them or a contract ended due to the occurrence of an occupational disability pursuant to para. 1, Litera b) in accordance with the rate plan in the form of a qualifying period insurance policy, provided a resumption of gainful employment can be expected.

II

(1) If the self-employed professional activity ends and at that time insurance cover exists at a rate level which requires self-employed professional activity, the insured person shall have the right to change to a rate level that provides for a permanent employment relation as an employee.

(2) If the insured person becomes unemployed after the occurrence of the insured event without being entitled to benefits due to unemployment, the three-month period of § 15 (1a) MB/KT 2009 shall be extended to 9 months. If the unemployment lasts longer, 50% of the insured daily allowance shall be paid after the 9 months until the end of the incapacity to work, but for a maximum of three further months, though up to a maximum of € 25 per day. The insurance relation shall cease at the latest upon expiry of this period. § 15 (1a) MB/KT 2009 shall not be prejudiced hereby.

(3) If a pension application has been submitted due to occupational disability or incapacity to be gainfully employed and the pension insurance institution has not yet decided on this application by

the end of the three-month period in § 15 (1b) MB/KT 2009, the insurance relation shall not cease in an insured event that has already occurred, at variance with § 15 (1b) MB/KT 2009; after expiry of this period, 50% of the insured daily sickness allowance, but no more than € 25 per day of incapacity to work, shall be paid until the end of the month in which the insured person receives the notice of pension or the notice of rejection of the pension application, but for a further three months at the latest. The insurance relation shall cease at the end of the month until which the daily sickness allowance has been paid.

(4) Notwithstanding the benefits pursuant to § 15 (3) of the rate conditions, the insurance relation shall cease upon relinquishment of gainful activity, upon occurrence of occupational disability (cf. § 15 (1b) MB/KT 2009) or upon receipt of an occupational disability pension or pension for the incapacity to be gainfully employed for the occupation previously exercised. In addition to the cases listed in § 15 (2) MB/KT 2009, the insurance relation may be continued for the duration of the interruption of gainful activity, the duration of the occupational disability or the duration of the receipt of an occupational disability pension or pension for incapacity to be gainfully employed with regard to the affected insured person within the framework of a qualifying period insurance policy.

In the event of a change of professional activity, the policyholder shall have the right to demand the continuation of the insurance with respect to the insured person at the same or a different daily sickness allowance rate, provided the conditions for eligibility for insurance are met. The insurer may make this continued insurance subject to special conditions.

(5) The continuation of an insurance relation in the form of a qualifying period insurance policy in accordance with § 15 (2) MB/KT 2009 and § 15 (4) of the rate conditions must be applied for within two months of the cessation of the insurance relation by termination, of the relinquishment of gainful activity, of the occurrence of an occupational disability or of the receipt of an occupational disability pension or pension for incapacity to be gainfully employed, or, if the event occurs at a later date, of the date on which it became known.

(6) Notwithstanding § 15 (1b) MB/KT 2009, the insurance relation may be continued in the case of an occupational disability upon application. The prerequisite for this shall be that income continues to be drawn from a professional activity. The other grounds for cessation in accordance with § 15 (1a) and c) to e) MB/KT 2009 shall not be prejudiced hereby.

(7) The daily sickness benefits insurance policy shall cease when the insured person reaches the age of 65. In such case, the policyholder may demand that the insurer accept the application to take out a new daily sickness benefit insurance policy starting at the age of 65 and ending at the latest at the age of 70. The insurer must inform the policyholder of this right at the earliest 6 months before the end of the insurance. If the application is submitted up to two months after reaching the age of 65, the insurer shall grant insurance cover without risk assessment or waiting periods, provided the insurance cover is not higher or more comprehensive than in the previous rate level. If the insurer has not informed the policyholder of the end of the insurance in accordance with Sentence 3 and if the application is made before the policyholder reaches the age of 66, Sentence 4 shall apply accordingly, whereby the insurance shall commence upon receipt of the application by the insurer; if the insured event has already occurred before the application is received, the insurer shall not be obliged to render benefits.

(8) § 15 (7), Sentences 2 and 4 of the rate conditions shall apply accordingly if a new daily sickness benefit insurance is applied for immediately following an insurance policy pursuant to § 15 (7), Sentences 4 and 5 of the rate conditions, which ends at the latest upon reaching the age of 75.

(9) If a divorce judgment or a judgment for the rescission of a life partnership exists, then the affected spouses or life partners shall have the right to continue their portions of the contract as independent insurance relations. This shall also apply if the spouses or life partners live separately.

(10) The conclusion of a special agreement in accordance with § 15 (1e) MB/KT 2009 must be applied for within 6 months of the relocation of the habitual place of residence at the latest.

(11) In the event of a relocation of the habitual plance of residence to a country other than the country referred to in § 1 (8) MB/KT 2009, the insurance relation shall also be converted into a qualifying period insurance policy. The transformation into a qualifying period insurance policy must be requested within 6 months after the relocation of the habitual place of residence.

Miscellaneous provisions

§ 16 Declarations of intent and notices

I

Declarations of intent and notices to the insurer must be in text form.

§ 17 Place of jurisdiction

I

(1) The courts of the place where the policyholder has his or her domicile or, in the absence of any domicile, his or her habitual place of residence shall be competent for actions based on the insurance relation against the policyholder.

(2) Actions against the insurer may be filed with the court at the domicile or habitual place of residence of the policyholder or at the court at the registered office of the insurer.

(3) If the policyholder relocates his or her domicile or habitual place of residence after the closing of the agreement to a state which is not a member state of the European Union or a contracting state of the Agreement on the European Economic Area, or if his or her domicile or habitual place of residence is not known at the time the action is filed, the court at the registered office of the insurer shall be competent.

II

Out-of-court settlement of disputes:

Hallesche Krankenversicherung a.G. takes part in the arbitration procedure of the consumer arbitration board "OMBUDSMAN for Private Health and Health Care Insurance", which you can reach as follows:

OMBUDSMAN for Private Health and Health Care Insurance
P.O. Box 060222
10052 Berlin
Phone: 0800/255 04 44
(free of charge from German telephone networks)
Fax: 030/20458931
E-Mail: ombudsmann@pkv-ombudsmann.de
Website: www.pkv-ombudsmann.de

If you have concluded your contract online, for example via our website, you can use the online dispute resolution platform set up by the European Commission. The platform can be accessed via the following link: http://ec.europa.eu/consumers/odr/

§ 18 Amendments to the General Terms and Conditions of Insurance

I

(1) In the event of any change in the circumstances of the health care system to be viewed as not merely temporary, these General Terms and Conditions of Insurance and the Rate Conditions may be adjusted to the altered circumstances, provided the changes appear necessary to sufficiently safeguard the interests of the policyholders and an independent trustee reviews the prerequisites for the changes and their adequacy. The changes shall be effective at the start of the second month following the notice to the policyholders of the changes and the applicable grounds.

(2) If a provision in the General Terms and Conditions of Insurance is declared invalid by a Supreme Court decision or by non-appealable administrative act, the insurer may replace such provision through a new provision, provided such provision is necessary for the continuation of the agreements or provided adherence to the agreement would represent an unreasonable hardship for either party without the new provision, also with due regard to the interests of the other party. The new provision shall only be valid if it adequately takes into account, while safeguarding the purpose of the agreement, the interests of the policyholder. Two weeks after the new provision and the applicable grounds have been communicated to the policyholder, the new provision shall form an integral component of the agreement.

Annex – Legislative texts

Insurance Agreement Act [Versicherungsvertragsgesetz, VVG]

§ 14 Due date of the cash benefit

(1) Cash benefits of the insurer shall be due upon the cessation of the investigations necessary to determine the insurance event and the scope of the benefits to be rendered by the insurer.

(2) If these investigations are not completed within one month after the notification of the insurance event, the policyholder may request installment payments in the minimum amount tentatively payable by the insurer. The running of the period shall be interrupted so long as the investigations cannot be completed as a consequence of the negligence of the policyholder.

(3) Any agreement through which the insurer is released from the duty to pay default interest shall be invalid.

§ 19 Notification duty

(2) If the policyholder breaches his or her notification duty in accordance with para. 1, the insurer may rescind the agreement.

(3) The rescission right of the insurer shall be excluded if the policyholder has not breached the notification duty either intentionally or due to gross negligence. In such event, the insurer shall have the right to terminate the agreement in observance of a notice period of one month.

(4) The rescission right of the insurer due to a grossly negligent breach of the notification duty and its termination right in accordance with para. 3, Sentence 2 shall be excluded if the insurer would have concluded the agreement had it had knowledge of the undisclosed circumstances, if at other terms and conditions. The other terms and conditions shall form an integral component of the agreement retroactively at the insurer's request; in the case of a breach of duty for which the policyholder is not responsible, as of the current insurance period.

§ 28 Breach of a contractual obligation

(1) In the event of a breach of a contractual obligation which is to be fulfilled by the policyholder in relation to the insurer before the occurrence of the insurance event, the insurer may terminate the agreement without notice within one month after which the insurer receives knowledge of the breach, unless the breach is not based on intentional action or gross negligence.

(2) If the agreement stipulates that the insurer is not obliged upon the breach of a contractual obligation to be fulfilled by the policyholder to render benefits, the insurer shall be free of the duty to render benefits, provided the policyholder has intentionally breached the obligation. In the event of a grossly negligent breach of the obligation, the insurer shall be entitled to reduce its benefits in corresponding proportion to the severity of the negligence of the policyholder; the burden of proof for the non-existence of gross negligence shall be borne by the policyholder.

(3) At variance with para. 2, the insurer shall be obliged to render benefits if the breach of the obligation was not the cause of the occurrence or the determination of the insurance event order for the determination or scope of the insurer's duty to render benefits. Sentence 1 shall not apply if the policyholder has fraudulently breached the obligations.

(4) In the event of a breach of a duty to provide information or clarification existing after the occurrence of an insurance event, the full or partial freedom of the insurer from the duty to render benefits in accordance with para. 2 shall be contingent on the prerequisite that the insurer has instructed the policyholder through separate notice in text form of this legal consequence.

§ 37 Default in payment of initial premium

(1) If the one-time or initial premium is not paid in due time, the insurer shall be entitled as long as the payment is not affected to rescind the agreement, unless the policyholder is not responsible for the non-payment.

(2) If the one-time or initial premiums are not paid upon the occurrence of the insurance event, the insurer shall not be obliged to render benefits, unless the policyholder is not responsible for the non-pay-

ment. The insurer shall only be free of the duty to render benefits if the insurer has made the policyholder aware through separate notice in text form or through a conspicuous indication in the insurance certificate of this legal consequence of the failure to pay the premium.

§ 38 Default in the payment of subsequent premiums

(1) If a subsequent premium is not paid in due time, the insurer may establish for the policyholder at the latter's cost in text form of payment period amounting to at least two weeks. The determination shall only be valid if the premium, interest and cost amounts in arrears are specified in detail along with the legal consequences associated with the expiry of the deadline in accordance with para.s 2 and 3; in the case of summarized agreements, the amounts must be specified separately.

(2) If the insurance event occurs after the expiry of the deadline and the policyholder is in default upon the occurrence with the payment of the premium or the interest or costs, the insurer shall not be obliged to render benefits.

(3) After expiration of the deadline, the insurer may terminate the agreement without notice, provided the policyholder is in default with the payment of the owed amounts. The termination may be associated with the determination of the payment period in such fashion that the termination becomes effective upon the expiry of the deadline, provided the policyholder is in default with the payment on such date; the policyholder must be expressly referred to this consequence upon the termination. The termination shall be invalid if the policyholder renders payment within one month after the termination or, if the termination is associated with the established deadline, within one month after the expiry of the deadline; para. 2 shall not be prejudiced hereby.

§ 196 Temporal limitation of the daily sickness benefit insurance

(1) In the case of daily sickness benefit insurance, it may be agreed for the insurance to cease when the insured person reaches the age of 65. In such case, the policyholder may demand that the insurer accept the application to take out a new daily sickness benefit insurance policy starting at the age of 65 and ending at the latest at the age of 70. The insurer must inform the policyholder of this right in text form at the earliest 6 months before the end of the insurance, enclosing the wording of this provision. If the application is submitted up to two months after reaching the age of 65, the insurer must grant insurance cover without a risk assessment or waiting periods, provided the insurance cover is not higher or more comprehensive than in the previous rate plan.

(2) If the insurer has failed to inform the policyholder of the cessation of the insurance in accordance with para. 1, Sentence 3 and the application is made before the policyholder reaches the age of 66, para. 1, Sentence 4 shall apply accordingly, whereby the insurance shall commence upon receipt of the application by the insurer. If the insured event has already occurred prior to receipt of the application, the insurer shall not be obliged to render any benefits.

(3) Para. 1, Sentences 2 and 4 shall apply accordingly if a new daily sickness benefit insurance policy is applied for immediately following an insurance policy pursuant to para. 1, Sentence 4 or para. 2, Sentence 1 which ends at the latest upon reaching the age of 75.

(4) The parties may agree on a later age than that specified in the preceding para.s.

Maternity Protection Act [Mutterschutzgesetz, MuSchG]

§ 3 Protection periods before and after childbirth

(1) The employer may not employ a pregnant woman in the last 6 weeks before delivery (protection period before delivery) unless she expressly declares her willingness to work.

She may revoke the declaration pursuant to Sentence 1 at any time with effect for the future. For the purpose of calculating the period of protection before delivery, the expected date of delivery shall be the date of delivery as indicated in the medical certificate or the certificate issued by a midwife or obstetrician. If a woman does not give birth on the expected date, the period of protection before the delivery shall be shortened or extended accordingly.

(2) The employer may not employ a woman until 8 weeks after she has given birth (protection period after delivery). The period of protection after delivery shall be extended to 12 weeks:

1. for premature births,
2. for multiple births and,
3. if a disability in the terms of § 2(1), Sentence 1 of Title Nine of the Social Code is medically diagnosed in the child before the expiry of 8 weeks after delivery.

In the event of premature delivery, the term of protection after delivery pursuant to Sentences 1 or 2 shall be extended by the period the term of protection before delivery is shortened pursuant to para. 1, Sentence 4. According to Sentence 2, No. 3, the protection period after delivery shall only be extended if the woman so requests.

Life Partnership Act [Lebenspartnerschaftsgesetz, LPartG]

§ 1 Form and prerequisites

(1) Two persons of the same sex, who declare to the civil registrar in person when simultaneously present that they want to maintain a partnership with each other for life (life partners) shall establish a life partnership. The declarations may not be issued under any condition or defined time.

(2) The civil registrar shall ask the life partners individually whether they want to establish a life partnership. If the life partners answer this question in the affirmative, the civil registrar shall declare that the life partnership has now been established. The establishment of the life partnership may occur in the presence of up to two witnesses.

(3) A life partnership cannot be validly established:

1. with a person who is a minor or with a third person who is married or already maintains a life partnership with another person;
2. between persons who are related to each other in direct line;
3. between full or half siblings;
4. if the life partners agree during the establishment of the life partnership that they do not want to establish any obligations pursuant to § 2.

(4) No petition for the establishment of a life partnership may be filed based on the promise to establish a life partnership. Section 1297(2) and §§ 1298 to 1302 of the Civil Code shall apply accordingly.