General Terms and Conditions of Insurance for the Hi.Germany Temporary Comprehensive Health Insurance (AVB/KKb)

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§ 1 What cover does this insurance provide?

(1) Who do you take out the insurance with?

We are the Hallesche Krankenversicherung a.G. which has its registered office in Stuttgart. You are our contract partner, also known as the policyholder. If you have insured yourself, you are also the insured person. You may also have insured other people as well. We also call them insured persons.

In order to make the General Terms and Conditions of Insurance easy to read, we generally only use the male gender when referring to people. However, this always refers to female persons as well.

(2) What is insured?

We provide insurance coverage for illnesses, → accidents and other events which are specified in the tariff. If an → insured event occurs we reimburse the costs of the → treatment that is provided and/or the costs of other agreed services. To find out exactly what we pay for, please consult our tariff.

This insurance coverage satisfies the → compulsory insurance requirements in Germany. Please see § 193 (3) of the German Insurance Contract Act (Versicherungsvertragsgesetz or VVG) which is attached.

(3) What is the maximum period of the insurance cover?

The policy does not have any minimum period of cover. It ends at the latest 60 months after the → start date of the insurance.

If immediately before the start of the insurance the insured person was insured under a different tariff for persons with a → temporary residence permit, the insurance period is shortened accordingly.

(4) What is an insured event?

An insured event is the medically necessary → treatment of the insured person due to an illness or the consequences of an accident. The insured event begins when the treatment starts; it ends when the insured person is medically assessed as no longer needing treatment.

An insured event is also

- the treatment of an insured person due to pregnancy, delivery, or miscarriage. This also includes the termination of a pregnancy if it is not illegal to do so.
- a medical check-up for the early detection of illnesses. In tariffs with benefits for in-patient → medical treatment, in-patient check-ups shall only be considered as an insured event if they have to be performed on an in-patient basis for medical reasons.
- transitional care in hospital, if and insofar as the tariff provides benefits for this.
- specialist out-patient palliative care and in-patient care in a hospice.

If the medical treatment has to be expanded to include an illness, or the consequences of an accident, that is not causally related to the illness or accident for which treatment has originally been provided, this will constitute a new insured event.

Depending on the tariff, there may be other insured events in respect of which insurance cover applies. We will specify this in the tariff.

(5) Where is the scope of the insurance cover defined?

The basis of your policy are

- Your → insurance certificate,
- Your tariff,
- these General Terms and Conditions of Insurance for the Temporary
- Comprehensive Health Insurance,
- the legal regulations in the Federal Republic of Germany, and
- the written agreements which we conclude with you.

§ 2 When does the insurance cover commence?

(1) When is your policy concluded and when does your insurance cover begin?

The policy is concluded once you have received the → insurance certificate or a written declaration stating that your application form has been received.

The insurance cover begins as from the date and time shown in the insurance certificate (commencement of the insurance). However, the insurance cover does not begin before you have concluded the contract.

If an → insured event has occurred before the start of the insurance cover, we will make payments un-

der the policy for the period as from the commencement of the insurance cover, if

- the insured event occurred after the policy was concluded, or
- this insured event was notified to us before the policy was concluded and we have not agreed otherwise with you.

If you extend the insurance cover, this applies accordingly to the additional benefits.

(2) When does the insurance cover begin in the case of new-born infants?

In the case of new-born infants the insurance cover begins as from the time of birth with no → risk loading. This only applies if you have notified the child to us no later than 2 months after the birth, and

- on the date of the birth one of the parents has been insured with us for at least 3 months, or
- the mother-to-be was not yet 20 weeks pregnant when she or the father-to-be applied for his/her own insurance cover.

In this case:

- You have to pay premiums for the child only as from the month which follows the birth.
- The insurance cover for the child cannot be for a greater amount or be more comprehensive than the cover for an insured parent. You may however choose a lower annual excess for the child.
- The insurance cover also applies to illnesses and anomalies which have arisen before or during the birth.
- The costs for the provision of accommodation, food and care for the healthy new-born infant in the hospital are also covered by the insurance.

We treat → adoption in the same way as birth if a person who is insured with us adopts a child who is still a minor. In this case we may demand a premium loading for any increased risk. The maximum premium loading is equal to the premium for the child.

§ 3 What do we pay for in countries other than Germany?

(1) What do we pay for treatment in other → EU and → EEA states and in Switzerland?

We pay for treatment subject to the following restriction:
The most that we pay in these countries is what we would have had to pay for the treatment concerned in Germany.

If we have provided our written agreement to make a payment

- in advance, or
- if the insured person needs to receive → in-patient emergency treatment when he is abroad owing to an emergency,

we will not apply this restriction.

If the insured person requires in-patient emergency care owing to an emergency, you must call our foreign emergency call service → without delay.

Our foreign emergency call service can be reached by calling the following telephone number: **+49 (0) 7 11/66 03-39 30**.

(2) What do we pay for treatment in other countries?

We pay for treatment subject to the following restrictions:

- The insured person has insurance cover for stays of up to 4 weeks. If a stay lasts for longer than that, cover is only provided for the first 4 weeks.
- If the insured person travels to his → home country, he has insurance cover for up to 12 weeks. If a stay lasts for longer than that, cover is only provided for the first 12 weeks.
- The insurance cover is extended beyond the periods that are specified here if the insured person is not well enough to undergo transportation. The insured person is then insured until he is able to be transported to Germany without endangering his health. The precise rules regarding return transportation to Germany can be found in your tariff (Hi.Medical L/S).
- The most that we pay in such cases is what we would have had to pay for the treatment concerned in Germany.

- If we have provided
  - our written agreement to make a payment in advance, or
  - if the insured person needs to receive → in-patient emergency treatment when he is abroad owing to an emergency,

  we waive this restriction.

If the insured person requires in-patient emergency care owing to an emergency, you must call our foreign emergency call service without delay.

Our foreign emergency call service can be reached by calling the following telephone number: **+49 (0) 7 11/66 03-39 30**.

(3) What happens if the insured person stays abroad for longer than 6 months?

According to these conditions the insured person stops being → normally resident in Germany if he spends a total of more than 6 months abroad in any one year.

We calculate the amount of time spent abroad by adding together all the stays abroad within a 12-month period. If the insured person interrupts the stay abroad by a period of less than 30 days, this period counts as part of the stay.

If an overall period abroad of 6 months is exceeded, the insurance cover ends. You should also read § 12 para. 1. regarding this.

This does not apply to stays in other EU or EEA states, or to stays in Switzerland. In these cases we do not cancel the insurance policy.

§ 4 What do we pay for if an → insured event occurs?

(1) What payment is provided by the insurance?

To find out what we will pay you should consult these General Terms and Conditions of Insurance and your tariff.

(2) What choice of doctors and treatment providers does the insured person have?

As long as the services to be provided are insured in the tariff, the insured person is free to choose any of the following persons:

- practice-based, licensed doctors and/or dentists,
- hospital doctors and → accident and emergency department doctors,
- emergency doctors/paramedics,
- alternative practitioners as defined in the German Non-Medical Practitioners Act (Heilpraktikergesetz),
- midwives and male midwives,
- approved psychotherapists and specialist psychotherapists. We also provide coverage for treatment by licensed psychological psychotherapists and paediatric and youth psychotherapists. In this case we pay for psychotherapy based on depth analysis and for analytical psychotherapy, systemic therapy, behavioural therapy as well as neuropsychological psychotherapy.

remedies (e.g. massages) and naturopathic treatments must be provided by:

- practice-based, licensed doctors, or
- alternative practitioners as defined in the German Non-Medical Practitioners Act (Heilpraktikergesetz), or
- state-accredited members of the healing and auxiliary healthcare professions, (e.g. masseurs/masseuses, physiotherapists, occupational therapists, speech therapists, podiatrists, dieticians, as well as nutritional/home economics experts and nutritional scientists.

In addition, the insured person can have out-patient treatment in

- the out-patient department of a hospital, or in
- a health centre or
- a social paediatrics centre.

(3) What choice of hospitals does the insured person have?

If the insured person requires in-patient treatment for medically necessary reasons, he has a free choice of hospital. The hospital must however satisfy the following conditions: It must

- be under full-time medical management,
- have sufficient capabilities for detecting and treating illnesses, and
- it must keep written records of the course of illnesses.

If such a hospital also provides → spa treatments, → sanatorium treatments or → rehabilitation measures, we only pay for the treatment if we have sent

you written confirmation beforehand that we will do so. This does not apply if

- the insured person was admitted on an → emergency basis.
- the hospital providing treatment is the only one in the area and the insured person has medically necessary treatments there which can only be carried out on an in-patient basis.
- an accident or an acute illness occurs during a stay in such a hospital, and the insured person therefore has to receive in-patient treatment there for medically necessary reasons.
- the insured person has to be operated on there as part of medically necessary in-patient treatment.
- in the case of → follow-up treatment according to § 5 para. 7.

(4) What points should be noted regarding medicines, dressings, remedies and medical aids?

The treating physicians referred to in para. 2 must prescribe the medicines, dressings, remedies and medical aids.

Medicines must be procured from the pharmacy.

Digital health applications must be a medical device of risk class I, IIa or IIb whose main function is essentially based on digital technologies and are intended to support the detection, monitoring, treatment or alleviation of diseases or the detection, treatment, alleviation or compensation of injuries or disabilities in the insured persons or in the care provided by the service providers named in § 4(2).

(5) For which methods and medicines do we pay if the insured person has to be examined and treated?

We pay for methods which are predominantly recognised by → conventional medicine. This also applies to medicines.

In addition, we pay for methods and medicines

- which have proved in practice to be equally likely to be successful. In that case we may however reduce our payments to the amount which would have been incurred if the existing methods and medicines used in conventional medicine had been used.
- which are used because no methods and medicines used in conventional medicine are available.

(6) How can you find out in advance what we will pay for?

We will tell you in advance whether we will reimburse costs, and if so which costs, if

- the insured person intends to have treatment and
- it is expected to cost more than € 2,000, and if
- you ask us in writing to do so.

Please note that: we can only provide information if the documents submitted by you permit us to do so.

We will provide you with the information

- at the latest after 4 weeks, or
- if the insured person requires urgent treatment we will do so → without delay, but at the latest after 2 weeks.

The period starts to run when your request is received by us. If we have missed this deadline, we will pay for the treatment in accordance with the tariff unless we can prove that it is not medically necessary.

§ 5 When do we not pay or only pay a restricted amount?

(1) When do we not pay?

We don't pay in the following cases:

- for illnesses and → accidents which the insured person has → intentionally caused, or for their consequences.
- for accommodation that is required due to a → need for care or secure accommodation.
- for treatments provided by spouses, → life partners, parents or children. We will reimburse proven material costs according to your tariff.
- for invoices from people or medical care establishments in respect of which we have decided, for important reasons, not to provide reimbursement. This applies only if we have informed you of this fact prior to the → insured event. Otherwise we will still pay for 3 months as from the time when we have notified you.

(2) Do we pay for → detoxification treatments?

We do not pay for out-patient and in-patient detoxification treatments unless we specifically state in the tariff that we will do so.

(3) Do we pay in the event of war, civil unrest and terrorism?

We do not pay if the insured person is injured as a result of events of war in Germany.

We also do not pay if the insured person is injured outside of Germany due to being actively involved in civil unrest.

We also do not pay if the insured person is injured due to events of war or terrorist attacks outside of Germany. However, we do pay if

- the Federal Foreign Office does not warn against travelling to the area concerned, or
- only issues a warning against travel to the area concerned when the insured person is already there, and
- he leaves the area → without delay, or
- through no fault of his own is prevented from leaving the area. This may, for instance, occur if the insured person would be putting his life at risk by attempting to leave the area.

(4) Do we pay in the event of pandemics?

We pay if the insured person receives treatment in Germany as a result of a pandemic.

We do not pay if the insured person receives treatment outside of Germany due to a pandemic. However, we do pay if

- the Federal Foreign Office does not warn against travelling to the area concerned, or
- if it only issues a warning against travel to the area concerned when the insured person is already there and is unable to leave the area due to travel restrictions.

(5) Do we pay for treatments at a → spa or → sanatorium?

We only pay for treatments at a spa or sanatorium if this is explicitly stated in the tariff.

(6) Do we pay for → rehabilitation measures?

We don't pay for rehabilitation measures. In the case of → follow-up treatment we pay according to § 5 para. 7.

(7) Do we pay for follow-up treatments?

We pay for medically necessary follow-up out-patient or in-patient treatments if we have explicitly agreed to such treatment beforehand in writing.

However, the insured person does not require our written agreement for the first 3 weeks of a follow-up treatment if the following conditions apply:

- the treatment begins within 28 days following his stay in hospital, and
- the treatment is carried out at an institution which a statutory provider of rehabilitation care has approved for the treatment in question.

If owing to medical reasons the insured person is unable to begin the follow-up treatment within 28 days, he will need to obtain our agreement. We will provide this agreement provided that this follow-up treatment which begins after this period is medically necessary. This may be the case, for instance, after radiotherapy for treating a tumour, or if a suitable institution is not immediately available.

You may also apply to us for an extension of the follow-up treatment. We will approve it as long as it is medically necessary.

If following a course of acute in-patient treatment the insured person is entitled to have rehabilitation care that is provided by a statutory provider of rehabilitation care, he must first make use of this statutory treatment option. We then deduct the services provided by the statutory treatment provider from our reimbursement of costs.

There are cases in which the insured person could receive statutory rehabilitation treatment but culpably fails to pursue this option. In this case we deduct the services that the statutory treatment provider would have provided if it had been requested to do so from the reimbursement that we provide.

(8) In which cases can we reduce the payment to a reasonable amount?

If a → medical treatment or other measure for which benefits are agreed exceeds the medically necessary level, we may reduce our payments to a reasonable amount.

If the costs of the medical treatment or other services are clearly disproportionate to the services that are provided, we shall not be obliged to provide full reimbursement of those costs.

(9) What happens if more than one party provides services?

If the insured person is entitled to payments that are to be provided by another party, he must first of

all make full use of such services. We deduct such payments from the reimbursement that we provide.

If as the result of the same insured event the insured person is entitled to payments from several parties, you will in total receive no more than the costs that have actually been incurred.

§ 6 How is reimbursement made if an → insured event occurs?

(1) What evidence and information do we require in order to be able to pay?

We don't have to make any payment if you do not provide the evidence demanded by us. If we do make a payment, the proofs become our property.

We require originals of invoices. If there is another insurance policy in place, copies of the invoices are sufficient. The payments made by the other insurer must be confirmed in those invoices.

The invoices must contain the following information:

- the first name and surname of the treated person,
- the designation of the illnesses (diagnoses),
- the dates of the treatment, and
- a list of the individual services provided by the party which has provided treatment, or the relevant clauses in the → Fee Schedules.

In the case of hospital invoices we must also be able to determine,

- the optional services which have been used by the insured person and which the hospital may invoice separately, and/or
- which care class he has used.

To find out the additional conditions that have to be fulfilled in order for us to be able to make payment to you, please read § 14 VVG (German Insurance Contract Act). You can find this in the Annex.

If the costs have been incurred in a foreign currency, we will convert them into euros. We do this using the rate for the day on which we receive the receipts. The exchange rate used is the European Central Bank's official euro exchange rate, or the exchange rate used by the Deutsche Bundesbank. If the insured person proves with the aid of a bank receipt that he has obtained a less favourable exchange rate, that rate applies.

(2) To whom do we make payment?

We make payment to you as the policyholder. If you would like us to make payment to the insured persons, please notify us in writing of this.

You may neither assign nor pledge your entitlements to payments. The prohibition of assignment pursuant to sentence 1 shall not apply to contracts concluded on or after October 1, 2021; statutory prohibitions of assignment shall remain unaffected.

(3) What costs can we deduct from the payment?

We can deduct the following costs:

- the costs of transferring money abroad if you do not provide us with the details of an account that is held in Germany,
- costs incurred for translations.

§ 7 What duties must you fulfil? What happens if you breach these duties?

(1) What duties must you fulfil?

We may demand the following:

- You and the person who is entitled to receive benefits according to § 6 para. 2 must provide us with any information that we need in order to be able to ascertain
  - whether an → insured event has occurred, and
  - whether we shall provide payment, and if so how much it will be.
- The insured person must submit to a medical examination by a doctor who is commissioned by us.
- The insured person
  - must lessen the loss insofar as it is possible to do so, and
  - must not do anything which hinders his recovery.
- If another insurance policy which provides the same → type of insurance cover is taken out for an insured person, you must inform us of this → without delay.

(2) What happens if you breach these duties?

If any of these duties is breached, we are either fully or partially freed from the obligation to make a payment to you. In this respect we abide by the rules which are set out in VVG § 28 para. 2 to 4. These provisions can be found in the Annex.

If you have taken out another insurance policy which provides the same type of insurance cover, we may also cancel this policy if

- you have not → informed us promptly of this fact, and if
- the other policy is based on a tariff which does not fulfil your → duty to take out insurance.

In this respect we abide by the provisions of VVG § 28 para. 1 (see Annex).

We may cancel the policy without giving any notice within one month after learning of the breach of duty.

We attribute the knowledge or fault of the insured person to you.

(3) What further duties must you fulfil?

You must inform us without delay if the insured person no longer has a temporary residence permit for Germany, or if other preconditions for eligibility for insurance cover no longer apply. In this regard please refer to the conditions which are set out in your tariff in relation to eligibility for insurance cover.

If the → insured person's → habitual place of residence is still in Germany, you may make use of the option for the insured person of continued insurance under our open-ended Comprehensive Health Insurance. Please read § 12 para. 3. regarding this.

(4) What points should be noted if you have claims against third parties?

If you or an insured person has claims for reimbursement against third parties, you or the insured person must assign those claims to us in writing. They may, for example, include:

- compensation claims against other insurers or individuals, or
- claims for the repayment of fees that have been paid in error.

The assignment is limited to the amount that we have paid under the insurance. If this duty is breached, we shall make appropriate use of the legal consequences that are set out in VVG § 86 para. 2 (see Annex). This provision is independent of statutory subrogation (transfer of a claim) according to VVG § 86 (see Annex).

§ 8 How do we calculate the premiums, and when do you have to pay the premiums?

(1) How do we calculate the premiums?

We have calculated the premiums for this insurance policy → in accordance with the method used for life insurance. The method that we use to calculate premiums is specified in our technical basis of calculation. The calculation is in accordance with the statutory rules in Germany.

In the case of children and young people the following applies:

- For a child you pay the premium for the 0-16 age group up until the end of the year preceding his 16th birthday.
- At the start of the next year we place the child into the 17-20 age group. You pay this premium up until the end of the year preceding his 20th birthday.
- At the start of the next year you pay the premium for the child which is used for adults aged 21.

If the premiums change, e.g. because you alter in the insurance cover, we base our calculations on the age of the insured person at the time when the change takes effect.

If the premiums change, we may also accordingly change any → risk loadings that have been agreed with you.

If you extend the insurance cover in such a way that there is an increased risk, we are entitled to apply an appropriate loading. We will debit it in addition to the premium only in relation to the additional insurance cover.

(2) When do you have to pay the premiums?

The premium is an annual premium which you have to pay at the start of each → insurance year. However, you can also pay it in equal monthly instalments. In this case we will defer each of the premium instalments to the date when it falls due on the first of each month. You must make payments to the account that we notify to you.

If the annual premium changes in the course of an insurance year,

- you have to pay the difference from the time of the change up to the start of the next annual period of insurance, or

- we will refund the difference to you if we reduce the premium.

The first premium or the first premium instalment falls due on the date on which the insurance commences. If the policy has been taken out after that date, then it falls due as from that later date.

(3) What happens if you don't pay the premiums or don't pay them on time?

There are various rules about this depending on the type of tariff that is used. It depends on whether or not the tariff → fulfils the duty that exists in Germany to take out insurance. Please read VVG § 193 para. 3. regarding this which is contained in the Annex.

a) For tariffs which fulfil the → compulsory insurance requirements in Germany (Hi.Dental L/S tariff), the following applies:
If you don't pay the first premium or a subsequent premium on time,
   - you may forfeit the insurance cover, and
   - we can cancel the policy.

   In this respect we comply with VVG § 37 to § 38. You can find these sections in the Annex.

b) In the case of tariffs which fulfil the compulsory insurance requirements in Germany (Hi.Medical L/S tariff), premium arrears may lead to the suspension of the insurance cover (see Annex to VVG § 193 para. 6 and 7). In this case, the insured person is deemed to be insured under the → emergency tariff according to VAG § 153 (see Annex). The respective applicable version of the General Terms and Conditions for the Emergency Tariff Plan (AVB/NLT) shall accordingly apply.

If the policy or a part of it is cancelled before its expiry date, we are only entitled to receive the premium for the period in which insurance cover has been provided. If we terminate the policy by

- withdrawing from the policy as set out in VAG § 19 para. 2 due to a breach of the → duty of disclosure (please refer to the Annex), or if
- we avoid it due to fraudulent deception,

we are entitled to the premium up to the point in time when the withdrawal or avoidance takes effect.

If we withdraw because the first premium or the first premium instalment has not been paid on time, we will demand an appropriate fee.

§ 9 When can you offset amounts against our claims?

You can offset amounts against our claims only if

- if your counterclaim is undisputed or if it
- is established by means of a non-appealable judgment.

As a member of an Insurance Association you may not offset against any amounts receivable that are based on the duty to pay premiums.

§ 10 When can we amend the premiums and the terms and conditions?

(1) When can we amend the premiums?

The amount of the payments that we are contractually obliged to make under the policy may change if, for instance,

- the costs of → medical treatments increase, or if
- insured medical services are used more frequently.

That is why at least once a year we compare for each tariff the required payments with the payments which we have calculated according to our technical bases of calculation.

If the required payments in relation to a → unit of observation differ by more than 5% from the calculated payments,

- we review all the premiums within that unit of observation and
- adjust them – insofar as this is required – once the proposed changes have been reviewed and agreed by the independent → trustee.

Subject to the aforementioned conditions, we may also appropriately amend the amount of an excess and/or a → risk loading.

If we amend the premiums, we may also amend the loading which is required for the limiting of the premium in the → basic tariff.

The adjustments take effect at the beginning of the second month after we have notified them.

(2) When can we change the insurance conditions?

In the event of a change of circumstances in the healthcare system which is not to be regarded as merely temporary, we may adjust these conditions

and the rate provisions according to the new circumstances. This presupposes that

- the changes appear to be necessary in order to adequately safeguard the policyholder's interests,
- an independent trustee has checked that the preconditions for the changes are in place, and
- he has confirmed that these changes are appropriate.

The changes take effect at the beginning of the second month after we have notified you of the changes and the relevant reasons for them.

We may in addition replace a provision of these conditions by a new provision if the provision to be replaced has been declared to be ineffective by a

- decision of the court of last resort, or
- by a non-appealable administrative act

This presupposes that

- this is necessary in order to continue the policy, or that
- the policy would impose undue hardship on one of the parties to it in the absence of this new provision. Due regard will also be paid to the interests of the other respective party.

The new provision will only take effect if it

- upholds the purpose of the policy, and
- takes appropriate account of the policyholder's interests.

The provision becomes part of your policy two weeks after we have informed you of the provision and the relevant reasons for it.

§ 11 When and how can you amend the insurance cover?

(1) When can you switch to the → basic tariff?

You may demand that an insured person under your policy is moved to the basic tariff. When this is done, due account will be taken of the rights that have been accrued by the insured person.

(2) What opportunities do you have to amend the insurance cover under our temporary health insurance?

You may change the insurance cover that is provided under our temporary Hi.Germany tariff. This presupposes that the insured person is able to be insured under the new tariff.

In this regard we take account of the accrued rights and the period for which the existing policy has been in force.

If the new insurance cover provides higher sums insured or wider cover, we may demand a risk assessment in return for providing the additional cover. If we establish that there is an increased level of risk, we will

- demand an appropriate → risk loading, or
- an exclusion of the benefits concerned.

If you change from one tariff to another, you will have to pay the premium for the new tariff. If we have already agreed with you an exclusion of benefits or the application of risk loadings,

- the exclusion will be incorporated and
- the loadings will be adapted to the new premium.

It is not possible to change the insurance cover if your insurance cover has been changed to a → qualifying period insurance or if it is → suspended.

(3) What opportunities do you have to change to our open-ended health insurance policy?

It is not possible to switch to an open-ended health insurance policy → which provides similar insurance cover.

However, the insured person has the option of being continued to be insured once the Hi.Medical L/S tariff ends. This is specified in § 12 para. 3.

§ 12 When does the policy end and when does the insurance cover end?

(1) When does the policy end?

The policy ends when

- you cancel the policy. Further information about this can be found in § 13.
- we cancel the policy. Please refer to § 14 for information about this.
- the maximum insurance period of 60 months is reached. Please also read § 1 para. 3. regarding this.
- an insured person is no longer → eligible for insurance under this tariff. Please read the respective tariff to find out when this is the case.
- you change your → habitual place of residence to a country other than a member state of the

→ EU or Switzerland or an → EEA state. In this case you cannot keep your policy in force. Please also read § 3 para. 3. regarding this.

The policy also ends upon your death. In this case the insured persons may continue the policy. In order to do this, they must appoint a new policyholder within 2 months after your death. If an insured person dies, only the part of the policy relating to him ends.

(2) Can the policy be continued after a divorce or separation?

You and your spouse may continue your respective parts of the policy on an independent basis,

- after divorcing or if
- you live separately.

We apply corresponding arrangements in the case of → life partners.

(3) What option does the insured person have to obtain follow-on insurance?

If the Hi.Medical L/S tariff ends, the insured person may seamlessly transfer to any of our available Comprehensive Health Insurance tariffs with unlimited duration. This presupposes that

- the → insured person's habitual place of residence is still in Germany,
- the insured person is eligible for insurance under the tariff,
- the insured person provides us with proof that he has a place of residence in Germany, and
- the premiums for the last 12 months have been paid in full.

The insured person may transfer without a risk assessment if he sends us a written request to do so within a month after the end of the Hi.Medical L/S tariff.

If an insured person has not previously had insurance for dental benefits and if he wants to take out insurance for such services in the future, we will not carry out a risk assessment in this regard. In this case we may exclude or reduce dental benefits.

If the insured person has changed to a different tariff, you must pay the premium for the new tariff. Benefit exclusions and → risk loadings under the old tariff are incorporated into the new tariff and are adjusted in line with the agreed level of risk.

(4) When does the insurance cover end?

If the policy ends, the insurance cover also ends. This also applies to ongoing claims.

§ 13 When and how can you cancel your policy?

There is no minimum period for which you have to keep the policy in force. You can give ordinary notice of cancellation to take effect at the end of the month in question. This is subject to us receiving your notice of cancellation → in writing at least 15 days prior to the end of the month. You may also restrict your notice of cancellation to specific insured persons or specific tariffs.

If we terminate the policy only in respect of specific insured persons or specific tariffs by giving notice of cancellation or by withdrawing from the policy or avoiding it, you may demand the cancellation of the remaining part of the policy. You must do this within 2 weeks after receiving our notice of cancellation

- and with effect from the end of the month in which our declaration is received by you, or
- in the case of cancellation on the date and at the time when this takes effect.

If the tariff fulfils the → compulsory insurance requirements, it is a condition of cancellation that

- the insured person obtains a seamless continuation of cover with another insurer. That insurance must fulfil the compulsory insurance requirements.
- you provide us with proof of this. You have 2 months to do so after giving notice of cancellation. If the cancellation date lies more than 2 months in the future, you have until this date to do so.

If you cancel the policy in relation to individual insured persons or as a whole, the insured persons have the right to continue the insurance if

- the insured persons appoint a new policyholder and
- they notify us of the person's identity within 2 months after you have given notice of cancellation.

Your cancellation shall only be valid if you prove to us that the affected insured persons have become aware of it.

§ 14 When and how can we cancel your policy?

We waive the right to give ordinary notice of cancellation in relation to your policy.

Therefore we can only provide → extraordinary notice of cancellation in accordance with the statutory provisions. We may also restrict the notice of cancellation to specific insured persons or specific tariffs.

§ 15 When and how can you change your policy to a → qualifying period insurance?

If you give notice of cancellation, you or the insured person may continue the policy on a qualifying period insurance.

A qualifying period insurance is also possible if

- the insured person is required to be insured under the statutory German health insurance scheme (GKV), or if he
- becomes entitled to take out a GKV family insurance policy, or
- is entitled to receive civil service benefits, or
- is entitled to free medical care.

You must apply for the qualifying period insurance within 2 months after the end of the tariff.

A qualifying period insurance is not possible if the insurance policy is terminated because the insured person transfers his → habitual place of residence to a country other than Germany. In this case, the policy cannot be continued.

§ 16 In what form must a notification to us be made?

Declarations of intent and notices to us must be in → writing.

§ 17 What must you do if your address or your name changes?

Please inform us → without delay if your address changes. If you fail to do so, we will send declarations to the last known address that we have for you. The same applies if your name changes.

If we send a registered letter to you at this address it will be deemed to have been delivered 3 days after it is sent.

§ 18 Where should legal proceedings be instituted?

(1) Where can you institute legal proceedings against us?

You can institute legal proceedings against us at the court which is responsible for the district:

- where we have our registered office,
- where your place of residence is located, or
- where you have your → habitual place of residence if you do not have a permanent place of residence.

(2) Where can we institute legal proceedings against you?

We can institute legal proceedings against you at the court which is responsible for the district

- where your place of residence is located, or
- where you have your habitual place of residence if you do not have a permanent place of residence.

(3) Where can we institute legal proceedings if you have moved your place of residence or if it is not known to us?

If you have moved your place of residence or your habitual place of residence to a country other than Germany, the court that is responsible for our registered office location has jurisdiction in relation to any legal proceedings. This also applies if we do not know where your habitual place of residence is.

Reference to the consumer arbitration board Ombudsman Private Health and Nursing Care Insurance

Policyholders who are not satisfied with decisions made by the insurer, or whose negotiations with the insurer have not led to the desired result, can turn to the Private Health and Nursing Care Insurance Ombudsman.

Ombudsman Private Health and Nursing Care Insurance
PO Box 06 02 22
10052 Berlin
Web: www.pkv-ombudsmann.de

The ombudsman for Private Health and Nursing Care Insurance is an independent arbitration board that works free of charge for consumers. The insurer

has undertaken to participate in the arbitration proceedings.

Consumers who have concluded their contract online (e.g. via a website) can also submit their complaint online to the http://ec.europa.eu/consumers/odr/ platform. Your complaint will then be forwarded via this platform to the Private Health and Nursing Care Insurance Ombudsman.

Note: The Private Health and Nursing Care Insurance Ombudsman is not an arbitration board and cannot make binding decisions on individual disputes.

Reference to the insurance supervision

If policyholders are not satisfied with the service provided by the insurer or if disagreements arise during the processing of the contract, they can also contact the supervisory authority responsible for the insurer. As an insurance company, the insurer is subject to supervision by the German Federal Financial Supervisory Authority.

Federal Financial Supervisory Authority (BaFin)
Sector Insurance Supervision
Graurheindorfer Straße 108
53117 Bonn
Mail: poststelle@bafin.de

Note: The BaFin is not an arbitration board and cannot make binding decisions on individual disputes.

Reference to the legal process

Regardless of the possibility of turning to the consumer arbitration board or the insurance supervisory authority, taking legal action is open to the policyholder.

Technical terms

Here we explain the technical terms which are used in our conditions and are marked with a → symbol.

Accident [Unfall]

An accident is a sudden, external event which acts on the body in such a way that the insured person involuntarily suffers an injury. Examples of the most common types of accidents are falls, road accidents, and sports injuries.

Adoption

The adoption must always be recognised in Germany. Then we treat the date of adoption as the date of birth.

Basic tariff [Basistarif]

The basic tariff is a legally prescribed tariff which is identical in the case of all health insurers. It provides benefits which are comparable to those under the statutory health insurance scheme (GKV), and it was introduced on 1 January 2009.

Compulsory insurance requirement [Pflicht zur Versicherung]

Since 2009 there has been a general compulsory insurance requirement in Germany. Anyone whose place of residence is in Germany must have health insurance. Depending on the conditions to which the person is subject, he has compulsory insurance under a statutory health insurance scheme (GKV), or he must voluntarily obtain statutory health insurance, or he may choose a private form of health insurance (PKV).

Conventional medicine [Schulmedizin]

The term “conventional medicine” designates the generally recognised form of medicine. This is taught and developed at universities and medical schools according to scientific principles.

Detoxification treatment [Entwöhnungsbehandlung]

Detoxification treatment is a medical rehabilitation measure, which specifically provides treatment for substance-related addictive illnesses such as dependency on alcohol, medicines or drugs. It is primarily intended to help the patient to permanently abstain from using the substance to which he is addicted, and to counteract as far as possible the negative physical and psychological impacts that are associated with dependency.

Duty of disclosure [Anzeigepflicht]

We can only offer insurance cover if we know beforehand precisely what the risk is of the insured persons incurring expenses relating to an illness. That is why you and the insured persons must notify all the materially relevant details for the assessment of risk. All the facts which we ask about in the insurance application form are materially relevant. They

include details concerning your state of health, occupation, age, and about any existing cover elsewhere, or any cover that you have applied for elsewhere.

The pre-contractual duty of disclosure ends once the application is submitted to us.

However, if we ask for information from you again in the period between when the application was submitted and when the policy is concluded, your pre-contractual duty of disclosure is revived.

EEA (European Economic Area) [EWR (Europäischer Wirtschaftsraum)]

The EEA comprises the → EU and the European Free Trade Association (EFTA). The EFTA states are Iceland, Liechtenstein and Norway.

Eligible for insurance [Versicherungsfähig]

Every tariff has specific conditions which the insured person must fulfil in order to be able to be insured under that tariff. They can be found in the tariff. If the insured person no longer fulfils those conditions, his insurance under the tariff concerned ends immediately.

Emergency [Notfall]

An emergency is a situation which will lead to serious injury or death unless immediate medical treatment is provided.

Emergency tariff [Notlagentarif]

Insured persons are allocated to the emergency tariff if they do not pay

- their premiums even after receiving reminders from us, and
- they must remain insured due to the legal obligation to have insurance.

It is therefore a de facto “non-payer's tariff”.

The scope of cover under the emergency tariff is significantly reduced. It reimburses the costs of treating acute illnesses and pain as well the costs that are incurred in connection with pregnancy and maternity treatments.

Equivalent insurance cover [Gleichartiger Versicherungsschutz]

Equivalent tariffs are those which include the same type of benefits. Examples of types of benefits are the reimbursement of costs for

- out-patient medical treatment,
- in-patient medical treatment, or
- dental treatment and the provision of dentures.

This applies in each case only to tariffs within comprehensive insurance and tariffs within supplementary insurance.

EU (European Union) [Europäische Union]

The following states are members: Belgium, Bulgaria, Denmark, Germany, Estonia, Finland, France, Greece, Ireland, Italy, Croatia, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Austria, Poland, Portugal, Romania, Sweden, Slovakia, Slovenia, Spain, the Czech Republic, Hungary and Cyprus. Great Britain left the European Union on 31 January 2020.

Extraordinary notice of cancellation [Außerordentliche Kündigung]

Extraordinary notice of cancellation is possible if, for example, you have committed a serious breach of the policy. This is the case if, for instance, you deceive us regarding accounting issues.

Fee Schedule [Gebührenordnung]

The Fee Schedule for Physicians (GOÄ) and the Fee Schedule for Dentists (GOZ) govern how private services provided by doctors and dentists are paid for, i.e. all medical and dental services that are not part of the statutory health insurance scheme (GKV). They set out the fees for medical and dental services.

Follow-up treatment [Anschlussheilbehandlung]

A follow-up treatment is a special form of rehabilitation. It takes place following acute in-patient treatment at a hospital.

Foreign countries [Ausland]

Foreign countries are deemed to be any countries outside of Germany. Your → home country is also deemed to be a foreign country.

Habitual place of residence [Gewöhnlicher Aufenthalt]

A person's habitual place of residence is where his life is based. If a person spends longer than 6 months at a time abroad, his life is no longer based in Germany.

Home country [Heimatland]

The home country is the country/countries of which the insured person is a citizen.

Insurance certificate [Versicherungsschein]

The insurance certificate is a document certifying that an insurance policy has come into force. It represents the policy arranged between you and us.

Insurance year [Versicherungsjahr]

The insurance year begins as from the time shown in the insurance certificate (start date of the insurance) and ends after one year. If the insurance begins, for instance, on 01.04.2021, the insurance year begins on 01.04.2021 and ends on 31.03.2022.

Insured event [Versicherungsfall]

An insured event is the medically necessary → treatment of the insured person due to an illness or the consequences of an → accident. The insured event begins with the treatment. It ends when the insured person is medically assessed as no longer needing treatment.

Depending on the tariff, there may be other instances in which cover applies.

Intentional [Vorsätzlich]

You act intentionally if you

- wish a specific outcome to occur, or
- regard the occurrence of an outcome as certain, or
- regard the occurrence of an outcome as possible and consciously accept that possibility.

Life partners [Lebenspartner]

Life partners are two people of the same gender who have entered into a lifetime partnership according to § 1 of the Lebenspartnerschaftsgesetz (Lifetime Partnership Act) (see Annex).

Medical treatment [Heilbehandlung]

Medical treatment attempts by using appropriate means to cure the illness or to heal the injury, and to alleviate it or prevent it from getting worse.

Need for care [Pflegebedürftigkeit]

This designates a condition in which an ill or handicapped person is permanently (for at least 6 months) unable to manage his day-to-day tasks without assistance and is therefore reliant upon care or help that is provided by other people.

Not fit enough to undergo transportation [Nicht transportfähig]

The insured person is so ill or injured that he must not be transported. He is not able to be transported even in a means of patient transport which is equipped with comprehensive medical facilities.

Qualifying period insurance [Anwartschaft]

During a qualifying period insurance the provision of benefits by us is suspended and you pay a significantly reduced premium. However, we guarantee that after the qualifying period we will provide you with the same cover as was provided previously. In doing so we do not take account of whether the insured person's state of health has deteriorated.

Rehabilitation measures [Rehabilitationsmaßnahmen]

Rehabilitation measures are comparable to treatments at a → spa or → sanatorium. However, unlike these treatments, rehabilitation measures are approved and paid for by a statutory provider of rehabilitation care, e.g. a pension insurer. Rehabilitation measures may be carried out on either an out-patient or in-patient basis, and generally in special institutions which are run by the statutory provider of rehabilitation care.

Risk loading [Risikozuschlag]

If an insured person has had specific pre-existing illnesses and therefore represents an increased level of risk, we may additionally demand a risk loading.

Sanatorium treatment [Sanatoriumsbehandlung]

Sanatoriums are deemed to be institutions where in-patient spa treatments are provided. They are managed and permanently supervised by a doctor.

Spa treatment [Kurbehandlung]

A spa treatment is normally undertaken in a spa town or health resort. It involves the use of specific treatment methods and therapies which prevent illness or which alleviate it after the acute phase. These may be provided on an out-patient or an in-patient basis (including overnight accommodation). Spa treatments include mother and child and father and child spa treatments.

Start date of the insurance [Versicherungsbeginn]

This is the date and time that is specified in the insurance certificate.

Suspension of cover [Ruhen]

The suspension of the insurance means that the reciprocal rights and duties under the insurance policy are suspended. However, the policy itself remains in force. During the period of suspension we do not provide any benefits and you don't have to pay any premium. A special form of suspension to which differing provisions apply is the → emergency tariff.

Trustees [Treuhänder]

Persons who exercise oversight on behalf of the insured persons.

Type of life insurance [Art der Lebensversicherung]

This means that the health insurance is calculated on the same basis as life insurance. Numerous requirements must be satisfied in this regard. For instance:

- A responsible actuary must ensure that the premium calculation complies with legislation.
- The actuarial methods must fulfil specific minimum requirements.
- Premium changes are made on the basis of an adjustment clause, and they must be approved by an independent expert, the 'trustee'.

Unit of observation [Beobachtungseinheit]

Units of observation are children, young people and adults.

Without delay [Unverzüglich]

Does not necessarily mean “immediately”, rather it means “without culpable hesitation”, i.e. “as quickly as possible”.

Written form [Textform]

Written form means in writing, but does necessitate a hand-written signature, e.g. a fax or email is sufficient.

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.

§ 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 intentio-

nally 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-payment. 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.

§ 86 Transfer of compensation claims

(1) If the policyholder is entitled to a compensation claim against the third party, such claim shall pass to the insurer if the insurer compensates the damage. The transfer may not be asserted to the detriment of the policyholder.

(2) The policyholder must safeguard its compensation claim or any right serving to secure such claim with due regard to the applicable formalities and deadlines and collaborate in the enforcement thereof by the insurer if necessary. If the policyholder intentionally breaches this obligation, the insurer shall not be obliged to render benefits insofar as the insurer cannot obtain any compensation in this regard as a consequence thereof. In the event of any grossly negligent breach of the obligation, the insurer shall be entitled to reduce its benefits in proportion to the severity of the policyholder's negligence; the burden of proof for the non-existence of any gross negligence shall be borne by the policyholder.

(3) If the compensation claim of the policyholder against a person with whom the policyholder is living in a household community upon the occur-

rence of the damage, the transfer may not be asserted in accordance with para. 1, unless this person has caused the damage intentionally.

§ 193 Insured person; insurance requirement

(3) Every person domiciled in Germany shall be obliged to take out and maintain with an insurance company licensed to do business in Germany for him- or herself and for the persons legally represented by him or her, insofar as such persons cannot conclude agreements themselves, healthcare cost insurance which must encompass at minimum a cost reimbursement for out-patient and in-patient medical treatment and in which the absolute and percentage deductibles agreed for benefits foreseen in the tariffs for out-patient and in-patient medical treatment are limited for each person to be insured to the amount of EUR 5,000 per calendar year; for persons entitled to assistance, the potential deductibles shall result through analogous application of the percentage share not encompassed by the assistance rate to the maximum amount of EUR 5,000. The duty in accordance with Sentence 1 shall not exist for persons who:

1. are insured or subject to insurance in the statutory health insurance scheme; or
2. have a claim to free therapeutic care, are entitled to assistance or have comparable claims in the scope of the respective entitlement; or
3. have a claim to benefits in accordance with Asylum Seeker Benefits Act (Asylbewerberleistungsgesetz); or
4. are recipients of current benefits in accordance with Chapters 3, 4, 6 and 7 of Title 12 of the Social Code for the duration of the benefit procurement and during periods of interruptions of the benefit procurement of less than one month, provided the benefit procurement began before 1 January 2009.

A healthcare cost insurance agreement concluded prior to 1 April 2007 shall satisfy the requirements in Sentence 1.

(6) If in relation to an insurance policy which fulfils the duty that is set out in paragraph 3 the policyholder is in payment arrears amounting to two months' worth of premiums, the insurer must issue a payment reminder notice to him. For each month or part thereof in which he is in arrears with the payment of the premium, the policyholder must pay a late payment surcharge of 1 percent of the premium arrears instead of arrears interest. If two months after the payment reminder is received the premium arrears together with the late payment surcharges are greater than the premium that is payable for one month, the insurer shall send a second reminder and will refer to the consequences according to Sentence 4. If one month after receipt of the second reminder the premium arrears together with the late payment surcharges are greater than the premium that is payable for one month, the policy shall be suspended as from the first day of the following month. The suspension of the policy does not occur, or it ends, if the policyholder or the insured person is or becomes in need of assistance according Book II or XII of the Social Code; the need for assistance must be certified at the policyholder's request by the body responsible for providing assistance in accordance with Book II or XII of the Social Code.

(7) During the period in which the policy is suspended the policyholder is deemed to be insured under the emergency tariff according to § 153 of the Versicherungsaufsichtsgesetz (Insurance Supervision Act). Risk loadings, benefit exclusions and excesses do not apply during this period. The insurer may demand that supplementary insurances be suspended, provided that the insurance specified in § 153 of the Versicherungsaufsichtsgesetz is in place. Switching into or out of the emergency tariff according to § 153 of the Versicherungsaufsichtsgesetz is excluded. A policyholder whose policy only provides the reimbursement of a percentage of the expenses that are incurred is deemed to be insured under a variant of the emergency tariff according to § 153 of the Versicherungsaufsichtsgesetz which provides benefits of 20%, 30% or 50% of the insured treatment costs, depending on which percentage is closest to the level of the agreed reimbursement.

Insurance Supervision Act [Versicherungsaufsichtsgesetz, VAG]

(1) Non-payers in accordance with § 193(7) of the Insurance Contract Act shall form a tariff in the terms of § 155(3), Sentence 1. The emergency tariff provides exclusively for the reimbursement of expenses for services necessary for the treatment of acute illnesses and pain as well as during pregnancy and motherhood. At variance therefrom, expenses are to be reimbursed for insured children and youth

particularly for preventative checkups for early detection of illnesses in accordance with legally initiated programs and for vaccinations recommended by the Standing Vaccination Commission at the Robert Koch Institute pursuant to § 20(2) of the Infection Protection Act.

(2) For all insured persons in the emergency tariff, a uniform premium is to be calculated; otherwise § 146(1), Nos. 1 and 2 shall apply. For insured persons whose agreement only provides for the reimbursement of a percentage of the expenses incurred, the emergency tariff grants benefits in the amount of 20, 30 or 50% of the insured treatment costs. § 152(3) shall apply accordingly. The calculated premiums from the emergency tariff may not be higher than necessary to cover the expenses for insurance events from the tariff. Additional expenses arising to warrant the limits mentioned in Sentence 3 are to be distributed equally among all policyholders of the insurer with an insurance meeting a requirement from § 193(3), Sentence 1 of the Insurance Contract Act. The old-age reserve is to be credited towards the premiums payable in the emergency tariff in such fashion that up to 25% of the monthly premium is rendered through withdrawals from the aging provision.

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.