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Insurance Contract Act 2008

(Versicherungsvertragsgesetz – VVG)

Insurance Contract Act of 23 November 2007 (Federal Law Gazette I, p. 2631), as last amended by Article 4 of the Act of 3 February 2026 (Federal Law Gazette 2026 I No. 28)

Part 1
General part

Chapter 1
Provisions applying to all classes of insurance

Division 1
General provisions

Section 1
Typical obligations

By the contract of insurance, the insurer undertakes to cover a specific risk of the policyholder, or of a third party, by paying a benefit on occurrence of the agreed insured event. The policyholder is obliged to pay the agreed contribution (insurance premium) to the insurer.

Section 1a
Distribution activities of the insurer

(1) The insurer must always act honestly, fairly and professionally vis-à-vis policyholders in their best interests in performing his or her distribution activities. Distribution activities are deemed to include

1. giving advice,
2. preparing insurance contracts, including contract proposals,
3. concluding insurance contracts, and
4. participating in the management and performance of insurance contracts, in particular in the event of a claim.

(2) Subsection (1) also applies to the provision of information on one or more insurance contracts on the basis of criteria chosen by a policyholder via a website or other media, as well as to the establishment of a ranking of insurance products, including a price and product

comparison, or a discount on the price of an insurance contract, if the policyholder is able to conclude an insurance contract directly or indirectly via a website or other medium.
(3) All information relating to the distribution activities, including advertising messages, which the insurer addresses to policyholders or potential policyholders must be fair and unambiguous, and may not be misleading. Advertising messages must always be clearly recognisable as such.

Section 2
Retroactive insurance

(1) The contract of insurance may provide for the insurance cover to begin prior to the date on which it was concluded (retroactive insurance).
(2) If the insurer knows, when submitting his or her contractual acceptance, that the occurrence of the insured event is impossible, he or she is not entitled to an insurance premium. If the policyholder knows, when submitting his or her contractual acceptance, that an insured event has already occurred, the insurer is not obliged to effect payment.
(3) If the contract is concluded by a representative, in the cases referred to in subsection (2) account is taken of both the knowledge of the representative and that of the person who he or she is representing.
(4) Section 37 (2) does not apply to retroactive insurance.

Section 3
Insurance policy

(1) The insurer provides the policyholder with an insurance policy in writing, on his or her request as a document.
(2) If the contract is not concluded through one of the insurer's domestic branch offices, the insurance policy must quote the insurer's address and that of the branch office through which the contract was concluded.
(3) If an insurance policy has been lost or destroyed, the policyholder may demand that the insurer issue a new insurance policy. If the insurance policy is subject to invalidation, the insurer is only obliged to issue the new insurance policy after the invalidation.
(4) The policyholder may demand at any time that the insurer provide him or her with copies of the declarations made in relation to the contract of insurance. If the policyholder requires the copies in order to undertake actions against the insurer which are bound by a specified time limit, and the insurer had not previously supplied them, the time limit is suspended from the time when the insurer receives the request until such time as the policyholder receives the copies.
(5) The costs of issuing a new insurance policy in accordance with subsection (3), and the copies in accordance with subsection (4), are met by the policyholder, and must be paid in advance on request.

Section 4
Insurance policy issued in the name of the holder

(1) Section 808 of the Civil Code applies to an insurance policy issued as a document in the name of the bearer.
(2) If the contract only provides for the insurer's liability upon the return of an insurance policy issued as a document, and if the policyholder declares that he or she is unable to return the insurance policy, the publicly certified acknowledgement that the obligation has lapsed suffices. Sentence 1 does not apply if the insurance policy is subject to invalidation.

Section 5
Deviating insurance policy

(1) If the content of the insurance policy deviates from the application made by the policyholder, or from the agreements concluded, the deviation is deemed to be approved if

the preconditions under subsection (2) are met, and the policyholder does not object in writing within one month of receipt of the insurance policy.
(2) The insurer is obliged to indicate to the policyholder when sending the insurance policy that deviations are deemed to have been approved if the policyholder does not object in writing within one month of receipt of the insurance policy. The policyholder's attention must be drawn to any deviation, and to the associated legal consequences, by means of conspicuous notes in the insurance policy.
(3) If the insurer has not fulfilled the obligations under subsection (2), the contract is deemed to have been concluded as per the content of the policyholder's application.
(4) An agreement by which the policyholder waives the right to avoid the contract on account of a mistake is void.

Section 6
Advising the policyholder

(1) If the difficulty in assessing the insurance being offered, or the policyholder himself or herself and his or her situation, gives occasion thereto, the insurer must ask him or her, prior to concluding the insurance contract, about his or her wishes and needs and, also bearing in mind an appropriate relation between the time and effort spent in providing this advice and the insurance premiums to be paid by the policyholder, the insurer advises the policyholder, and states reasons for each of the pieces of advice, in respect of a particular insurance policy. He or she documents this, taking into account the complexity of the contract of insurance being offered.
(2) Section 6a applies to the transmission of the advice given, and to the reasons therefor.
(3) The policyholder may waive the right to advice, and documentation thereof, in accordance with subsections (1) and (2) by a separate written declaration in which the insurer explicitly indicates that such waiving may have an unfavourable effect on his or her option for asserting a claim for damages against the insurer in accordance with subsection (5). In the case of a distance contract within the meaning of section 312c of the Civil Code, the policyholder may waive the contract in text form.
(4) The obligation under subsection (1) sentence 1 also applies after the contract has been concluded for the entire term of the insurance agreement, insofar as it is clear that the insurer recognises that the policyholder requires information and advice; subsection (3) sentence 2 applies accordingly. The policyholder may in individual cases waive the right to advice by written declaration.
(5) If the insurer breaches an obligation under subsections (1), (2) or (4), he or she is liable to indemnify the policyholder for any loss or damage resulting therefrom. This does not apply if the insurer is not responsible for the breach of obligation.
(6) Subsections (1) to (5) do not apply to contracts of insurance covering a jumbo risk within the meaning of section 210 (2), or if the contract is negotiated with the policyholder by an insurance broker.

Section 6a
Details concerning the provision of information

(1) The advice to be given in accordance with section 6, and the reasons therefor, are communicated to the policyholder as follows:

1. on paper;

2. clearly and precisely, and in a manner that is understandable to the policyholder;

3. in an official language of the Member State in which the risk is located, or in which the commitment is entered into, or in any other language agreed by the parties, and

4. free of charge.

(2) In derogation from subsection (1) no. 1, the information may also be provided to the policyholder via one of the following media:

1. via a permanent data medium other than paper, if the use of the permanent data medium is appropriate in the context of the business transacted, and the policyholder had the choice between information being provided on paper and on a permanent data medium, and has opted for this data medium, or

2. via a website if access is personalised for the policyholder, or if the following conditions are met:

a) the provision of this information via a website is appropriate in the context of the business transacted;

b) the policyholder has consented to the provision of information via a website;

c) the address of the website, and the place where the information is stored there, have been communicated electronically to the policyholder;

d) it is ensured that this information remains available on the website for as long as it is reasonably necessary for the policyholder to be able to retrieve it.

(3) The provision of information by means of a permanent data medium other than paper, or via a website in the context of business that has been transacted, is deemed to be appropriate if it is proven that the policyholder has regular Internet access. The notification of an e-mail address on the part of the policyholder for the purposes of such business is deemed as constituting such proof.
(4) In the case of a contact by telephone, even if the policyholder has opted to receive the information referred to in subsection (2) on a permanent medium other than paper, the information referred to in subsection (1) or subsection (2) is provided to the policyholder directly after the conclusion of the insurance contract.

Section 7
Information provided to the policyholder; authorisation to issue statutory ordinance

(1) The insurer informs the policyholder in writing of his or her terms of contract, including the general terms and conditions of insurance, as well as the information set out in a statutory ordinance referred to in subsection (2), in good time before the policyholder submits his or her contractual acceptance. This information is provided clearly and comprehensibly, in keeping with the means of communication employed. If, on the request of the policyholder, the contract is concluded by telephone or using another means of communication which does not permit the information to be provided in writing prior to the policyholder's contractual acceptance, that information must be provided without undue delay after the contract has been concluded; this also applies if the policyholder explicitly waives the right to information by a separate written declaration prior to submitting his or her contractual acceptance.
(2) The Federal Ministry of Justice and Consumer Protection is authorised, with the consent of the Federal Ministry of Finance, to determine the following by statutory ordinance without the consent of the Bundesrat, for the purposes of providing comprehensive information to the policyholder:

1. which details of the contract, in particular in respect of the insurer, the benefit offered, the general terms and conditions of insurance and of revocation, are provided to the policyholder,

2. which other information is provided to the policyholder in respect of life insurance, in particular regarding the expected benefits, their determination and

calculation, regarding a model calculation, and acquisition and distribution costs and the administrative costs, insofar as these are set off against insurance premiums, and regarding other costs,

3. which other information is provided in respect of health insurance, in particular regarding the development and form of insurance premiums, and the acquisition and distribution costs and the administrative costs,

4. what information is provided to the policyholder if the insurer has contacted him or her by telephone, and

5. in what manner this information is to be provided.

(3) The following are to be complied with when determining the notifications in accordance with subsection (2),

1. the information prescribed in accordance with Directive 2009/138/EC in the version of 27 November 2024,

2. the information prescribed in accordance with Directive 2011/83/EU in the version of 28 February 2024,

3. the information prescribed in accordance with Directive (EU) 2016/97 in the version of 5 December 2023,

4. the technical implementation standards established by the European Insurance and Occupational Pensions Authority in accordance with Directive (EU) 2016/97 in the version of 5 December 2023 and adopted by the Commission of the European Union in accordance with Article 15 of Regulation (EU) No 1094/2010 in the version of 27 November 2024, and

5. the delegated acts adopted by the Commission in accordance with Article 29 (4)(b) and Article 30 (6) of Directive (EU) 2016/97 in the version of 5 December 2023, in each case in conjunction with Article 38 of Directive (EU) 2016/97 in the version of 5 December 2023.

(4) The statutory ordinance referred to in subsection (2) furthermore specifies what information the insurer must communicate in writing throughout the policy period; this applies in particular in the case of changes to information previously supplied, further in respect of health insurance in the event of increases in insurance premiums, and regarding the possibility of changing tariffs, as well as in respect of life insurance with surplus sharing regarding the development of the policyholder's entitlements.
(5) Subsections (1) to (4) do not apply to insurance contracts covering a jumbo risk within the meaning of section 210 (2). If the policyholder under such contract is a natural person, the insurer is to inform him or her in writing prior to the conclusion of the contract of applicable law and the competent supervisory body.

Section 7a
Cross-selling

(1) If an insurance product is offered together with an ancillary product or service which is not insurance, as a package, or as part of a package or of the same agreement, the insurer informs the policyholder whether the components can be purchased separately from one another; if this is the case, he or she provides a description of the components of the agreement, or of the package, and provides separate documentation of the costs and charges for each component.
(2) If a package is offered the insurance cover of which differs from the insurance cover that would accrue were its components to be purchased separately, the insurer provides the

policyholder with a description of the components of the package and of the manner in which their interaction alters the insurance cover.
(3) If an insurance product complements a service that is not insurance, or a good forming part of a package or of the same agreement, the insurer offers the policyholder the opportunity to purchase the good or service separately. This does not apply if the insurance product complements the following:

1. an investment service or activity as defined in Article 4 (1) and (2) of Directive 2014/65/EU of the European Parliament and of the Council,

2. a credit agreement within the meaning of Article 4 (3) of Directive 2014/17/EU of the European Parliament and of the Council, or

3. a payment account within the meaning of Article 2 (3) of Directive 2014/92/EU of the European Parliament and of the Council.

(4) In cases falling under subsections (1) to (3), insurers ascertain the wishes and needs of the policyholder in relation to the insurance products forming part of the package or of the same agreement.
(5) The insurer may only conclude a residual debt insurance contract referring to a general consumer loan contract if the policyholder has submitted the contractual acceptance at the earliest one week subsequent to the conclusion of a general consumer loan contract. If the insurer fails to comply with this obligation, the residual debt insurance contract is null and void. The policyholder of a group insurance contract for residual debt insurance policies has the obligations of an insurer vis-à-vis the insured person. The insured person has the rights of a policyholder, in particular the right of revocation.

Section 7b
Information to be provided in the case of insurance-based investment products

(1) In the case of products which constitute insurance-based investment products within the meaning of Article 2 (1) no. 17 of Directive (EU) 2016/97, appropriate information on the distribution of insurance-based investment products, and on all costs and charges, is made available to the policyholder in good time prior to the conclusion of the contract. This information includes the following as a minimum:

1. if advice is provided, information as to whether the policyholder is offered a regular assessment, in accordance with section 7c, of the suitability of the insurance-based investment product that is being recommended to that policyholder;

2. appropriate guidelines and warnings on the risks associated with insurance-based investment products, or with specific investment strategies that have been proposed;

3. information on the distribution of the insurance-based investment product, including the cost of advice and the cost of the insurance-based investment product that is being recommended to the policyholder;

4. how the policyholder can effect payments, including third-party payments.

(2) Information on all costs and charges, including costs and charges related to the distribution of the insurance-based investment product, which are not caused by the underlying market risk, is provided in aggregate form; the total costs and the cumulative effect on the investment return must be understandable; furthermore, a list of the costs and charges is made available to the policyholder at his or her request. This information is made available to the policyholder on a regular basis, but at least annually, during the life of the investment.

Section 7c
Assessment of insurance-based investment products; reporting requirement

(1) When giving advice on an insurance-based investment product, the insurer enquires as to the following:

1. knowledge and experience of the policyholder in the investment field with regard to the specific product type or the specific type of service,

2. the financial circumstances of the policyholder, including the ability of the policyholder to bear losses, and

3. the investment objectives, including the policyholder's risk tolerance.

The insurer may only recommend insurance-based investment products to the policyholder that are suitable for the policyholder, and which in particular correspond to the policyholder's risk tolerance and ability to bear losses. The insurer may only recommend a package of services or products bundled in accordance with section 7a as part of investment advice if the entire package is suitable for the customer.
(2) The insurer must always verify whether the insurance product is appropriate for the policyholder. In order to assess the appropriateness, the insurer must ask the policyholder for information regarding his or her knowledge and experience in the investment field in relation to the specific type of product or service. If a package is offered in accordance with section 7a, the insurer takes into account whether the package is appropriate. If the insurer is of the opinion that the product is inappropriate for the policyholder, he or she warns the policyholder. If the policyholder does not provide the information referred to in subsection (1) sentence 1, or if he or she does not provide sufficient information regarding his or her knowledge and experience, the insurer warns him or her that he or she is unable to assess whether the product under consideration is appropriate for him or her due to insufficient information. These warnings may be given in a standardised format.
(3) If insurers do not provide the advice referred to in subsection (1), they may distribute insurance-based investment products without the verification provided for in subsection (2) if the following conditions are met:

1. the activities relate to one of the following insurance-based investment products:

   a) contracts exclusively involving investment risks arising from financial instruments that are not considered to constitute complex financial instruments within the meaning of Directive 2014/65/EU, and do not have a structure that makes it difficult for the policyholder to understand the risks associated with the investment, or

   b) other non-complex insurance-based investment products;

2. the distribution activity is carried out at the instigation of the policyholder;

3. the policyholder has been unambiguously informed that the insurer has not verified the appropriateness of the insurance-based investment products offered when performing the distribution activity; such warning may be given in a standardised form;

4. the insurer fulfils his or her obligations to avoid conflicts of interest.

(4) The insurer draws up a record of the agreements concluded with the policyholder concerning the rights and obligations of the parties, as well as the conditions under which the insurance company provides services to the policyholder. The rights and obligations of the contracting parties may be governed by making reference to other documents or legal texts.
(5) The insurer must provide the policyholder with appropriate reports on the services provided on a permanent data medium. These reports contain regular communications to the policyholder, taking into account the nature and complexity of the respective insurance-based investment products, as well as the nature of the service provided for the policyholder, and where appropriate the costs associated with the transactions carried out and the

services provided. If the insurer provides an advisory service with regard to an insurance-based investment product, he or she provides the policyholder with a declaration on a permanent data medium prior to the conclusion of the contract, listing the advisory service provided and the preferences, objectives and other customer-specific characteristics that have been taken into account thereby. Section 6a applies; the declaration may not however be made via a website. If the insurance contract is concluded using a means of distance communication, and prior handing over of the declaration of appropriateness is not possible, the insurer may make the declaration of appropriateness available to the policyholder on a permanent data medium without undue delay after conclusion of the insurance contract, provided that the following conditions are met:

1. the policyholder has agreed to this procedure, and

2. the insurer has offered to the policyholder to postpone the time of conclusion of the contract in order to enable the policyholder to receive the declaration of appropriateness in advance thereof.

If the insurer has informed the policyholder that he or she will carry out a regular assessment of appropriateness, each regular report must include an updated statement regarding the extent to which the insurance-based investment product is consistent with the policyholder's preferences, objectives and other customer-specific characteristics.

Section 7d
(repealed)

Section 8
Policyholder's right of revocation; authorisation to issue statutory ordinances

(1) The policyholder may revoke his or her contractual agreement within 14 days. The policyholder declares his or her revocation to the insurer in writing, but need not state any reason; timely dispatch suffices for compliance with the time limit. Section 356a of the Civil Code applies to distance contracts in accordance with section 312c of the Civil Code which are concluded via an online user interface.
(2) The revocation period begins on conclusion of the contract. It does not however begin before the policyholder receives the following documents in writing:

1. the insurance policy and the terms of the contract, including the general terms and conditions of insurance, as well as the other information to be provided in accordance with the Information Obligation Ordinance on the Insurance Contract Act (*VVG-Informationspflichtenverordnung*), and

2. an instruction regarding the existence of the right of revocation in accordance with subsection (1), information on the revocation period and on the arrangements for exercising the right of revocation, including the name and the address of the person to whom the revocation is to be stated at which documents may be served, and any amount which the policyholder has to pay, as well as the consequences of failing to exercise this right.

With regard to insurance products for which a key information document in accordance with Regulation (EU) No 1286/2014, or a PEPP key information document, is to be drawn up in accordance with Article 26 of Regulation (EU) 2019/1238, the revocation period does not commence before the key information document, or the PEPP key information document, has also been made available. Proof of receipt of the documents in accordance with sentences 2 and 3 is incumbent on the insurer.

(3) The right of revocation does not apply

1. to contracts of insurance with a term of less than one month,

2. to contracts of insurance for provisional cover, unless they are distance contracts in accordance with section 312c of the Civil Code,

3. to contracts of insurance with pension funds based on the provisions set out in a contract of employment, unless they are distance contracts in accordance with section 312c of the Civil Code,

4. to contracts of insurance covering a jumbo risk in accordance with section 210 (2).

(4) The right of revocation ceases to apply if the contract has been wholly fulfilled by both sides, at the explicit request of the policyholder, before the policyholder has exercised his or her right of revocation. The right of revocation ceases to apply at the latest twelve months and 14 days after conclusion of the contract. This does not apply if the policyholder was not informed, in accordance with subsection (2) sentence 2 number 2, of his or her right of revocation in accordance with subsection (1).
(5) The instruction to be given in accordance with subsection (2) sentence 1 no. 2 is deemed to meet the requirements stipulated therein if the model of the Annex to the present Act is used in text form. The insurer may deviate from the model, in compliance with subsection (2) sentence 1 no. 2. Sentence 1 applies accordingly if the deviation is limited to format and font size, in compliance with subsection (2) sentence 2 no. 2, or to the insurer inserting addenda such as the firm name or a mark of the insurer. Sentences 1 to 3 do not apply to distance contracts in accordance with section 312c of the Civil Code.
(6) The Federal Ministry of Justice and Consumer Protection is authorised, with the consent of the Federal Ministry of Finance, to determine the obligations to provide information in accordance with Subdivision 2 of the Annex by statutory ordinance, without the consent of the Bundesrat, and to alter the Notice on drafting issued in this regard, if this is necessary in order to adapt the obligations to provide information in accordance with Subdivision 2 of the Annex, and the Notice on drafting issued in this regard, in line with an amendment of the Information Obligation Ordinance on the Insurance Contract Act.

Section 9
Legal consequences of revocation

(1) If the policyholder exercises the right of revocation in accordance with section 8 (1), the payments received are to be refunded promptly, at the latest within a 30-day period. The period begins for the insurer on receipt of the revocation notice, and for the policyholder on its submission.
(2) If insurance cover begins prior to the end of the revocation period, in derogation from subsection (1), the insurer is only obliged to refund to the policyholder the share of the premiums paid for the period after receipt of the revocation notice if the policyholder

1. has been properly instructed with regard to this legal consequence prior to submitting his or her contractual acceptance, and

2. he or she has explicitly agreed, in the case of a distance contract in accordance with section 312c of the Civil Code, that the insurance cover begins prior to the end of the revocation period.

The policyholder in this case does not have to refund claims which he or she has asserted under the insurance contract prior to exercising the right of revocation on the basis of an insured event.
(3) If the insurance cover begins prior to the end of the revocation period, and if the precondition in accordance with subsection (2) sentence 1 number 1 has not been met, in derogation from subsection (1), the insurer must

1. refund the share of the premiums paid for the period after receipt of the revocation notice, and

2. additionally refund the premiums paid for the first year of the insurance cover, unless the policyholder has claimed under the insurance contract prior to exercising the right of revocation on the basis of an insured event.

Subsection (2) sentence 2 applies accordingly to the policyholder.
(4) If the insurance cover begins prior to the end of the revocation period, and if the preconditions in accordance with subsection (2) sentence 1 number 1 or 2 are not met, in the case of a distance contract in accordance with section 312c of the Civil Code, only subsection (1) applies, unless the policyholder has claimed under the insurance contract prior to exercising the right of revocation on the basis of an insured event. In such cases, in derogation from subsection (1), the insurer

1. must refund the share of the premiums accounted for by the period after receipt of the revocation notice, and

2. must only refund the share of the premiums accounted for by the period up to receipt of the revocation notice which exceeds the claims asserted by the policyholder.

Subsection (2) sentence 2 applies accordingly to the policyholder.
(5) If the policyholder has effectively exercised his or her right of revocation in accordance with section 8, he or she is also no longer bound by a contract associated with the insurance contract. An associated contract is deemed to exist if it is connected to the revoked contract and relates to a service of the insurer or of a third party on the basis of an agreement between the third party and the insurer. The policyholder may not incur any costs as a result of exercising the right of revocation.

Section 10
Beginning and expiry of insurance

If the length of the insurance cover is determined according to days, weeks, months or a period of several months, the insurance cover begins at the start of the day on which the contract is concluded; it expires at the end of the last day of the policy period.

Section 11
Renewal, termination of the contract

(1) If, in the case of an insurance agreement for a fixed period, the possibility of renewal is agreed in advance in case the insurance agreement is not terminated prior to the end of the policy period, the renewal is void insofar as it refers to a period of more than one year.
(2) Where an insurance agreement is concluded for an unlimited period, both contracting parties may only terminate the agreement as per the end of the current period of insurance. They may agree to waive the right of termination for no more than two years.
(3) The period of notice must be the same for both contracting parties; it may not be less than one month, and no more than three months.
(4) A policyholder may terminate a contract of insurance concluded for a period of more than three years to the end of the third or each successive year, subject to a notice period of three months.

Section 12
Period of insurance

The period of insurance is one year unless the insurance premium is determined for shorter periods.

Section 13
Change of address and name

(1) If the policyholder has not informed the insurer of a change of address, the dispatch of a letter sent recorded delivery to the policyholder’s last known address suffices in respect of a declaration of intention to be made to the policyholder. The declaration is deemed to have

been received three days after the letter was dispatched. Sentences 1 and 2 apply accordingly in respect of a change of the policyholder's name.
(2) If the policyholder has taken out the insurance in his or her business enterprise, subsection (1) sentences 1 and 2 apply accordingly in the event of his or her business establishment relocating.

Section 14
Due date of cash benefit

(1) The insurer is liable to pay a cash benefit when enquiries necessary to establish the occurrence of the insured event and the extent of the insurer's liability have been concluded.
(2) If these enquiries have not been concluded one month after notification of the occurrence of the insured event has been given, the policyholder may demand part payment in the amount which the insurer will at least be expected to pay. The time limit is suspended for as long as the enquiries cannot be concluded on account of the fault of the policyholder.
(3) An agreement on account of which the insurer is released from the obligation to pay interest on arrears is void.

Section 15
Suspension of limitation period

Where a claim arising from a contract of insurance has been registered with the insurer, the period of limitation is suspended until such time as the applicant has received the insurer's decision in writing.

Section 16
Insurer's insolvency

(1) If insolvency proceedings have been opened against the assets of the insurer, the insurance agreement ends one month after proceedings are opened; it remains effective against the insolvency estate until such time.
(2) The provisions of the Insurance Supervision Act (*Versicherungsaufsichtsgesetz*) in respect of the effects of the opening of insolvency proceedings remain unaffected.

Section 17
Prohibition of assignment of things exempt from seizure

Where the insurance cover relates to things exempt from seizure, a claim arising from the contract of insurance may only be assigned to those of the policyholder's creditors who have provided him or her with other things to replace the destroyed or damaged things.

Section 18
Deviating agreements

Agreements deviating from section 3 (1) to (4), section 5 (1) to (3), sections 6 to 9, section 11 (2) to (4), section 14 (2) sentence 1, and section 15, to the detriment of the policyholder are not permitted.**Division 2**

Duty of disclosure, aggravation of risk, other incidental obligations

Section 19
Duty of disclosure

(1) The policyholder discloses to the insurer before making his or her contractual acceptance the risk factors known to him or her which are relevant to the insurer's decision to conclude the contract with the agreed content, and which the insurer has requested in writing. If, after receiving the policyholder's contractual acceptance, and before accepting the contract, the insurer asks such questions as are referred to in sentence 1, the policyholder is also under the duty of disclosure as regards these questions.
(2) If the policyholder breaches his or her duty of disclosure under subsection (1), the insurer may withdraw from the contract.

(3) The insurer's right to withdraw from the contract is ruled out if the policyholder breached his or her duty of disclosure neither intentionally nor by acting with gross negligence. In such cases, the insurer has the right to terminate the contract subject to a notice period of one month.
(4) The insurer's right to withdraw from the contract on account of grossly negligent breach of the duty of disclosure, and his or her right to terminate the contract in accordance with subsection (3) sentence 2, is ruled out if he or she would also have concluded the contract in the knowledge of the facts which were not disclosed, albeit with other conditions. The other conditions become an integral part of the contract with retroactive effect on the request of the insurer; in the case of a breach of duty for which the policyholder does not bear responsibility, they become an integral part of the contract as of the current period of insurance.
(5) The insurer is only entitled to the rights under subsections (2) to (4) if he or she has instructed the policyholder in writing, in separate correspondence, of the consequences of any breach of the duty of disclosure. These rights do not exist if the insurer was aware of the disclosed risk factors, or of the incorrectness of the disclosure.
(6) In the event of subsection (4) sentence 2 leading to an increase in the insurance premium of more than 10 percent on account of an amendment to the contract, or if the insurer refuses to cover the risk for the undisclosed circumstance, the policyholder may terminate the contract without prior notice within one month of receipt of the insurer's communication. The insurer notifies the policyholder of this right in the communication.

Section 20
Policyholder's representative

If the contract is concluded by a person representing the policyholder, both the representative's knowledge and fraudulent conduct, as well as the policyholder's knowledge and fraudulent conduct, are taken into account in the application of section 19 (1) to (4) and section 21 (2) sentence 2, and subsection (3) sentence 2. The policyholder may only invoke the duty of disclosure not having been breached intentionally or with gross negligence if neither the representative nor the policyholder has incurred responsibility for intent or gross negligence.

Section 21
Exercising the insurer's rights

(1) The insurer must assert the rights afforded him or her in accordance with section 19 (2) to (4) in writing within one month. The period commences at such time as the insurer learns of the breach of the duty of disclosure on which the right he or she is asserting is founded. When exercising his or her rights, the insurer discloses the circumstances on which his or her declaration is based; he or she may subsequently disclose further circumstances as grounds for his or her declaration if the time limit in accordance with sentence 1 has not yet expired.
(2) In the event of a withdrawal in accordance with section 19 (2) after the occurrence of the insured event, the insurer is not obliged to effect payment, unless the breach of the duty of disclosure refers to a circumstance which is responsible neither for the occurrence nor for the establishment of the occurrence of the insured event, or for the establishment or the extent of the insurer's liability. If the policyholder has fraudulently breached the duty of disclosure, the insurer is not obliged to effect payment.
(3) The rights of the insurer in accordance with section 19 (2) to (4) lapse five years after the contract expires; this does not apply to insured events which occurred prior to the expiry of this time limit. If the policyholder has breached the duty of disclosure intentionally or by acting fraudulently, this period is ten years.

Section 22
Fraudulent misrepresentation

The right of the insurer to avoid the contract on account of fraudulent misrepresentation remains unaffected.

Section 23
Aggravation of risk

(1) After submitting his or her contractual acceptance, the policyholder may not aggravate the risk insured, or permit its aggravation by a third party, without the consent of the insurer.
(2) If the policyholder recognises after the fact that he or she has aggravated or permitted an aggravation of the risk insured without the consent of the insurer, he or she must disclose the aggravation of the risk insured to the insurer without undue delay.
(3) If, after the policyholder has submitted his or her contractual acceptance, an aggravation of the risk insured occurs in derogation from his or her intention, he or she must disclose the aggravation to the insurer without undue delay as soon as he or she has learned thereof.

Section 24
Termination of the contract due to aggravation of the risk insured

(1) If the policyholder breaches his or her duty under section 23 (1), the insurer may terminate the contract of insurance without prior notice, unless the insurer has breached the duty neither intentionally nor by acting with gross negligence. If the breach is based on ordinary negligence, the insurer may terminate the contract subject to a notice period of one month.
(2) If an aggravation of the risk insured in accordance with section 23 (2) and (3) occurs, the insurer may terminate the contract subject to a notice period of one month.
(3) The right of termination in accordance with subsections (1) and (2) lapses if it is not exercised within one month after the insurer learns of the aggravation of the risk insured, or if the state of affairs which existed prior to the aggravation is re-established.

Section 25
Increase in insurance premium due to aggravation of risk

(1) Rather than terminating the contract of insurance, the insurer may, from such time as the aggravation of the risk insured occurred, demand an insurance premium commensurate with the aggravation of the risk insured in accordance with his or her business principles, or may exclude insurance cover for the aggravated risk. Section 24 (3) applies accordingly in respect of the lapse of this right.
(2) If the insurance premium increases by more than 10 percent in consequence of an aggravation of the risk insured, or if the insurer rules out insurance cover for the aggravated risk, the policyholder may terminate the contract without prior notice within one month of receipt of the communication from the insurer. The insurer must inform the policyholder of this right in his or her communication.

Section 26
Release from liability due to aggravation of risk

(1) If the insured event occurs subsequent to an aggravation of the risk insured, the insurer is not liable if the policyholder intentionally breached his or her duty under section 23 (1). In the event of a grossly negligent breach, the insurer is entitled to reduce his or her benefits payable commensurate with the severity of the policyholder's fault; the burden of proof that there was no gross negligence is on the policyholder.
(2) In the cases of aggravation of insured risk in accordance with section 23 (2) and (3), the insurer is not obliged to effect payment if the insured event occurs later than one month after the time when the insurer should have received notification, unless the insurer was aware of the aggravation of the risk insured at that point in time. He or she is liable if the breach of the duty of disclosure in accordance with section 23 (2) and (3) was not intentional; subsection (1) sentence 2 applies in the event of a grossly negligent breach.

(3) The insurer is obliged to effect payment, in derogation from subsections (1) and (2) sentence 1,

1. if the aggravation of the risk insured was not the cause of the occurrence of the insured event or of the extent of the liability, or

2. if at the time of the occurrence of the insured event the insurer's termination period had expired and the contract was not terminated.

Section 27
Immaterial aggravation of risk

Sections 23 to 26 do not apply if the aggravation of the risk insured is only immaterial or if, based on the circumstances, it can be deemed to have been agreed that the aggravation is also to be covered.

Section 28
Non-observance of an incidental obligation

(1) In the event of the non-observance of an incidental obligation which the policyholder must fulfil vis-à-vis the insurer prior to the occurrence of an insured event, the insurer may terminate the contract without prior notice within one month after learning of the non-observance, unless the non-observance was not intentional or based on gross negligence.
(2) Where the contract provides that the insurer is not obliged to effect payment in the event of the non-observance of an incidental obligation on the part of the policyholder, he or she is released from the liability if the policyholder intentionally breached the obligation. In the case of grossly negligent non-observance of the obligation, the insurer is entitled to reduce any benefits payable commensurate with the severity of the policyholder's fault; the burden of proof that there was no gross negligence is on the policyholder.
(3) In derogation from subsection (2), the insurer is liable insofar as the non-observance of the obligation caused neither the occurrence nor the establishment of the insured event, or the establishment or the extent of the insurer's obligation to effect payment. Sentence 1 does not apply if the policyholder fraudulently breached the obligation.
(4) The condition on which the insurer's entire or partial release from liability in accordance with subsection (2) is based is, in the event of a violation of an existing duty to provide information or duty of disclosure after the occurrence of an insured event, the fact that the insurer informed the policyholder of this legal consequence, in separate correspondence and in writing.
(5) An agreement based on which the insurer is entitled to withdraw from the contract in the event of the non-observance of an incidental obligation is void.

Section 29
Partial withdrawal, partial termination, partial release from liability

(1) If the conditions according to which the insurer is entitled, in line with the provisions set out in the present division, to withdraw from or to terminate the contract are only met with regard to a part of the objects or persons to which the contract refers, the insurer only has the right to withdraw from or to terminate the contract for the remainder if it is to be assumed that the insurer would not have concluded the contract for this part alone with the same conditions.
(2) If the insurer exercises his or her right to withdraw from or terminate the contract in respect of a part of the objects or persons, the policyholder is entitled to terminate the insurance agreement regarding the remainder. The termination must be declared at the latest at the end of the period of insurance in which the insurer's withdrawal or termination becomes effective.
(3) If the conditions under which the insurer is partially or wholly released from liability due to a breach of the provisions regarding aggravation of the risk insured are only met regarding a part of the objects or persons to which the insurance refers, subsection (1) applies

accordingly to the release from liability.**Section 30**
Notification of the occurrence of the insured event

(1) The policyholder notifies the insurer of the occurrence of the insured event without undue delay after he or she has learned thereof. If a third party is entitled to the right to the insurer's benefit, the third party is also obliged to notify the insurer.
(2) An insurer may not invoke an agreement according to which the insurer is not obliged to effect payment in the event of the breach of the duty of notification in accordance with subsection (1) sentence 1 if he or she learns about the occurrence of an insured event in good time by other means.

Section 31
The policyholder's duty to disclose information

(1) After the occurrence of an insured event, the insurer may demand that the policyholder disclose to him or her all the information necessary to establish the occurrence of the insured event or the extent of the insurer's liability. The insurer may demand proof to the extent that the policyholder may be reasonably expected to obtain such proof.
(2) If a third party has the right to receive benefits from the insurer, he or she must also fulfil the obligations under subsection (1).

Section 32
Deviating agreements

Agreements deviating from sections 19 to 28 (4), and section 31 (1) sentence 2, to the detriment of the policyholder are not permitted. Agreement may however be reached to the effect that any notification to which the policyholder is obliged in accordance with the provisions of the present division must be made in writing.

Division 3
Premium

Section 33
Due date

(1) The policyholder must pay a single premium or, where payment of recurrent premiums has been agreed, must pay the first premium, without delay 14 days after receipt of the insurance policy.
(2) If the insurer previously collected the premium, the policyholder is not obliged to transfer the premium until requested to do so in writing by the insurer.

Section 34
Payment by a third party

(1) The insurer must accept insurance premiums due to him or her, or other payments to which he or she is entitled, from the insured person on the basis of the contract if the insurance is taken out for the account of a third party from a beneficiary who has acquired the right to the insurer's benefits, as well as from a lien creditor, even if he or she could refuse to accept the payment in accordance with the provisions of the Civil Code.
(2) A right of lien on the insurance claim may also be asserted on the basis of the contributions, including all interest payments which the lien creditor has used to pay premiums or other payments to which the insurer is entitled on the basis of the contract.

Section 35
Offsetting by the insurer

The insurer may offset a due insurance premium, or other due claim, under the contract against a claim arising on the basis of the insurance, even if a third party and not the policyholder is entitled to the claim.

Section 36
Place of performance

(1) The place of performance for payment of the insurance premium is the policyholder's respective place of residence. The policyholder must however transfer the insurance premium to the insurer at his or her own risk, and at his or her own expense.
(2) If the policyholder has taken out the insurance in his or her business enterprise, and his or her business establishment is located elsewhere, the place of performance is the place of the business establishment, and not his or her place of residence.

Section 37
Delayed payment of first insurance premium

(1) If the single premium, or the first premium, is not paid in good time, the insurer is entitled to withdraw from the contract as long as the payment has not been made, unless the policyholder is not responsible for the non-payment.
(2) If the single premium, or first premium, has not been paid when the insured event occurs, the insurer is not obliged to effect payment, unless the policyholder is not responsible for the non-payment. The insurer is only released from liability if he or she had informed the policyholder of the legal consequence of non-payment of the premium in writing in a separate communication or by means of a conspicuous note in the insurance policy.

Section 38
Delayed payment of subsequent premium

(1) If a subsequent premium is not paid in good time, the insurer may set the policyholder a payment deadline of no less than two weeks, at his or her expense and in writing. The setting of the deadline is only effective if it details the individual amounts of the premium which are in arrears, the interest and the costs, as well as quoting the legal consequences associated in accordance with subsections (2) and (3) with expiry of the time limit; in the case of consolidated contracts, the amounts must be quoted separately.
(2) If the insured event occurs after the deadline expires, and if the policyholder is in arrears as regards the payment of the premium or of the interest or costs, the insurer is not obliged to effect payment.
(3) The insurer may, after the deadline expires, terminate the contract without prior notice insofar as the policyholder is in arrears as regards the payment of the due amounts. The termination may be linked to the setting of the payment deadline in such a way that it becomes effective once the deadline expires if the policyholder is in arrears as regards the payment at that point in time; the policyholder must be explicitly informed of this in the termination. The termination becomes void if the policyholder effects the payment within one month after the contract has been terminated or, if it has been linked to the setting of a deadline, within one month after the deadline expires; subsection (2) remains unaffected.

Section 39
Termination of the contract before the agreed date

(1) In the event of the termination of the insurance agreement prior to the end of the period of insurance, the insurer is only entitled to that share of the premium for that period of insurance which corresponds to the period in which the insurance cover existed. If the insurance agreement is terminated on account of withdrawal in accordance with section 19 (2), or on account of avoidance by the insurer due to fraudulent misrepresentation, the insurer is entitled to the insurance premium up until such time as the declaration of withdrawal or avoidance becomes effective. If the insurer withdraws on the basis of section 37 (1), he or she may demand an appropriate fee.
(2) If the insurance agreement ends in accordance with section 16, the policyholder may demand the repayment of that share of the premium which corresponds to the period following the termination of the insurance agreement, minus the costs arising for that period.

Section 40
Termination on account of increase in premium

(1) If the insurer increases the premium on the basis of an adjustment clause without the scope of the insurance cover changing in relation thereto, the policyholder may terminate the contract with immediate effect within one month of receipt of the communication from the insurer, at the earliest however at such time as the increase in the insurance premium becomes effective. The insurer must inform the policyholder of his or her right to terminate the contract in the communication. The policyholder must receive the communication at the latest one month before the increase in the insurance premium becomes effective.
(2) Subsection (1) applies accordingly if the insurer reduces the scope of the insurance cover on the basis of an adjustment clause without reducing the premium accordingly.

Section 41
Reduction of the premium

If a higher premium has been agreed on account of certain risk-aggravating circumstances, and these circumstances have ceased to exist or become immaterial after the policyholder has submitted an application, or after the contract has been made, the policyholder may demand that the premium be reduced commensurately from such time as the insurer is in receipt of the demand. This also applies if the assessment of the higher insurance premium was occasioned by incorrect statements made on the basis of a mistake on the part of the policyholder concerning such a circumstance.

Section 42
Deviating agreements

Agreements deviating from section 33 (2) and sections 37 to 41 to the detriment of the policyholder are not permitted.

Division 4
Insurance for the account of a third party

Section 43
Definitions

(1) The policyholder may conclude the contract of insurance in his or her own name for the account of another, with or without naming the insured third party (insurance for the account of a third party).
(2) If the contract of insurance is concluded for another, it is assumed in cases of doubt, even if the third party is named, that the policyholder is not acting as his or her agent but in his or her own name for the account of a third party.
(3) If the circumstances do not indicate that the contract of insurance is to be concluded for another, it is deemed to have been made for the policyholder’s own account.

Section 44
Rights of the insured person

(1) In the case of insurance for the account of a third party, the insured person holds the rights resulting from the contract of insurance. Only the policyholder may however demand that the insurance policy be sent to him or her.
(2) The insured person may only lay claim to his or her rights without the agreement of the policyholder, and assert these rights in court, if he or she is in possession of the insurance policy.

Section 45
Rights of the policyholder

(1) The policyholder may dispose of the rights to which the insured person is entitled on the basis of the contract of insurance in his or her own name.

(2) If an insurance policy has been issued, the policyholder is only authorised to receive benefits from the insurer, and to assign the rights of the insured person without the agreement of the insured person, if he or she is in possession of the insurance policy.
(3) The insurer is only liable towards the policyholder if the insured person has given his or her consent to the insurance.

Section 46
Rights between the policyholder and the insured person

The policyholder is not obliged to hand over the insurance policy to the insured person or, in the event of insolvency proceedings having been opened with regard to his or her assets, to the insolvency estate, until his or her claims against the insured person have been satisfied with regard to the insured thing. He or she may satisfy these claims from the claim for compensation against the insurer and, after it has been collected, from the compensation paid before the insured person and the latter's creditors.

Section 47
Knowledge and conduct of the insured person

(1) Insofar as the knowledge and conduct of the policyholder are of legal significance, in the case of insurance for the account of a third party, account is also taken of the knowledge and conduct of the insured person.
(2) Account is not taken of the knowledge of the insured person if the contract was made without his or her knowledge, or it was impossible or unreasonable for him or her to inform the policyholder in good time. The insurer need not accept the objection cited against him or her that the contract was made without the knowledge of the insured person if the policyholder concluded the contract without being instructed to do so by the insured person, and did not indicate to the insurer at the time the contract was concluded that he or she was concluding the contract without having been instructed to do so by the insured person.

Section 48
Insurance for the account of "whom it may concern"

If the insurance is taken out for the account of "whom it may concern", or if the contract provides in another manner that it is to remain unspecified whether an own interest or the interest of another is to be insured, sections 43 to 46 apply if it can be concluded from the circumstances that the interest of another is insured.

Division 5
Provisional cover

Section 49
Content of the contract

(1) If the essential content of a contract of insurance refers to the insurer granting provisional cover, the contracting parties may agree that the insurer only send the policyholder the terms of the contract and the information in accordance with section 7 (1) in conjunction with the statutory ordinance referred to in section 7 (2) on request, and at the latest with the insurance policy. Sentence 1 does not apply to a distance contract within the meaning of section 312c of the Civil Code.
(2) If the general terms and conditions of insurance are not sent to the policyholder when the contract is concluded, the conditions normally applied by the insurer at that point in time become an integral part of the contract for provisional cover, in the absence of such conditions those conditions applied by the insurer to the main contract even without an explicit note to that effect. In cases of doubt regarding the conditions which apply to the contract, the conditions applied by the insurer which are the most favourable for the policyholder at the time of the conclusion of the contract become an integral part of the contract.

Section 50
Non-formation of the main contract

If, in the event of the non-formation of the main contract, the policyholder is compelled to pay a premium for provisional cover, the insurer is entitled to that share of the premium commensurate with the period of the provisional cover which would be payable in the event of the main contract being formed.

Section 51
Payment of the premium

(1) The beginning of the insurance cover may be made dependent on the payment of the premium insofar as the insurer has drawn the policyholder's attention to this condition in writing in a separate communication or by means of a conspicuous note in the insurance policy.
(2) Agreements deviating from subsection (1) to the detriment of the policyholder are not permitted.

Section 52
Termination of the contract

(1) The contract for provisional cover expires at the latest at such time as similar insurance cover begins based on a main contract concluded by the policyholder, or another contract for provisional cover. If the beginning of the insurance cover under the main contract, or under the other contract for provisional cover, is made dependent on the payment of the premium by the policyholder, the contract for provisional cover expires in the event of non-payment or delayed payment of the premium, in derogation from sentence 1, at the latest at such time as the policyholder is in arrears as regards the payment of the insurance premium, provided that the insurer informed the policyholder of this legal consequence in writing in a separate communication, or by means of a conspicuous note in the insurance policy.
(2) Subsection (1) does not apply if the policyholder concludes the main contract or the other contract for provisional cover with another insurer. The policyholder must inform the previous insurer, without undue delay, of the fact that the contract has been concluded.
(3) If the main contract is not concluded with the insurer with whom the contract for provisional cover is made because the policyholder withdraws his or her contractual acceptance in accordance with section 8, or submits an objection in accordance with section 5 (1) and (2), the contract for provisional cover expires at the latest when the insurer receives the withdrawal or objection.
(4) If the insurance agreement was entered into for an indefinite period, each of the contracting parties may terminate the contract without prior notice. The insurer's termination does not however become effective until two weeks after receipt.
(5) Agreements deviating from subsections (1) to (4) to the detriment of the policyholder are not permitted.

Division 6
Open policy

Section 53
Duty to give notice

If a contract is made in such a manner that, at the time when the contract is concluded, only the class of insured interest is designated, and it is only specified to the insurer in detail once the contract has been concluded (open policy), the policyholder is obliged either to give notice of the individual insured risks without undue delay or, if the insurer has waived that right, of the agreed basis on which the insurance premium is to be calculated or, if this has been agreed, to apply for a cover note in each respective case.

Section 54
Breach of the duty to give notice

(1) If the policyholder has failed to give notice of an insured risk, or of the agreed basis on which the premium is to be calculated, or to apply for the cover note, or has made a mistake in so doing, the insurer is not obliged to effect payment. This does not apply if the policyholder has neither violated the duty to give notice and file an application intentionally, or by acting with gross negligence, and the notice given or the application submitted, or the mistake is corrected without undue delay after he or she learns of the mistake.
(2) If the policyholder intentionally violates the duty to give notice and file an application, the insurer may terminate the contract without notice. The insurance of individual risks for which the insurance cover has begun continues if no other agreements have been reached which extend beyond the end of the open policy, until such time as the agreed term of the insurance of these individual risks ends. The insurer may further demand payment of the insurance premium which would have had been payable until the termination becomes effective if the policyholder had met the duty to give notice.

Section 55
Individual policy

(1) If, in the case of an open policy, an insurance policy has been issued for an individual risk (individual policy), or a certificate of insurance has been issued, the insurer is only liable on presentation of the document. He or she is released from obligation by performance to the bearer of the document.
(2) If the document has been lost or destroyed, the insurer is not liable until the document has been declared invalid or a security has been paid; no security payment by guarantors is permitted. This also applies to the insurer's obligation to issue a replacement certificate.
(3) The content of the individual policy, or of a certificate of insurance, is deemed to have been approved by the policyholder in derogation from section 5 if the policyholder does not revoke it without undue delay after receipt of the certificate. The right of the policyholder to avoid the approval on account of a mistake remains unaffected.

Section 56
Breach of the duty of disclosure

(1) In derogation from section 19 (2), the insurer is not permitted to rescind in the event of a breach of the duty of disclosure; the insurer may terminate the contract within one month after learning of the non-disclosure, or incorrect disclosure, of the circumstance, and may refuse performance. The insurer remains obliged to effect payment if the non-disclosure, or incorrect disclosure, of the circumstance was not the cause of the occurrence of the insured event or of the extent of the obligation to effect payment.
(2) If the insurer refuses performance, the policyholder may terminate the contract. The right to terminate the contract lapses if it is not exercised within one month of the time when the policyholder receives the insurer's decision to refuse performance.

Section 57
Change in risk insured

(1) The policyholder informs the insurer without delay of any change in the risk insured.
(2) Where the policyholder has not informed the insurer of an aggravation of the risk insured, the insurer is not liable if the insured event occurs after the time when the insurer should have received the notification. He or she is only obliged to effect payment

1. if he or she knew about the aggravation of the risk insured at such time as he or she should have been notified thereof,

2. if the duty of disclosure was breached neither intentionally, nor by acting with gross negligence, or

3. insofar as the aggravation of the risk insured was not the cause of the occurrence of the insured event or the extent of the liability.

(3) In derogation from section 24, the insurer is not entitled to terminate the contract on account of an aggravation of the risk insured.

Section 58
Non-observance of an incidental obligation

(1) In the case of an open policy, where the policyholder culpably fails to fulfil an incidental obligation to be fulfilled prior to the occurrence of an insured event, the insurer is not liable in respect of an insured individual risk to which the breached incidental obligation applies.
(2) In the case of culpable non-observance of an incidental obligation, the insurer may terminate the contract within one month of learning of the non-observance, subject to a notice period of one month.**Division 7**
Insurance intermediaries, insurance advisers

Subdivision 1
Duties to notify and advise

Section 59
Definitions

(1) Insurance intermediaries within the meaning of the present Act are insurance agents and insurance brokers. Sections 1a, 6a, 7a, 7b and 7c apply accordingly to insurance intermediaries. A person who carries out a distribution activity within the meaning of section 1a (2) without satisfying the requirements set out in subsection (2) or (3) below is also deemed to be an insurance intermediary.
(2) ‘Insurance agent’ within the meaning of the present Act is anyone contracted by an insurer or insurance agent to arrange or conclude contracts of insurance on a commercial basis.
(3) ‘Insurance broker’ within the meaning of the present Act is anyone who contracts to arrange or conclude contracts of insurance for a client on a commercial basis without having being contracted to do so by an insurer or an insurance agent. An insurance broker is deemed to be anyone giving the person wishing to take out insurance the impression that he or she is providing the services of an insurance broker within the meaning of sentence 1.
(4) ‘Insurance adviser’ within the meaning of the present Act is anyone advising third parties on a commercial basis in respect of agreeing, amending or examining contracts of insurance, or in respect of making claims arising under contracts of insurance on the occurrence of an insured event, or anyone representing the policyholder out of court vis-à-vis the insurer without receiving an economic benefit from an insurer, or without being dependent on him or her in any other manner. Sections 1a, 6a, 7a, 7b and 7c apply accordingly to insurance advisers.

Section 60
Basis on which insurance intermediary provides advice

(1) The insurance broker is obliged to base his or her advice on a sufficient number of contracts of insurance and insurers available on the market so that he or she is in a position to make his or her recommendation, based on professional criteria, regarding which contract of insurance is suited to meeting the needs of the person wishing to take out insurance. This does not apply if he or she explicitly informs the person wishing to take out insurance in individual cases prior to contractual acceptance of the limited selection of insurers and contracts.
(2) An insurance broker who informs a person wishing to take out insurance of the limited selection in accordance with subsection (1) sentence 2, and an insurance agent, must inform the person wishing to take out insurance on which market and information basis they are providing their services, and must state the names of the insurers on the basis of which they

are giving advice. The insurance agent must also name the insurer on behalf of whom he or she is working, and state whether he or she is working exclusively for him or her.
(3) The person wishing to take out insurance may waive the right to the notifications and information in accordance with subsection (2) by separate written declaration.

Section 61
Insurance intermediary's duties of advice and documentation

(1) If the difficulty of assessing the insurance being offered, or the person wishing to take out insurance himself or herself, and his or her situation, gives occasion thereto, the insurance intermediary must ask the person wishing to take out insurance about his or her wishes and needs and, also bearing in mind the relations between the time and effort spent providing the advice and the premium to be paid by the policyholder, must advise the person wishing to take out insurance, and state reasons for each piece of advice given in respect of a particular insurance. He or she must document this in accordance with section 62, taking account of the complexity of the contract of insurance being offered.
(2) The person wishing to take out insurance may waive the right to the advice or documentation in accordance with subsection (1) by separate written declaration in which he or she is explicitly informed by the insurance intermediary of the fact that a waiver of the right may have an unfavourable effect on the option the person wishing to take out insurance has of asserting a claim for damages against the insurance intermediary in accordance with section 63. If the contract is a distance contract within the meaning of section 312c of the Civil Code, the policyholder may waive the right thereto in text form.

Section 62
Time and form of the information

(1) The policyholder is provided, in a clear and comprehensible written form, with the information in accordance with section 60 (2) before submitting his or her contractual acceptance, and the information in accordance with section 61 (1) before the contract is concluded.
(2) The information in accordance with subsection (1) may be given orally if the person wishing to take out insurance so wishes, or if and insofar as the insurer grants provisional cover. In such cases, the information must be provided to the person wishing to take out insurance in writing without undue delay after the contract has been concluded, at the latest together with the insurance policy; this does not apply to contracts for provisional cover for compulsory insurance.

Section 63
Obligation to pay damages

The insurance intermediary is obliged to compensate for loss incurred by the person wishing to take out insurance on account of a breach of one of the duties under section 60 or section 61. This does not apply if the insurance intermediary is not responsible for the breach of duty.

Section 64
Securing payment to the policyholder's benefit

The person wishing to take out insurance must authorise the insurance intermediary in writing by separate declaration to accept benefits from the insurer which the latter must pay to the policyholder on the basis of a contract of insurance.

Section 65
Jumbo risk

Sections 60 to 63 do not apply to the arranging of contracts of insurance for jumbo risks within the meaning of section 210 (2).

Section 66
Other exceptions

Section 1a (2), sections 6a, 7b and 7c, sections 60 to 64, section 69 (2), and section 214, do not apply to insurance intermediaries working on a secondary activity basis in accordance with section 34d (8) no. 1 of the Trade Regulation Act (*Gewerbeordnung*). Insurance intermediaries acting on a secondary activity basis must provide the policyholder with information regarding their identity and address, as well as concerning the procedures via which policyholders and other interested parties may lodge complaints, prior to concluding an insurance contract. They must hand over the information sheet on insurance products to the policyholder prior to conclusion of the contract.

Section 67
Deviating agreements

Agreements deviating from sections 60 to 66 to the detriment of the policyholder are not permitted.

Section 68
Insurance advisers

The provisions set out in section 60 (1) sentence 1, section 61 (1), and sections 62 to 65 and section 67, that are applicable to insurance brokers apply accordingly to insurance advisers. Further duties of the insurance adviser resulting from the contractual relationship remain unaffected.

Subdivision 2
Power of agency

Section 69
Statutory power of attorney

(1) The insurance agent is deemed to have power of attorney in respect of

1. taking receipt of applications for the purposes of concluding a contract of insurance and its revocation, as well as declarations made prior to the conclusion of a contract and other declarations made by the policyholder,

2. taking receipt of applications for the renewal of or amendment to a contract of insurance and its revocation, termination, rescission and other declarations relating to the insurance agreement, as well as any information to be provided by the policyholder throughout the policy period, and

3. passing on to the policyholder any insurance policies or renewal policies drawn up by the insurer.

(2) The insurance agent is deemed to have power of attorney to accept payments which the policyholder effects in connection with the arranging or conclusion of a contract of insurance. The policyholder only accepts a restriction to this power of attorney to his or her detriment if he or she was aware of the restriction when making the payment, or was not aware of it as a consequence of gross negligence.
(3) The burden of proof regarding the submission or the content of the application, or another declaration of intent in accordance with subsection (1) nos. 1 and 2, is on the policyholder. The burden of proof regarding any breach of the duty of disclosure or of a duty on the part of the policyholder is on the insurer.

Section 70
Knowledge of the insurance agent

If the knowledge of the insurer is of relevance in accordance with the present Act, the knowledge of the insurance agent is equivalent to the knowledge of the insurer. This does

not apply to the knowledge of the insurance agent gained when not engaged in his or her activity as agent and not connected in any manner to the contract of insurance in question.

Section 71
Authorisation to acquire contracts

If the insurance agent is authorised to acquire contracts of insurance, he or she is also authorised to agree amendments or extensions to such contracts, and to make declarations of termination and withdrawal.

Section 72
Restriction of the power of agency

Any restriction of the power of agency to which the insurance agent is entitled in accordance with section 69 and section 71 based on the general terms and conditions of insurance is void vis-à-vis the policyholder and third parties.

Section 73
Employees and intermediaries not working on a commercial basis

Sections 69 to 72 apply accordingly to an insurer's employees who are contracted to arrange or conclude contracts of insurance, and to persons working independently as agents in the arranging or concluding contracts of insurance but not on a commercial basis.

Chapter 2
Indemnity insurance

Division 1
General provisions

Section 74
Overinsurance

(1) If the sum insured considerably exceeds the value of the insured interest (insurable value), each contracting party may request that the sum insured be reduced with immediate effect in order to eliminate the overinsurance, thereby also reducing the premium proportionally.
(2) If the policyholder concludes the contract with the intention of gaining an illegal pecuniary benefit on account of the overinsurance, the contract is void; the insurer is entitled to the premium up until such time as he or she learned of the circumstances establishing nullity.

Section 75
Underinsurance

If the sum insured is considerably less than the insurable value on the occurrence of the insured event, the insurer is only liable in the proportion that the sum insured bears to this value.

Section 76
Agreed value

The insurable value may be determined by agreeing a certain amount (agreed value). The agreed value is also deemed to be the value of the insured interest on occurrence of the insured event, unless it considerably exceeds the actual insurable value at that point in time. If the sum insured is less than the agreed value, the insurer is only liable to compensate the loss in the proportion that the insurable value bears to the agreed value, even if the agreed value is considerably overstated.

Section 77
Several insurers

(1) Anyone who insures the same interest against the same risk with several insurers is obliged to inform each insurer about the other insurance policies without undue delay. He or she names the other insurers and the sum insured in his or her communication.
(2) Subsection (1) applies accordingly if the profit lost in respect of the same interest is insured with one insurer, but other loss is insured with another insurer.

Section 78
Liability in the case of multiple insurance

(1) If one interest is insured against the same risk with several insurers, and the sums insured exceed the insurable value, or for other reasons the sum of damages which would have to be paid by the insurer if the other insurance did not exist exceeds the total loss (multiple insurance), the insurers are liable as joint and several debtors in such a manner that each insurer must pay the sum in accordance with his or her contract, but the policyholder cannot demand more than the total amount of the loss.
(2) As regards the insurers, they are liable in relation to each other to effect payment in proportion to the amounts for which they are liable in accordance with each respective contract. If foreign law is applicable to one of the insurance policies, the insurer to whom foreign law applies may only assert a claim for compensation against the other insurer if he or she is personally liable to pay compensation under the relevant law.
(3) With regard to liability insurance of combinations of vehicles, in case of multiple insurance, the insurers are obliged in relation to each other on a pro rata basis in accordance with the provision contained in section 19 (4) of the Road Traffic Act (*Straßenverkehrsgesetz*). If an accident is caused by a combination of vehicles, and if the vehicle liability insurer of the trailer is not obliged to fully compensate the third party, this insurer is to inform the third party at his or her request without undue delay regarding the identity of the vehicle liability insurer of the tractor or, if he or she is unable to identify the vehicle liability insurer of the tractor, regarding the compensation mechanism in accordance with Article 10 of Directive 2009/103/EC of the European Parliament and of the Council of 16 September 2009 relating to insurance against civil liability in respect of the use of motor vehicles, and the enforcement of the obligation to insure against such liability (OJ L 263 of 7 October 2009, p. 11), amended by Directive (EU) 2021/2118 (OJ L 430 of 2 December 2021, p. 1).
(4) If the policyholder has taken out multiple insurance with the intention of thereby gaining an illegal pecuniary benefit, each contract made with that intention is void; the insurer is entitled to the insurance premium up until such time as he or she learned of the circumstances establishing the nullity.

Section 79
Elimination of multiple insurance

(1) If the policyholder has concluded the contract on account of which multiple insurance arose without knowing that multiple insurance arose thereby, he or she may demand that the contract concluded at a later date be rescinded, or the sum insured be reduced, also reducing the insurance premium proportionally to that share not covered by the earlier insurance.
(2) Subsection (1) also applies if multiple insurance arose on account of the fact that the insurable value decreased after the conclusion of several contracts of insurance. If several contracts of insurance were concluded in such cases, at the same time or with the consent of the insurers, the policyholder may only demand the pro rata reduction of the sums insured and of the premiums.

Section 80
Lack of insured interest

(1) The policyholder is not obliged to pay the insurance premium if no insured interest exists when the insurance cover begins; this also applies if the interest does not arise in the case of

insurance taken out for a future enterprise or for another future interest. The insurer may however demand an appropriate fee.
(2) If the insured interest ceases to exist once the insurance cover begins, the insurer is entitled to the premium to which he or she would have been entitled if the insurance had only been applied for up until the time when the insurer learned of the cessation of the interest.
(3) If the policyholder has insured a non-existent interest with the intention of thereby gaining an illegal pecuniary benefit, the contract is null and void; the insurer is entitled to the premium paid up until the time when he or she learns of the circumstances establishing the nullity.

Section 81
Causing the insured event

(1) The insurer is not obliged to effect payment if the policyholder intentionally causes the insured event.
(2) If the policyholder causes the insured event by gross negligence, the insurer is entitled to reduce the benefits payable commensurate with the severity of the fault of the policyholder.

Section 82
Loss avoidance and minimisation

(1) The policyholder must, on the occurrence of the insured event, ensure that the loss is avoided or minimised wherever possible.
(2) The policyholder must follow the instructions of the insurer, where reasonable, and obtain instructions, circumstances permitting. If several insurers involved in the contract of insurance issue different instructions, the policyholder must act at his or her own proper discretion.
(3) In the event of the breach of an incidental obligation under subsections (1) and (2), the insurer is not obliged to effect payment if the policyholder intentionally breached the incidental obligation. In the event of a grossly negligent breach, the insurer is entitled to reduce the benefits payable commensurate with the severity of the policyholder's fault; the burden of proof that there was no gross negligence is on the policyholder.
(4) In derogation from subsection (3), the insurer is liable insofar as the breach of the incidental obligation is the cause neither of the establishment of the occurrence of the insured event, nor of the establishment of the extent of the liability. Sentence 1 does not apply if the policyholder has fraudulently breached the obligation.

Section 83
Reimbursement of expenses

(1) The insurer reimburses the policyholder's expenses in accordance with section 82 (1) and (2), even if they remain unsuccessful, to the extent that the policyholder could deem them necessary based on the circumstances. The insurer advances the amount of the necessary expenses on the request of the policyholder.
(2) If the insurer is entitled to reduce the benefits payable, he or she may also reduce the amount of the expenses reimbursed in accordance with subsection (1) accordingly.
(3) Expenses incurred by the policyholder on account of his or her following the insurer's instructions are also reimbursed to the extent that they exceed the sum insured, taken together with the other compensation.
(4) In the case of livestock insurance, the costs of feeding and keeping the livestock, as well as the costs of veterinary examinations and treatment, are not classed as expenses to be reimbursed by the insurer in accordance with subsections (1) to (3).

Section 84
Consulting an expert

(1) If the contract provides for experts to establish the individual prerequisites for the claim arising under the insurance, or the amount of the loss, the establishment is not binding if it

obviously deviates considerably from the facts and circumstances. The prerequisites are established by a judicial ruling in such cases. This also applies if the experts are unable or unwilling to carry out the establishment, or delay the establishment.
(2) If the contract provides for the experts to be appointed by the court, the local court has jurisdiction for appointing the experts in whose district the loss occurred. Jurisdiction may be transferred to another local court by explicit agreement between the contracting parties. The order on account of which the application for the appointment of experts is granted is not contestable.

Section 85
Costs of establishing the loss

(1) The insurer reimburses to the policyholder those costs arising in the establishment and determination of the loss to be compensated to the extent that the expenses were necessary in view of the circumstances. These costs are also reimbursed to the extent that they exceed the sum insured, taken together with the other compensation.
(2) The insurer does not reimburse costs incurred by the policyholder on account of drawing on the services of an expert or counsel, unless the policyholder is contractually obliged to do so or was requested to do so by the insurer.
(3) If the insurer is entitled to reduce the benefits payable, he or she may also reduce the costs reimbursed accordingly.

Section 86
Assignment of claims

(1) If the policyholder is entitled to claim damages from a third party, this claim is assigned to the insurer insofar as the insurer compensates for the loss. The claim may not be assigned to the detriment of the policyholder.
(2) The policyholder safeguards his or her claim for damages, or a right serving to safeguard this claim, in accordance with the applicable form and time requirements, and assists the insurer wherever necessary in asserting them. If the policyholder intentionally breaches this obligation, the insurer is not obliged to effect payment insofar as he or she cannot as a result claim compensation for it from a third party. In the event of a grossly negligent breach of the obligation, the insurer is entitled to reduce the benefits payable, commensurate with the severity of the policyholder's fault; the burden of proof that there was no gross negligence is on the policyholder.
(3) If the policyholder claims compensation from a person with whom he or she is sharing a common household when the loss occurs, assignment in accordance with subsection (1) may not be asserted, unless that person intentionally caused the loss.**Section 87**
Deviating agreements

Agreements deviating from sections 74, 78 (4), sections 80, 82 to 84 (1) sentence 1, and section 86, to the detriment of the policyholder are not permitted.

Division 2
Property insurance

Section 88
Insurable value

Unless otherwise agreed, the insurable value – where the insurance refers to an item or to an aggregate of items – is deemed to be the amount which the policyholder must spend on occurrence of the insured event to replace or to restore the insured property to mint condition, minus the reduced market value resulting from the difference between old and new.

Section 89
Insurance for an aggregate of items

(1) Insurance taken out for an aggregate of items covers each individual item belonging to the aggregate of items.
(2) If the insurance is taken out for an aggregate of items, it covers the items belonging to those persons with whom the policyholder is sharing a common household on occurrence of the insured event, or who are employed by the policyholder at that time and are working at a location covered by the insurance. The insurance is thus deemed to have been taken out for the account of a third party.

Section 90
Extended reimbursement of expenses

If the policyholder pays expenses in order to avoid an immediately imminent insured event or to minimise its impacts, section 83 (1) sentence 1, as well as subsections (2) and (3), apply accordingly.

Section 91
Interest on compensation

One month after notification is given of the insured event, four per cent interest is added to the compensation to be paid by the insurer, unless other higher interest rates can be demanded on other legal grounds. The time limit is suspended for as long as the loss or damage cannot be established as a result of the policyholder's fault.

Section 92
Termination of the contract after an insured event

(1) Each party may terminate the insurance agreement after the occurrence of the insured event.
(2) The termination is only permissible up until the end of one month after the conclusion of negotiations in respect of the compensation. The insurer adheres to a one-month period of notice. The policyholder may not terminate the contract for a later point in time than the end of the current period of insurance.
(3) In the case of hail insurance, the insurer may only terminate the contract as per the end of the period of insurance in which the insured event occurred. If the policyholder terminates the contract as per an earlier point in time than the end of that period of insurance, the insurer is nevertheless entitled to the premium for the current period of insurance.

Section 93
Replacement clause

If the insurer is only obliged under the contract to pay a share of the compensation in the case of replacement or repair of the insured object, the policyholder may not demand payment of an amount in excess of the insurable value until replacement or repair is guaranteed. The policyholder is obliged to repay any compensation to the insurer, minus the insurable value of the object, if the object was not replaced or repaired within an appropriate period as a result of the policyholder's fault.

Section 94
Effectiveness of payment vis-à-vis mortgage creditors

(1) In the case of section 93 sentence 1, a payment made without the guarantee of replacement or repair is only effective vis-à-vis a mortgage creditor if the insurer or the policyholder has informed him or her that the payment is to be made without the guarantee, and no less than one month has elapsed since receipt of the communication.
(2) If the amount of compensation is not to be utilised to restore or replace the property in accordance with the terms of the contract, the insurer is permitted not to pay with effect vis-à-vis a mortgage creditor until he or she, or the policyholder, has notified the mortgagee of that intention, and no less than one month has elapsed since receipt of the communication.

(3) The mortgage creditor may object to payment vis-à-vis the insurer for a period of one month only. The communications referred to under subsections (1) and (2) may be omitted if they would necessitate an unreasonable amount of time and effort; the time limit in such cases begins on the due date for payment of the amount of compensation.
(4) If the mortgage creditor has notified the insurer of his or her mortgage, a payment made without the guarantee of restoration or replacement only becomes effective vis-à-vis the mortgage creditor if the latter has agreed in writing to effect payment.
(5) Subsections (1) to (4) apply accordingly if the property is burdened with a land charge, annuity land charge, or other charges on land.

Section 95
Sale of the insured object

(1) If the policyholder sells the insured object, the policyholder assigns to the buyer the rights and obligations resulting throughout the period of his or her ownership.
(2) The seller and the buyer are liable as joint and several debtors for the premium payable during the current period of insurance at such time as the seller assigns the rights to the buyer.
(3) The insurer must not accept the assignment against him or her until he or she has learned thereof.

Section 96
Termination of the contract subsequent to a sale

(1) The insurer is entitled to terminate the insurance agreement vis-à-vis the buyer of an insured object subject to a notice period of one month. The right to terminate the contract lapses if it is not exercised within one month of the insurer learning of the sale.
(2) The buyer is entitled to terminate the insurance agreement with immediate effect, or as per the end of the current period of insurance. The right to terminate the contract lapses if it is not exercised within one month of the purchase, in the case of a lack of the buyer's knowledge of the existence of an insurance, within one month after he or she learns thereof.
(3) In the event that the insurance agreement is terminated in accordance with subsection (1) or (2), the seller is obliged to pay the premium; the buyer is not liable to pay the premium.

Section 97
Disclosure of the sale

(1) The seller or the buyer must disclose the sale to the insurer without undue delay. Where no disclosure has been made, the insurer is not obliged to effect payment if the insured event occurs later than one month after the time when the insurer should have received the disclosure, and the insurer would not have concluded the contract with the buyer which existed with the seller.
(2) In derogation from subsection (1) sentence 2, the insurer is obliged to effect payment if he or she knew of the sale at such time as he or she should have received the disclosure, or if the time limit for the insurer to terminate the contract had expired at the time of the occurrence of the insured event, and he or she did not terminate the contract.

Section 98
Protection afforded to the buyer

The insurer may not refer to any provision of the contract of insurance which derogates from sections 95 to 97 to the detriment of the buyer. The contract may however provide that the termination of the contract by the buyer in accordance with section 96 (2), and the disclosure of the sale, must be made in writing.

Section 99
Foreclosure, acquisition of the right of use

Sections 95 to 98 apply accordingly where ownership of an insured object is assigned on the basis of foreclosure, or a third party acquires the entitlement to insured produce of the soil on the basis of usufruct, a lease contract or a similar agreement.**Part 2**
Individual classes of insurance

Chapter 1
Liability insurance

Division 1
General provisions

Section 100
Insurer's liability

In the case of liability insurance, the insurer is obliged to release the policyholder from any claims asserted by a third party on the basis of the policyholder's responsibility for a fact arising during the period of insurance, and to avoid unfounded claims.

Section 101
Legal protection costs

(1) The insurance also covers the judicial and extra-judicial costs arising from claims asserted by a third party insofar as the circumstances necessitate the expenditure. The insurance further covers expenses incurred on the instruction of the insurer by defence counsel in criminal proceedings initiated on the basis of an act which could result in the policyholder becoming liable vis-à-vis a third party. The insurer advances the costs at the policyholder's request.
(2) If a sum insured has been determined, the insurer also reimburses the costs of a legal dispute conducted at his or her instigation, and the costs for defence counsel in accordance with subsection (1) sentence 2, insofar as they exceed the sum insured plus the insurer's expenses for indemnifying the policyholder. This also applies to interest payments which the policyholder owes to the third party as a result of a delay in satisfying the third party occasioned by the insurer.
(3) If the policyholder is released from the obligation of avoiding the execution of a judicial decision by furnishing security or a deposit, the insurer effects payment of the security or deposit. This obligation only applies up to the amount of the sum insured; if the insurer is obliged in accordance with subsection (2) over and above that amount, the surplus amount is added to the sum insured. The insurer is released from the obligation under sentence 1 if he or she acknowledges that the third party's claim vis-à-vis the policyholder is well founded.

Section 102
Employer's liability insurance

(1) If the insurance has been taken out for a business enterprise, it covers liability insurance for those persons authorised to represent the enterprise, as well as those persons employed by the enterprise. The insurance is thus deemed to be taken out for the account of a third party.
(2) Should the business enterprise be sold to a third party, or taken over by a third party on account of usufruct, a lease contract or a similar agreement, the policyholder assigns to the third party the rights and obligations resulting from the insurance agreement throughout the period of his or her entitlement. Section 95 (2) and (3), as well as section 96 and section 97, apply accordingly.

Section 103
Causing the insured event

The insurer is not obliged to effect payment if the policyholder has intentionally and unlawfully caused the loss suffered by the third party.

Section 104
Policyholder's duty of disclosure

(1) The policyholder is obliged to disclose to the insurer within one week those facts which could give rise to his or her responsibility vis-à-vis a third party. If the third party asserts a claim against the policyholder, the policyholder is obliged to disclose that fact to the insurer within one week after the claim is asserted.
(2) Where a claim is asserted against the policyholder in court, legal aid is applied for, or a third-party complaint is filed against him or her in court, he or she is obliged to disclose that fact to the insurer without undue delay. This also applies when investigative proceedings have been initiated against the policyholder on account of the occurrence of the loss giving rise to the claim.
(3) Timely dispatch of the notice of disclosure suffices for compliance with the time limits under subsections (1) and (2). Section 30 (2) applies accordingly.

Section 105
Acknowledgement by the policyholder

Agreements are void in accordance with which the insurer is not obliged to effect payment if the policyholder satisfies the third party or acknowledges his or her entitlement without the insurer's consent.

Section 106
Due date for performance

The insurer is obliged to release the policyholder from the third party's claim within two weeks, beginning at the time when the third party's claim is established with binding effect for the insurer by final judgment, acknowledgement or settlement. If the third party has been satisfied by the policyholder with binding effect for the insurer, the insurer is obliged to pay the compensation to the policyholder within two weeks after the third party has been satisfied. The insurer is obliged to pay any costs to be reimbursed in accordance with section 101 within two weeks after communication of the calculation.

Section 107
Entitlement to a pension

(1) Where the policyholder is obliged to pay a pension to the third party, the insurer is only liable to pay a pro rata share of the pension if the sum insured is not equal to the capital value of the pension.
(2) If the policyholder is obliged, by operation of law, to pay the third party a security for the pension that he or she is liable to pay, the insurer's obligation covers the payment of the security. Subsection (1) applies accordingly.

Section 108
Right of recourse provision

(1) The policyholder's right of recourse against the insurer is ineffective vis-à-vis the third party. A legal act of disposal is equal to an act of disposal based on execution or attachment execution.
(2) Assignment of the right of recourse to the third party may not be ruled out by the general terms and conditions of insurance.

Section 109
Several injured parties

If the policyholder bears responsibility towards several third parties, and their claims are in excess of the sum insured, the insurer pays these claims in proportion to their amounts. If the sum insured is thereby exhausted, a third party not taken into consideration during the

allocation may not subsequently invoke section 108 (1) if the insurer had not expected, and need not have expected, that these claims would be asserted.

Section 110
Policyholder's insolvency

In the event of insolvency proceedings being opened in respect of the assets of the policyholder, the third party may request separate satisfaction from the policyholder's right of recourse on account of the claim due to him or her against the policyholder.

Section 111
Termination of the contract after an insured event

(1) If, after the occurrence of the insured event, the insurer has acknowledged, or wrongly rejected, the policyholder's recourse, each party may terminate the insurance agreement. This also applies if the insurer instructs the policyholder to allow a legal dispute in respect of the third party's claim.
(2) The contract may only be terminated within one month after the acknowledgement or rejection of the right of recourse, or after the judgment in the legal dispute with the third party became final. Section 92 (2) sentence 2, and subsection (3), apply.

Section 112
Deviating agreements

Agreements deviating from section 104 and section 106 to the detriment of the policyholder are not permitted.

Division 2
Compulsory insurance

Section 113
Compulsory insurance

(1) Liability insurance which a policyholder is obliged by legal provision to take out (compulsory insurance) must be concluded with an insurance company authorised to do business in Germany.
(2) The insurer confirms in writing to the policyholder, quoting the sum insured, that he or she is obliged to take out the compulsory insurance in accordance with a legal provision, to which reference must be made.
(3) The provisions of the present division also apply insofar as the contract of insurance grants cover in excess of the prescribed minimum requirements.

Section 114
Scope of the insurance cover

(1) In the case of compulsory insurance, the minimum sum insured is 250,000 euros per claim, and one million euros for all claims per insurance year, unless otherwise provided by legal provision.
(2) The contract of insurance may specify the content and scope of the compulsory insurance in greater detail insofar as this does not endanger the fulfilment of the respective objective of the compulsory insurance, and unless explicitly otherwise provided by legal provision. Any excess on the part of the policyholder cannot be cited against the third party, and cannot be asserted against a co-insured person.

Section 115
Direct claim

(1) The third party may also assert his or her claim for compensation against the insurer

1. in the case of liability insurance for the fulfilment of a duty to take out insurance in accordance with section 1 of the Compulsory Insurance Act (*Pflichtversicherungsgesetz*), or in accordance with section 3 of the Foreign Vehicles Compulsory Insurance Act (*Auslandsfahrzeug-Pflichtversicherungsgesetz*), or

2. where insolvency proceedings have been opened in respect of the assets of the policyholder, or an application for such opening has been dismissed on account of a lack of insolvency estate, or a provisional insolvency administrator has been appointed, or

3. if the policyholder's whereabouts are unknown.

The entitlement to a claim exists within the framework of the insurer's liability under the insurance agreement and, insofar as no liability exists, within the framework of section 117 (1) to (4). The insurer pays the compensation in money. The insurer and the policyholder liable to pay compensation are liable as joint and several debtors.
(2) The claim under subsection (1) is subject to the same limitation period as is the claim for compensation against the policyholder liable to pay compensation. The limitation commences at the time when the limitation period on the claim for compensation against the policyholder liable to pay compensation commences; it however ends at the latest after ten years, beginning when the loss is incurred. Where notice of the third party's claim has been given to the insurer, limitation is suspended up until the time when the claimant receives the insurer's decision in writing. The suspension, the end of the suspension, and the re-commencement of the limitation on the claim against the insurer, are also effective against the policyholder liable to pay compensation and vice versa.

Section 116
Joint and several debtors

(1) The insurer is solely liable as regards the relationship between the joint and several debtors under section 115 (1) sentence 4, insofar as he or she is obliged to indemnify the policyholder based on the insurance agreement. If no such obligation exists, the policyholder is solely liable in respect of the relationship between them. The insurer may request compensation for expenses which he or she could permissibly deem necessary, given the circumstances.
(2) The limitation on claims resulting from subsection (1) commences at the end of the year in which the third party's claim is satisfied.

Section 117
Liability vis-à-vis third parties

(1) If the insurer is wholly or partially released from liability to the policyholder, his or her liability towards the third party nevertheless remains.
(2) A circumstance which results in the non-existence or the termination of the insurance agreement is only effective in consideration of the third party one month after the insurer has notified the competent agency of this circumstance. This also applies if the insurance agreement ends on account of time lapsed. The time limit does not commence before the insurance agreement has ended. A circumstance as described in sentences 1 and 2 may also be cited against the third party if, prior to the point in time at which the loss arose, the competent agency had received confirmation of a new insurance taken out based on a relevant law. The above provisions of the present division do not apply if no competent agency has been appointed to receive the notification in accordance with sentence 1.
(3) In the cases described in subsections (1) and (2), the insurer is only liable within the framework of the prescribed minimum sum insured and the risk assumed by him or her. He or she is not obliged to effect payment insofar as the third party may receive compensation for his or her loss from another indemnity insurer, or from a social insurance agency.
(4) If the insurer's obligation to effect payment in accordance with subsection (1) or (2) coincides with a liability to pay compensation on the basis of a negligent breach of official

duty, the liability to pay compensation in accordance with section 839 (1) of the Civil Code is not ruled out in the relationship with the insurer on account of the fact that the preconditions for the insurer's liability are met. Sentence 1 does not apply if the public official is personally liable in accordance with section 839 of the Civil Code.
(5) Insofar as the insurer satisfies the third party in accordance with subsections (1) to (4), and no case as described in section 116 exists, the third party's claim against the policyholder is assigned to him or her. The assignment may not be asserted to the detriment of the third party.
(6) Where insolvency proceedings are opened against the assets of the insurer, the insurance agreement does not end, in derogation from section 16, until one month after the insolvency administrator has notified the competent agency of this circumstance; it remains effective against the insolvency estate up until such time. If no competent agency has been appointed to take receipt of the notification in accordance with sentence 1, the insurance agreement ends one month after the policyholder has been notified of the opening of insolvency proceedings; the notification must be made in writing.

Section 118
Order of precedence of several claims

(1) If the claims for compensation to be paid on the basis of the same occurrence of loss are in excess of the sum insured, the sum insured is disbursed to those entitled to compensation according to the following order of precedence, in the event of equal precedence commensurate with their amounts:

1. claims arising from personal injury, insofar as the injured persons cannot receive compensation for their injuries from the injuring party, from another insurer as their liability insurer, from a social insurance agency, or from another third party;

2. claims arising from other injuries to natural or legal persons under private law, insofar as the injured parties cannot receive compensation from the injuring party, from another insurer as their liability insurer, or from a third party;

3. claims arising from personal injury or other injuries assigned to insurers or other third parties under private law;

4. claims assigned to social insurance agencies;

5. all other claims.

(2) If the sum insured is exhausted taking account of subordinate claims, a rightful claimant who is to be afforded precedence, and who has not been taken into consideration during the allocation, may not subsequently invoke subsection (1) if the insurer did not anticipate, and also need not have anticipated, that this claim would be asserted.

Section 119
Third party's incidental obligations

(1) The third party notifies the insurer in writing of the loss occurrence from which he or she wishes to derive a claim against the policyholder, or against the insurer in accordance with section 115 (1), within two weeks after he or she has learned of the loss occurrence; timely dispatch suffices for compliance with the time limit.
(2) If the third party asserts the claim against the policyholder in court, he or she must notify the insurer in writing of that fact without undue delay.
(3) The insurer may demand information from the third party insofar as it is necessary for the establishment of the loss occurrence and of the amount of the loss. The insurer may also request that proof be furnished insofar as the third party can be reasonably expected to obtain such proof.

Section 120
Non-observance of an incidental obligation by the third party

Where the third party culpably breaches the incidental obligation under section 119 (2) or (3), the insurer's liability in accordance with section 115 and section 117 is limited to that amount which he or she would also have had to pay, had the obligation been duly fulfilled, insofar as the third party had previously been informed explicitly and in writing of the consequences of non-observance.

Section 121
Offsetting against third parties

Section 35 does not apply vis-à-vis third parties.

Section 122
Sale of the insured object

Sections 95 to 98 concerning the sale of insured object are applied accordingly.

Section 123
Recourse in the case of several insured parties

(1) If, in the case of insurance taken out for the account of a third party, the insurer is not liable to the policyholder, he or she may only cite this against an insured party authorised to independently assert his or her rights arising from the contract of insurance if the circumstances on which the exemption from obligation to effect payment are based on the insured person himself or herself, or if these circumstances were known to the insurer, or were not known to the insurer on account of gross negligence.
(2) The extent of the obligation to effect payment under subsection (1) is determined in accordance with section 117 (3) sentence 1; section 117 (3) sentence 2 does not apply. Section 117 (4) applies accordingly.
(3) Insofar as the insurer pays the claim in accordance with subsection (1), he or she may have recourse to the policyholder.
(4) Subsections (1) to (3) apply accordingly if the time limit under section 117 (2) sentences 1 and 2 has not yet expired, or if the insurer has not notified the competent agency that the insurance agreement has ended.

Section 124
Extent of legal force

(1) Where it has been established by final judgment that the third party has no right to claim compensation, the judgment, if issued between the third party and the insurer, is also effective to the advantage of the policyholder; if it is issued between the third party and the policyholder, it is also effective to the advantage of the insurer.
(2) If the third party's claim against the insurer has been established by final judgment, acknowledgement or settlement, the policyholder against whom claims have been asserted by the insurer on the basis of section 116 (1) sentence 2 must accept this establishment unless the insurer has culpably violated the obligation to avoid unfounded claims for compensation and to minimise or duly establish the loss.
(3) Subsections (1) and (2) do not apply insofar as the third party may not assert his or her claim for damages against the insurer in accordance with section 115 (1).

Chapter 2
Legal expenses insurance

Section 125
Insurer's liability

In the case of legal expenses insurance, the insurer is obliged, to the agreed extent, to provide the benefits necessary in order to defend the legal interests of the policyholder, or of the insured person.

Section 126
Claims processing company

(1) Where risks in the sphere of legal expenses insurance are insured along with other risks, the insurance policy must separately quote the scope of the legal expenses insurance cover and the premium payable therefor. If the insurer hires an independent claims processing company to handle these claims, the name of this company must be quoted on the insurance policy.
(2) If an independent claims processing company is hired to deal with these claims, claims arising under a legal expenses insurance contract may only be asserted against that company. The title is effective for and against the legal expenses insurer. Section 727 of the Code of Civil Procedure applies accordingly.

Section 127
Freedom of choice of lawyer

(1) The policyholder is entitled to freely choose a lawyer to represent his or her interests in court and administrative proceedings from among the circle of lawyers whose fees the insurer will cover in accordance with the contract of insurance. This provision also applies if the policyholder is entitled to claim legal expenses for the representation of other legal interests.
(2) A lawyer is also anyone authorised to exercise the profession in accordance with the designations set out in the Annex to section 1 of the Act Regulating the Activity of European Lawyers in Germany (*Gesetz über die Tätigkeit europäischer Rechtsanwälte in Deutschland*) of 9 March 2000 (Federal Law Gazette I, pp. 182 and 1349), as last amended by Article 1 of the Act of 26 October 2003 (Federal Law Gazette I, p. 2074).

Section 128
Procedure for calling in an expert opinion

In the event that the insurer denies his or her liability because defence of the legal interests does not have sufficient prospects of success, or is wanton, the contract of insurance must provide for a procedure to call in an expert opinion, or for another procedure with comparable guarantees of impartiality in which a decision can be taken regarding the differences of opinion between the parties concerning the prospects of success or the wantonness of prosecution. The insurer draws the policyholder's attention to this fact when denying his or her obligation to effect payment. If the contract of insurance does not provide for any such procedure, or the insurer fails to provide this information, the policyholder's need for legal protection is deemed to have been acknowledged in individual cases.

Section 129
Deviating agreements

Agreements deviating from sections 126 to 128 to the detriment of the policyholder are not permitted.

Chapter 3
Transport insurance

Section 130
Extent of risk accepted

(1) In the case of the insurance of goods against the risks of transportation by land or inland waterways, as well as the concomitant storage, the insurer bears all the risks to which the goods are exposed throughout the period of cover.

(2) If a ship is insured against the risks of inland waterway transportation, the insurer bears all the risks to which the ship is exposed throughout the period of cover. The insurer is also liable for that loss incurred by the policyholder as a result of a collision between ships, or of a collision with fixed or floating objects, on account of having to replace loss incurred by a third party.
(3) Insurance against the risks of inland waterway transportation covers contributions to gross average insofar as the average measure serves the avoidance of loss to be compensated by the insurer.

Section 131
Breach of the duty of disclosure

(1) In derogation from section 19 (2), the insurer's withdrawal is ruled out in the event of a breach of the duty of disclosure; the insurer may terminate the contract and refuse performance within one month from the time when he or she learns that the circumstance was not disclosed, or was not disclosed correctly. The insurer remains liable insofar as the circumstance which was not disclosed, or was not disclosed correctly, was not the cause of the occurrence of the insured event or of the extent of the liability.
(2) If the insurer refuses performance, the policyholder may terminate the contract. The right to terminate the contract lapses if it is not exercised within one month after the time when the policyholder receives the insurer's decision to refuse performance.

Section 132
Change of risk insured

(1) In derogation from section 23, the policyholder may aggravate the risk insured, or change it in another manner, and permit changes by a third party. He or she must disclose the change to the insurer without undue delay.
(2) If the policyholder has not provided notification of an aggravation of the risk insured, the insurer is not obliged to effect payment if the insured event occurs after such time as the insurer should have received the notification. He or she is obliged to effect payment

1. if he or she was aware of the aggravation of the risk insured at the time when he or she should have received the notification,

2. if the duty of disclosure was not breached, either intentionally or by acting with gross negligence, or

3. insofar as the aggravation of the risk insured was not the cause of the occurrence of the insured event or of the extent of the liability.

(3) In derogation from section 24, the insurer is not entitled to terminate the contract on account of an aggravation of the risk insured.

Section 133
Transportation in breach of contract

(1) If the goods are transported by a means of transport other than that agreed, or are reloaded although direct transportation was agreed, the insurer is not obliged to effect payment. This provision also applies if only a specific means of transport, or a specific transport route, was agreed.
(2) The insurer is obliged to effect payment if, after the beginning of the insurance, the transportation was changed or relinquished without the consent of the policyholder, or as the result of an insured event. Section 132 applies.
(3) In those cases described under subsection (2), the insurance covers the costs of the reloading or the temporary storage, as well as the additional costs of the reforwarding.

Section 134
Unsuitable means of transport

(1) If no specific means of transport has been agreed for the forwarding of the goods, the policyholder, insofar as he or she has any influence thereon, is obliged to use a means of transport which is suited to taking on board and transporting the goods.
(2) If the policyholder breaches this incidental obligation intentionally, or by acting with gross negligence, the insurer is not liable, unless the breach was not the cause of the occurrence of the insured event or of the extent of the liability.
(3) If the policyholder learns of the unsuitability of the means of transport, he or she must notify the insurer of that fact without undue delay. Section 132 applies.

Section 135
Reimbursement of expenses

(1) Expenses incurred by the policyholder in loss avoidance or minimisation, as well as the costs of the ascertainment and establishment of the loss, are also reimbursed by the insurer insofar as they do not exceed the sum insured when added to the remaining compensation.
(2) If expenses have been incurred in loss avoidance or minimisation, or in the ascertainment and establishment of the loss, or to restore or improve the property damaged by the insured event, or contributions have been made to gross average, or if the policyholder has become personally liable to pay such contributions, the insurer reimburses the loss caused by the subsequent occurrence of the insured event, without consideration for the earlier expenses and amounts to be reimbursed by him or her.

Section 136
Insurable value

(1) The insurable value of the goods is deemed to be the common market value and, in the absence of such value, the common value of the goods at the place of shipping at the beginning of the insurance, plus insurance costs, costs arising up until the time when the transporter takes receipt of the goods, and the final amount of freightage paid.
(2) The value determined in accordance with subsection (1) is also deemed to be the insurable value on occurrence of the insured event.
(3) Where goods are damaged on arrival at their place of delivery, their value at that place in their damaged state is deducted from the value which they would have at that place in an undamaged state. The fraction of the insurable value corresponding to the ratio between the reduction in value, and their value in their undamaged state, is deemed to be the amount of damage.

Section 137
Causing an insured event

(1) The insurer is not obliged to effect payment if the policyholder causes the insured event intentionally, or by acting with gross negligence.
(2) The policyholder is not responsible for the conduct of the ship’s crew when navigating the ship.

Section 138
Exclusion of liability for ships

In the case of insurance of a ship, the insurer is not obliged to pay compensation for loss arising on account of the fact that the ship was not in a fit state to sail, or not sufficiently equipped, or not sufficiently manned when it set sail. This provision also applies to loss only arising as a result of the wear and tear on board a ship in normal use.**Section 139**
Sale of the insured object or goods

(1) In the case of the sale of an insured object for which an individual policy, or a certificate of insurance, has been issued, the buyer is not liable to pay the premium, in derogation from section 95. The insurer may not refer vis-à-vis the buyer to his or her not being obliged to effect payment on account of non-payment of the insurance premium, or on account of the

non-payment of a security, unless the buyer knew the grounds for the non-obligation to effect payment, or should have known thereof.
(2) In derogation from section 96, the insurer is not entitled to terminate the contract on account of the sale of the insured goods.
(3) In derogation from section 97, the policyholder is not obliged to notify the insurer of the sale.

Section 140
Sale of the insured ship

If an insured ship is sold, the insurance ends, in derogation from section 95, when the ship is transferred to the buyer, in the case of ships which are en route, when the ship is transferred to the buyer at the port of destination.

Section 141
Release following payment of the sum insured

(1) After the occurrence of the insured event, the insurer is entitled to release himself or herself from all further liabilities by paying the sum insured. The insurer remains liable to reimburse those expenses which arose in loss avoidance or minimisation, or to replace or repair the insured object before the policyholder received his or her declaration of intent to release himself or herself by paying the sum insured.
(2) The right of the insurer to release himself or herself by paying the sum insured lapses if the policyholder does not receive the declaration within one week after the time when the insurer learned of the occurrence of the insured event and of its immediate consequences.

Chapter 4
Building fire insurance

Section 142
Disclosures to mortgage creditors

(1) In the case of building fire insurance, the insurer must disclose, in writing and without undue delay, to a mortgage creditor who has declared his or her mortgage in the event that the single or first premium is not paid in good time, or the policyholder is given a deadline by when he or she must pay a subsequent premium. This also applies if the insurance agreement is terminated once the deadline expires on account of the non-payment of the subsequent premium.
(2) The insurer informs a mortgage creditor who has declared his or her mortgage in writing of the occurrence of the insured event within one week after he or she has learned thereof, unless the loss or damage is immaterial.

Section 143
Continuation of liability vis-à-vis mortgage creditors

(1) In the event of a subsequent premium not being paid in good time, the insurer remains obliged to effect payment to a mortgage creditor who has declared his or her mortgage up until one month after the time when the mortgage creditor was informed of the setting of the deadline for payment or, if this information was not communicated, notification has been given of the termination of the contract.
(2) The termination of the insurance agreement does not become effective against a mortgage creditor who has declared his or her mortgage until two months after the time when the insurer informed him or her of the termination and, insofar as this had not occurred, until such time as the contract was terminated or he or she learned thereof in another manner. Sentence 1 does not apply if the insurance agreement is terminated on account of the non-payment of the insurance premium by means of the insurer’s rescission or termination of the contract, or the policyholder’s termination of the contract to which the mortgage creditor agreed.

(3) Subsection (2) sentence 1 applies accordingly to the effectiveness of an agreement between the insurer and the policyholder on account of which the scope of the insurance cover is reduced, or in accordance with which the insurer is only obliged to effect payment in respect of compensation to restore the insured building.
(4) The nullity of the contract of insurance cannot be asserted against a mortgage creditor who has declared his or her mortgage. The insurance agreement however expires vis-à-vis him or her two months after the time when he or she has been informed of the nullity by the insurer, or he or she has learned of the nullity by another means.

Section 144
Termination of the contract by the policyholder

Where a mortgage creditor has declared his or her mortgage, a termination of the insurance agreement by the policyholder is only effective, in derogation from section 92 (1) and section 96 (2), if the policyholder has provided proof no less than one month before the end of the contract of insurance that, at the time when the termination was permissible at the latest, there was no mortgage on the property, or that the mortgage creditor had agreed to the contract being terminated. The agreement may not be refused without sufficient grounds.

Section 145
Assignment of the mortgage

Insofar as the insurer satisfies the mortgage creditor in accordance with section 143, the mortgage is assigned to him or her. The assignment may not be asserted to the detriment of an equal or subordinate mortgage creditor towards whom the insurer remained liable.

Section 146
Duty of the insurer to provide confirmation and disclose information

The insurer is obliged to provide confirmation of declaration to a mortgage creditor who has declared his or her mortgage and, on request, to disclose information regarding the existence of insurance cover and regarding the amount of the sum insured.

Section 147
Change of mortgage creditor's address and name

If the mortgage creditor has not disclosed a change in his or her address or name to the insurer, section 13 (1) applies accordingly to the insurer's notifications and communications in accordance with section 142 and section 143.

Section 148
Other charges on real property

If land charges, annuity rent charges, and other charges on land, have been taken out on the real property, sections 142 to 147 apply accordingly.

Section 149
Owner's charges on real property

The rights under sections 142 to 148 may not be asserted to the advantage of mortgages, land charges or annuity rent charges to which the policyholder is entitled.**Chapter 5**
Life insurance

Section 150
Insured person

(1) Life insurance may be taken out for the policyholder, or for another person.
(2) Where the life insurance is taken out against the death of another person, and the agreed benefit exceeds normal funeral costs, the written agreement of the other person is necessary for the contract to be effective; this does not apply in the case of life insurance policies in company pension schemes. If the other person has no legal capacity to act, or only limited

capacity to act, or if a custodian has been appointed and the policyholder is entitled to represent that person's interests, he or she may not represent the other person when giving his or her consent thereto.
(3) If one parent takes out the insurance for an under-age child, the child's consent is only required if, in accordance with the contract, the insurer is to be liable even in the event of the child dying before reaching the age of seven, and the benefit agreed for this event exceeds normal funeral costs.
(4) Insofar as the supervisory body has determined a specific maximum amount for normal funeral costs, this amount prevails.

Section 151
Medical examination

Agreement on the insured person undergoing a medical examination does not establish the insurer's right to conduct that examination.

Section 152
Revocation by the policyholder

(1) In derogation from section 8 (1) sentence 1, the revocation period is 30 days. In derogation from section 8 subsection (4) sentence 2, the right of revocation ceases to apply at the latest 24 months and 30 days after conclusion of the contract. Section 8 subsection (5) sentence 4 does not apply.

(2) If the insurance cover begins prior to the end of the revocation period, and if the precondition in accordance with section 9 subsection (2) sentence 1 number 1 is met, the insurer is to refund to the policyholder, in derogation from section 9 subsection (1),

1. the share of the premiums accounted for by the period after receipt of the revocation notice, and

2. the surrender value, including surplus sharing in accordance with section 169.

(3) If the insurance cover begins prior to the end of the revocation period, and if the precondition in accordance with section 9 subsection (2) sentence 1 number 1 is not met, the insurer is to refund to the policyholder, in derogation from section 9 subsection (1),

1. the share of the premiums accounted for by the period after receipt of the revocation notice, and

2. the surrender value, including surplus sharing in accordance with section 169, or, if this is more favourable for the policyholder, the insurance premiums paid for the first year.

(4) Section 9 subsections (2) to (4) do not apply.
(5) In derogation from section 33 (1), the single or first premium is payable without undue delay 30 days after receipt of the insurance policy.

Section 153
Surplus sharing

(1) The policyholder is entitled to a share of the profit and valuation reserves (surplus sharing), unless surplus sharing is ruled out by explicit agreement; surplus sharing may only be ruled out in full.
(2) The insurer applies a causation-based procedure to the surplus sharing; other comparable, suitable principles of distribution may be agreed. The amounts within the meaning of section 268 (8) of the Commercial Code are not taken into account.
(3) The insurer determines the valuation reserves annually, and assigns them by calculation according to a causation-orientated procedure. When the contract expires, the amount to be

determined for that point in time is halved, and half is paid to the policyholder; earlier payment may be agreed. Supervisory regulations regarding safeguarding the ability to perform the obligations from the insurance policies in the long term, in particular section 89, section 124 (1), section 139 (3) and (4), and sections 140 and 214, of the Insurance Supervision Act remains unaffected.
(4) In the case of pension insurance policies, the end of the savings accumulation period is the relevant time in accordance with subsection (3) sentence 2.

Section 154
Model calculation

(1) If the insurer quotes in figures the amount of the possible benefits over and above the contractually guaranteed payments in connection with the offer or conclusion of a life insurance policy, he or she is obliged to provide the policyholder with a model calculation which states the possible maturity benefit based on the actuarial principles for premium calculation with three different rates of interest. This provision does not apply to risk insurance policies and contracts which provide for benefits of the type described in section 124 (2) sentence 2 of the Insurance Supervision Act.
(2) The insurer clearly and comprehensibly indicates to the policyholder that the model calculation only represents a model based on fictitious assumptions, and that the policyholder cannot derive any contractual claims against the insurer from the model calculation.

Section 155
Balance notification

(1) In the case of insurance policies with surplus sharing, the insurer informs the policyholder annually in writing of the current balance of his or her claims, including surplus sharing. In doing so, he or she must state to what extent this profit participation is guaranteed. The insurer indicates the following in detail:

1. the agreed payment on occurrence of an insured event, plus surplus sharing, at the relevant point in time that is specified in the balance notification,

2. the agreed payment, plus guaranteed surplus sharing, at the end of the life of the contract, or when the pension commences, provided that the contract is continued unchanged,

3. the agreed payment, plus guaranteed surplus sharing, as per the end of the life of the contract, or as per the time when the pension commences, provided that the insurance is premium free,

4. the amount disbursed in the event of termination on the part of the policyholder,

5. the total of the premiums paid in the case of contracts concluded from 1 July 2018 onwards; furthermore, information on the total of the premiums paid may be requested in text form.

(2) The insurer is at liberty to provide further information. The balance notification may be combined with other notifications that are to be made on an annual basis.
(3) If the insurer has provided figures regarding the possible future progression of the surplus sharing, he or she must indicate to the policyholder how the actual development deviates from the figures that were initially quoted.

Section 156
Knowledge and conduct of the insured person

Insofar as the knowledge and conduct of the policyholder are of any legal significance under the present Act, in the case of insurance taken out for another person, account is also taken of that other person's knowledge and conduct.

Section 157
Declaring incorrect age

Where the insured person's age has been declared incorrectly, the insurer's liability changes in the proportion that the insurance premium commensurate with his or her actual age bears to the agreed insurance premium. In derogation from section 19 (2), the insurer only has the right to withdraw from the contract on account of the breach of the duty of disclosure if he or she would not have concluded the contract had the age been declared correctly.

Section 158
Change in risk

(1) An aggravation of the risk insured is only deemed to be such change in the risk factors regarded as constituting an aggravation of the risk insured by explicit agreement; the agreement must be made in writing.
(2) An insurer may no longer assert an aggravation of the risk insured once five years have elapsed since the increase. If the policyholder has intentionally or fraudulently breached his or her obligation under section 23, this time limit is ten years.
(3) Section 41 applies with the proviso that a reduction of the premium may only be demanded on account of such a reduction of risk factors deemed to be so by explicit agreement.**Section 159**

Appointment of beneficiary

(1) In cases of doubt, the policyholder is entitled, without the consent of the insurer, to appoint a third party as beneficiary, and to replace the thus appointed third party with the name of another.
(2) A third party beneficiary by revocable designation does not acquire the right to payment of the insurer's benefit until the insured event occurs.
(3) A third party beneficiary by irrevocable designation acquires the right to payment of the insurer's benefit at the time when he or she is designated as beneficiary.

Section 160
Interpretation of the appointment of beneficiary

(1) If several persons are appointed as beneficiaries without determining their shares, they are entitled to benefit in equal share. The share not acquired by any one beneficiary accrues to the remaining beneficiaries.
(2) If the insurer's benefit is to be paid to the policyholder's heirs on his or her death, in cases of doubt those appointed as heirs on his or her death are entitled to benefit in relation to their shares in the inheritance. A waiving of the right to the inheritance has no influence on the entitlement.
(3) Where the right to the insurer's benefit is not acquired by the third party beneficiary, it is due to the policyholder.
(4) Where the tax authorities are appointed as heirs, they are not entitled to benefit within the meaning of subsection (2) sentence 1.

Section 161
Suicide

(1) In the case of a whole life insurance, the insurer is not obliged to effect payment if the insured person intentionally commits suicide before three years have elapsed since the conclusion of the contract of insurance. This does not apply if the act was committed while a person was in a state of morbid disturbance of mind precluding their ability to freely determine their intent.

(2) The time limit under subsection (1) sentence 1 may be increased by individual agreement.
(3) Where the insurer is not obliged to effect payment, he or she must pay the surrender value plus surplus sharing in accordance with section 169.

Section 162
Killing by the beneficiary

(1) If the insurance has been taken out against the death of a person other than the policyholder, the insurer is not obliged to effect payment if the policyholder intentionally causes the death of the other by an unlawful act.
(2) If a third party has been appointed beneficiary, the appointment is deemed not to have occurred if the third party intentionally causes the death of the insured person by an unlawful act.

Section 163
Change in premium and benefits payable

(1) The insurer is entitled to re-determine the agreed premium if

1. the need for benefits has changed, not only temporarily and unforeseeably, in respect of the bases for calculating the agreed premium,

2. the re-determined premium is appropriate and necessary in accordance with the amended bases of calculation in order to guarantee the continuous satisfiability of the insurance benefit, and

3. an independent trustee has examined and confirmed the bases of calculation and the conditions under nos. 1 and 2.

Any re-determination of the premium is ruled out insofar as the insurance benefits payable at the time of the first and renewed determination were insufficiently calculated, and a prudent and conscientious actuary should have recognised that fact, particularly based on the statistical bases of calculation available at that point in time.
(2) The policyholder may request that the insurance benefit be reduced accordingly instead of an increase in the premium in accordance with subsection (1). In the case of an insurance free of premium (fully paid-up insurance), the insurer is entitled to reduce the insurance benefit under the conditions set out in subsection (1).
(3) The re-determination of the insurance premium, and the reduction of the insurance benefit, become effective at the start of the second month after the policyholder has been informed about the re-determination or the reduction and the relevant reasons.
(4) The trustee does not become involved in accordance with subsection (1) sentence 1 no. 3 if the re-determination or the reduction of the insurance benefit requires the authorisation of the supervisory body.

Section 164
Adjustment of the terms

(1) If a provision of the insurer's general terms and conditions of insurance has been declared void by a decision of one of the highest courts, or by a final administrative act, the insurer may replace it with a new rule if this is necessary to continue the contract, or if continuing the contract without the new rule would represent undue hardship for either party, even taking into account the interests of the other party. The new rule is only effective if it takes appropriate account of the concerns of the policyholder and is in keeping with the objective of the contract.
(2) The new rule in accordance with subsection (1) becomes an integral part of the contract two weeks after the policyholder has been informed of the new rule and of the relevant grounds.

Section 165
Fully paid-up insurance

(1) The policyholder may demand at any time from the end of the current period of insurance that the insurance be converted into a fully paid-up insurance, insofar as the agreed minimum insurance cover is achieved. If that is not the case, the insurer must pay the applicable surrender value plus surplus sharing in accordance with section 169.
(2) Fully paid-up insurance benefits are calculated in accordance with the accepted actuarial rules, using the bases for calculating the insurance premium based on the surrender value in accordance with section 169 (3) to (5), and are quoted in the contract for each insurance year.
(3) Fully paid-up insurance benefits are calculated for the end of the current period of insurance, taking into account any premium payments in arrears. The policyholder's claims arising from surplus sharing remain unaffected.

Section 166
Termination of the contract by the insurer

(1) If the insurer terminates the contract of insurance, the insurance is converted into fully paid-up insurance on termination. Section 165 applies to the conversion.
(2) In the case of section 38 (2), the insurer is liable to that extent to which he or she would have been liable if the insurance had been converted into fully paid-up insurance on occurrence of the insured event.
(3) When setting a deadline for payment in accordance with section 38 (1), the insurer must indicate that the insurance is being converted.
(4) In the case of a life insurance policy concluded by the employer for the benefit of his or her employees, the insurer informs the insured person in writing of the setting of the payment deadline in accordance with section 38 (1), and of the fact that the insurance is being converted, and grants them a payment period of no less than two months.

Section 167
Conversion to qualify for exemption from attachment

The life insurance policyholder may demand at any time that the insurance be converted, as per the end of the current period of insurance, into an insurance policy which meets the requirements of section 851c (1) of the Code of Civil Procedure. The costs of the conversion are borne by the policyholder.

Section 168
Termination of the contract by the policyholder

(1) Where continuous insurance premiums are payable, the policyholder may terminate the insurance policy at any time as per the end of the current period of insurance.
(2) If an insurance policy covers a risk for which the insurer is certain to be liable, the policyholder's right to terminate the contract also applies if the premium consists of a single payment.
(3) Subsections (1) and (2) do not apply to a contract of insurance which is to serve as retirement provision

1. if the contracting parties have ruled out, in the case of a basic pension contract certified in accordance with section 5a of the Pension Contracts Certification Act (*Altersvorsorgeverträge-Zertifizierungsgesetz*), the cashing in of the claims in accordance with section 10 (1) no. 2 sentence 1 (b) of the Income Tax (*Einkommensteuergesetz*), or

2. insofar as the contracting parties have irrevocably ruled out cashing in, and this exclusion is required in order to provide protection from attachment in accordance with section 851c of the Code of Civil Procedure, or with section 851d of the Code of Civil Procedure.

Section 169
Surrender value

(1) If an insurance policy offers insurance cover for a risk for which the insurer is certain to be liable, and the insurance agreement is rescinded because the policyholder terminates the contract, or because the insurer rescinds or avoids the policy, the insurer pays the surrender value.
(2) The surrender value is only paid insofar as this value does not exceed the payment made on occurrence of the insured event when the contract is terminated. The share of the surrender value not paid after that time is used for the fully paid-up insurance. In the case of rescission or avoidance of the contract. the full surrender value is paid.
(3) The surrender value is the premium reserve of the insurance, calculated with effect to the end of the current insurance period according to the accepted actuarial rules using the bases of premium calculation, in the case of the termination of the insurance agreement the amount of the premium reserve resulting from a symmetrical allocation of the calculated acquisition and distribution costs for the first five insurance years; the regulations stipulated by the supervisory authorities in respect of maximum zillmerising rates remain unaffected. The policyholder is to be informed of the surrender value, and of the extent to which it is guaranteed, before he or she submits his or her contractual acceptance; the statutory ordinance referred to in section 7 (2) specifies further particulars. If the insurer's headquarters are located in another Member State of the European Union, or in another state party to the Agreement on the European Economic Area, he or she may base his or her calculation of the surrender value on another reference value comparable in that state, rather than on the premium reserve.
(4) In the case of fund-based insurance policies, and of other insurance policies which provide for benefits of the type described in section 123 (2) sentence 2 of the Insurance Supervision Act, the surrender value is calculated based on the accepted actuarial rules as an end value of the insurance, insofar as the insurer does not guarantee payment of a specific benefit; subsection (3) applies in all other cases. The principles on which the calculation is based are cited in the contract.
(5) The insurer is only entitled to deduct the amount calculated in accordance with subsection (3) or (4) if it has been agreed, put in figures, and is appropriate. An agreement regarding a deduction for as yet unsettled acquisition and distribution costs is void.
(6) The insurer may reduce the amount calculated in accordance with subsection (3) by an appropriate amount insofar as this is necessary to rule out a risk to the policyholder's concerns, especially a risk to the continuous satisfiability of the obligations arising from the contracts of insurance. The reduction is limited to one year in each instance.
(7) In addition to the amount calculated on the basis of subsections (3) to (6), the insurer pays the policyholder the surplus sharing already assigned to him or her, insofar as this has not already been added to the amount calculated in accordance with subsections (3) to (6), as well as the final surplus sharing provided for in accordance with the relevant general terms and conditions of insurance in the event of the termination of the contract; section 153 (3) sentence 2 remains unaffected.

Section 170
Right of subrogation

(1) If attachment is executed on the insurance claim, or compulsory execution has been carried out, or insolvency proceedings are opened against the assets of the policyholder, the designated beneficiary may, with the consent of the policyholder, subrogate to the contract of insurance. Where the beneficiary subrogates, he or she must satisfy the demands of the creditor initiating the proceedings, or of the insolvency estate, up to the amount of the payment which the policyholder could demand from the insurer in the event of the termination of the contract of insurance.

(2) Where no beneficiary is designated or named, the policyholder's spouse or life partner, or children, are entitled to the same right.
(3) The subrogation is effected by giving notice thereof to the insurer. The notification may only be made within one month after the time when the person entitled to subrogate learns of the attachment, or after the insolvency proceedings have been opened.

Section 171
Deviating agreements

Agreements deviating from section 152 (1) to (4), and sections 153 to 155, as well as sections 157, 158, 161 and sections 163 to 170, to the detriment of the policyholder, the insured person, or the person entitled to subrogation, are not permitted. Agreement may be reached to the effect that the policyholder's request for conversion in accordance with section 165, and his or her termination of the contract in accordance with section 168, must be made in writing.**Chapter 6**

Occupational disability insurance

Section 172
Insurer's liability

(1) In the case of occupational disability insurance, the insurer is liable to pay the agreed benefits for any occupational disability arising after the beginning of the insurance.
(2) 'Occupational disability' refers to anyone who, in consequence of sickness, physical injury or loss of strength over and above what is normal for their age, can probably no longer wholly or partially exercise their most recently exercised profession in the long run to the same extent as when they had no health impairments.
(3) The insurer may agree as a further precondition for his or her liability that the insured person does not or cannot exercise another profession which he or she is in a position to take on based on his or her training and skills, and which corresponds to his or her previous position in life.

Section 173
Acknowledgement

(1) After a claim has been filed, the insurer declares in writing when due whether he or she acknowledges his or her obligation to effect payment.
(2) The acknowledgement may only be time-barred once. It is binding up to the end of the time limit.

Section 174
Release from liability

(1) Where the insurer establishes that the preconditions for his or her liability are no longer met, he or she is only released from his or her liability if he or she has indicated this change to the policyholder in writing.
(2) The insurer is only released from liability three months after receipt of the declaration under subsection (1) at the earliest.

Section 175
Deviating agreements

Agreements deviating from section 173 and section 174 to the detriment of the policyholder are not permitted.

Section 176
Applicable provisions

Sections 150 to 170 apply accordingly to occupational disability insurance insofar as this does not conflict with the specific nature of this insurance.

Section 177
Similar contracts of insurance

(1) Sections 173 to 176 apply accordingly to all contracts of insurance in which the insurer promises to pay claims arising on account of a permanent impairment of the policyholder's capacity to work.
(2) Subsection (1) does not apply to accident insurance, or to health insurance contracts whose subject-matter is the risk of an impairment of the policyholder's capacity to work.

Chapter 7
Accident insurance

Section 178
Insurer's liability

(1) In the case of accident insurance, the insurer is liable following an accident involving the insured person, or an event contractually deemed equivalent to an accident.
(2) An accident is deemed to have occurred where the insured person involuntarily suffers a health impairment on account of a sudden event having an external impact on his or her body. Involuntariness is assumed until such time as the opposite is proven.**Section 179**
Insured person

(1) The accident insurance may be taken out against the occurrence of an accident involving the policyholder or another person. In cases of doubt, an insurance policy against accidents involving another person is deemed to have been taken out for the account of a third person.
(2) If the insurance against accidents involving another person is taken out by the policyholder for his or her own account, the written agreement of the other person is required for the contract to become effective. If the other person has no legal capacity to act, or only limited legal capacity to act, or if a custodian has been appointed to him or her and the policyholder is entitled to represent the person's interests, he or she may not represent the other person when giving his or her consent thereto.
(3) Insofar as, in cases under subsection (2), the knowledge and conduct of the policyholder is of legal significance under the present Act, account is also taken of the knowledge and conduct of the other person.

Section 180
Invalidity

The insurer owes the promised payments to the agreed extent in the case of invalidity if the insured person's physical or mental capacity is permanently impaired on account of the accident. Such impairment is deemed permanent if it is expected to last for more than three years and no change in the situation is to be expected.

Section 181
Aggravation of risk

(1) An aggravation of the risk insured is only deemed to be such change in the circumstances which is to be classed as an aggravation of the risk insured by explicit agreement; the agreement must be made in writing.
(2) If, in the event of an aggravation of risk insured, lower insurance benefits are payable in accordance with the insurer's applicable tariff if the premium does not change, these are deemed to have been agreed one month after the aggravation of the risk insured begins. The insurer may only assert more comprehensive rights if the policyholder fraudulently failed to disclose the aggravation of the risk insured.

Section 182
Contributory causes

Where it has been agreed that the right to the agreed payment lapses or is reduced if illnesses or ailments have contributed to the health impairments or their consequences following an insured event, the insurer provides proof that the conditions for the lapse or reduction of the claim exist.

Section 183
Causing the insured event

(1) The insurer is not liable if, in cases of section 179 (2), the policyholder intentionally caused the insured event through an unlawful act.
(2) If a third party has been designated as a beneficiary, the appointment is deemed not to have occurred if the third party intentionally caused the insured event through an unlawful act.

Section 184
Loss avoidance and minimisation

Section 82 and section 83 do not apply to accident insurance.

Section 185
Appointment of beneficiary

Where it has been agreed that the insurer is to pay out a capital sum, sections 159 and 160 apply accordingly.**Section 186**
Insurer's duty to provide information

If the policyholder gives notice of the occurrence of an insured event, the insurer provides him or her with information in writing regarding the contractual preconditions for a claim and due dates, as well as deadlines which must be adhered to. Should this information not be provided, the insurer may not refer to any failure to meet a deadline.

Section 187
Acknowledgement

(1) After an application for a claim has been filed, the insurer declares in writing, within one month after submission of the documents necessary for its assessment, whether and to what extent he or she acknowledges his or her liability. If the application is for payment of an invalidity benefit, the time limit is three months.
(2) If the insurer acknowledges the claim, or the policyholder and the insurer have agreed the reason for and the amount of the claim, the payment is due within two weeks. If the liability has been established on the merits only, the insurer pays an appropriate advance on the policyholder's request.

Section 188
Re-assessment of invalidity

(1) Where the payment of benefits has been agreed in the event of invalidity, each contracting party is entitled to have the degree of invalidity re-assessed annually, no more than three years after the accident occurred at the latest. In the case of child accident insurance, the time limit may be extended within which a re-assessment may be requested.
(2) Once the insurer declares that he or she is liable, the policyholder must be instructed regarding his or her right to have the degree of invalidity re-assessed. If such instruction is not given, the insurer may not refer to any delay in the policyholder's request to have the degree of invalidity re-assessed.

Section 189
Consulting an expert, costs of ascertaining the loss

Section 84 and section 85 (1) and (3) apply accordingly.

Section 190
Compulsory insurance

If the taking out of accident insurance is compulsory under a legal provision, the insurer certifies to the policyholder, quoting the sum insured, that accident insurance exists in accordance with the legal provision, to which reference must be made.

Section 191
Deviating agreements

Agreements deviating from section 178 (2) sentence 2 and section 181, as well as sections 186 to 188, to the detriment of the policyholder or the insured person are not permitted.

Chapter 8
Health insurance

Section 192
Typical obligations incumbent on the insurer

(1) In the case of cost-of-illness insurance, the insurer is obliged to reimburse any expenses for medically necessary treatment due to sickness, or in consequence of an accident, and for other agreed services to the agreed extent, including those expenses associated with pregnancy and childbirth, as well as out-patient medical check-ups for the early diagnosis of diseases in accordance with statutory programmes.
(2) The insurer is not liable to pay claims in accordance with subsection (1) insofar as the expenses for treatment or other services are manifestly disproportionate to the services performed.
(3) The contracting parties may agree that the content of the cost-of-illness insurance contract covers additional services directly linked to those referred to in subsection (1), especially

1. providing advice regarding the services referred to in subsection (1), as well as regarding the providers of such services;

2. providing advice regarding the entitlement to remuneration of those providing the services referred to in subsection (1);

3. avoiding unauthorised entitlements to remuneration of those providing the services referred to in subsection (1);

4. providing support to insured persons when asserting claims on account of the incorrect provision of the services referred to in subsection (1) and the consequences resulting therefrom;

5. directly settling accounts for services referred to in subsection (1) with the providers thereof.

(4) In the case of daily hospital allowance insurance, the insurer is obliged to pay the agreed daily hospital allowance for medically necessary in-patient treatment.
(5) In the case of daily sickness allowance insurance, the insurer is obliged to reimburse the earnings lost as a result of the illness or accident due to the incapacity to work by paying the agreed daily sickness allowance. He or she is furthermore obliged to compensate for the loss of earnings occurring during the protection periods in accordance with section 3 (1) and (2) of the Maternity Protection Act (*Mutterschutzgesetz*), and on the day of delivery, by the agreed daily sickness allowance, unless the insured person is entitled to other reasonable compensation for the loss of earnings caused during this period.
(6) In the case of long-term nursing care insurance, the insurer is obliged, in the event of the need for long-term nursing care, to reimburse to the agreed extent the expenses for caring for the insured person (long-term nursing care costs insurance), or to pay the agreed daily

allowance (daily long-term nursing allowance insurance). Subsection (2) applies accordingly to long-term nursing care costs insurance. The provisions of Book 10 of the Social Code concerning private long-term nursing care insurance remain unaffected.
(7) In the case of cost-of-illness insurance in the basic tariff in accordance with section 152 of the Insurance Supervision Act, and in the emergency tariff in accordance with section 153 of the Insurance Supervision Act, the service-provider may also assert his or her claim to remuneration for services provided against the insurer insofar as the insurer is obliged by the insurance agreement to effect payment. The insurer and the policyholder are liable as joint and several debtors as concerns the obligation incumbent on the insurer to effect payment emanating from the insurance agreement. Insofar as the insurer provides the payment to the service-provider, or to the policyholder, in the emergency tariff in accordance with section 153 of the Insurance Supervision Act owed from the insurance agreement, it is released from its obligation to effect payment vis-à-vis the service-provider. The insurer may not offset in the basic tariff in accordance with section 152 of the Insurance Supervision Act, and in the emergency tariff in accordance with section 153 of the Insurance Supervision Act, an insurance premium due to it from cost-of-illness insurance or private compulsory long-term care insurance against a claim of the policyholder from these insurance policies. Section 35 does not apply.
(8) Prior to commencing medical treatment the cost of which is likely to exceed 2,000 euros, the policyholder may demand information from the insurer in text form regarding the extent of insurance cover for the intended medical treatment. If the implementation of the medical treatment is urgent, the insurer issues information without delay, accompanied by reasoning, at the latest after two weeks, otherwise after four weeks; attention is paid here to a cost estimate submitted by the policyholder, and to other documents. The period commences on receipt of the request for information by the insurer. If the information is not issued within the period, it is presumed until proof of the contrary by the insurer that the intended medical treatment is necessary.

Section 193
Insured person; obligatory insurance

(1) The health insurance may be taken out for the policyholder, or for another person. The insured person is that person for whom the insurance is taken out.
(2) Where the knowledge and the conduct of the policyholder are of legal significance under the present Act, in the case of insurance for another person, account is also taken of the knowledge and conduct of that person.
(3) Each person with a place of residence in Germany is obliged to conclude and maintain, with an insurance company licensed to operate in Germany, for himself or herself and for the persons legally represented by him or her, insofar as they are not themselves able to conclude contracts, a cost-of-illness insurance which comprises at least a cost refund for out-patient and in-patient treatment, and in which the absolute and percentage excesses for out-patient and in-patient treatment which have been agreed for services covered by the respective tariff for each person to be insured are limited to an amount of 5,000 euros per calendar year; for persons entitled to medical expenses assistance, the possible excesses emerge through the analogous application of the percentage not covered by the rate of medical expenses assistance to the maximum amount of 5,000 euros. The obligation in accordance with sentence 1 does not apply to persons who

1. are insured or subject to obligatory insurance in statutory health insurance, or

2. have a right to free treatment, to medical expenses assistance, or to comparable rights to the extent of the respective entitlement, or

3. have a right to benefits in accordance with the Asylum-Seekers Benefits Act, or

4. are recipients of recurrent benefits in accordance with the Chapters 3, 4 and 7 of Book 10 of the Social Code, and recipients of benefits in accordance with Part 2 of Book 10 of the Social Code, for the duration of the receipt of such benefits and during periods of an interruption of the receipt of benefits of less than one month if the receipt of benefits commenced prior to 1 January 2009.

A cost-of-illness insurance contract agreed prior to 1 April 2007 is deemed to meet the requirements of sentence 1.

(4) If conclusion of contract is applied for later than one month after emergence of the obligation in accordance with subsection (3) sentence 1, a premium supplement is payable. This is one month's contribution for each further month of non-insurance commenced, from the sixth month of non-insurance one-sixth of one month's contribution for each further month of non-insurance commenced. If it is impossible to ascertain the duration of non-insurance, it is presumed that the insured party was not insured for at least five years. The premium supplement is payable once in addition to the recurrent premium. The policyholder may demand respite from the insurer in respect of the premium supplement if the insurer's interests can be satisfied by agreeing an appropriate payment by instalments. Interest is applied to the amount to which the respite relates. If the conclusion of the contract is applied for by 31 December 2013, no premium supplement is payable. This applies accordingly to contracts concluded by 31 July 2013 for outstanding premium supplements in accordance with sentence 1.

(5) The insurer is obliged to grant insurance in the basic tariff in accordance with section 152 of the Insurance Supervision Act

1. to all who are persons voluntarily insured in statutory health insurance

   a) within six months after the introduction of the basic tariff,

   b) within six months of commencement of the possibility to change envisioned in Book 5 of the Social Code in the context of their voluntary insurance agreement,

2. to all persons with a place of residence in Germany who are not subject to obligatory insurance in statutory health insurance, who do not belong to the group of individuals in accordance with no. 1, or subsection (3) sentence 2 nos. 3 and 4, and who have not already agreed private cost-of-illness insurance with an insurance company licensed to operate in Germany satisfying the obligation in accordance with subsection (3),

3. to persons who are entitled to medical expenses assistance, or who have comparable entitlements, insofar as they require supplementary insurance cover to meet the obligation in accordance with subsection (3) sentence 1,

4. to all persons with a place of residence in Germany who have agreed private cost-of-illness insurance within the meaning of subsection (3) with an insurance company licensed to operate in Germany, and whose contract is concluded subsequent to 31 December 2008.

If the private cost-of-illness insurance contract was concluded prior to 1 January 2009, on change or termination of the contract, the conclusion of a contract in the basic tariff may be demanded with the policyholder's own insurance company, or with another insurance company, old-age reserves being carried forward in accordance with section 204 (1) only until 30 June 2009. The application must already be accepted if, in case of termination of a contract with another insurer, termination in accordance with section 205 (1) sentence 1 did not yet take effect. The application may only be rejected if the applicant was already insured by the insurer, and the insurer

1. has contested the contract of insurance because of threat or fraudulent misrepresentation, or

2. has rescinded the contract of insurance because of an intentional breach of the obligation to provide information prior to conclusion of contract.

(6) If the policyholder is in arrears in respect of an insurance policy satisfying the obligation in accordance with subsection (3) with payment in the amount of premium shares for two months, the insurer issues him or her with a reminder. In place of interest on arrears, the policyholder pays a late payment charge of 1 percent of the premium payment in arrears for each commenced month of premium payment in arrears. If, two months after receipt of the reminder, the premium payment in arrears, including the late payment charges, is higher than the premium share for one month, the insurer issues a second reminder and indicates the consequences in accordance with sentence 4. If the amount of the premium payment in arrears, including the late payment charges, remains higher than the premium share for one month after receipt of the second reminder, the contract is suspended from the first day of the following month onwards. Suspension of the contract does not come into effect, or is terminated, when the policyholder or the insured person are or become in need of assistance within the meaning of Book 2 or 12 of the Social Code; need of assistance is certified, on request by the policyholder, by the competent funding organisation in accordance with Book 2 or 12 of the Social Code.
(7) As long as the contact is suspended, the policyholder is deemed to be insured in the emergency tariff in accordance with section 153 of the Insurance Supervision Act. No risk premiums, exclusions from benefits, or excesses, apply during this period. The insurer may demand that supplementary insurance policies be suspended as long as the insurance applies in accordance with section 153 of the Insurance Supervision Act. A change to or from the emergency tariff in accordance with section 153 of the Insurance Supervision Act is ruled out. A policyholder whose contract only provides for a refund of a percentage of the expenditure incurred is deemed to be insured in a variant of the emergency tariff in accordance with section 153 of the Insurance Supervision Act providing for benefits in the amount of 20, 30 or 50 percent of the insured treatment costs, depending on what percentage is closest to the extent of the agreed refund.
(8) The insurer sends to the policyholder in text form a notification of the continuation of the contract in the emergency tariff in accordance with section 153 of the Insurance Supervision Act, and of the premium payable. In doing so, the consequences of offsetting the old-age reserve in accordance with section 153 (2) sentence 6 of the Insurance Supervision Act for the amount of the premium payable in future is indicated to the policyholder in a prominent form. The insurer may have information on insurance in the emergency tariff in accordance with section 12h of the Insurance Supervision Act noted on an electronic health card in accordance with section 291a (1a) of Book 5 of the Social Code.
(9) If all premium shares which are in arrears, including the late payment charges and the collection costs, are paid, the contract is continued from the first day of the month after next in the tariff in which the policyholder was insured prior to the occurrence of the suspension. Here, the policyholder is placed as he or she was prior to being insured in the emergency tariff in accordance with section 153 of the Insurance Supervision Act, apart from the shares of the old-age reserve used up during the suspension period. Premium adjustments and amendments to the general terms and conditions of insurance carried out during the suspension period apply from the day of continuation onwards.
(10) If the policyholder has taken the health insurance out for another person, subsections (6) to (9) apply accordingly to the insured person.
(11) In case of insurance in the basic tariff in accordance with section 152 of the Insurance Supervision Act, the insurance company may demand additional insurance policies to be suspended if and for as long as an insured person is dependent on halving the contribution in accordance with section 152 (4) of the Insurance Supervision Act.

Section 194
Applicable provisions

(1) Sections 74 to 80, and sections 82 to 87, apply insofar as the insurance cover is granted in accordance with the principles of indemnity insurance. Sections 23 to 27, and section 29, do not apply to health insurance. Section 19 (4) does not apply to health insurance if the policyholder is not responsible for the breach of the duty of disclosure. In derogation from section 21 (3) sentence 1, the time limit for asserting the insurer's rights is three years.
(2) Section 86 (1) and (2) apply accordingly if the policyholder, or an insured person, is entitled to the repayment of remuneration paid without legal basis to the provider of services for which the insurer has paid compensation on the basis of the contract of insurance.
(3) Sections 43 to 48 apply to health insurance with the proviso that only the insured person may demand payment of the insurance benefit if the policyholder has designated him or her in writing to the insurer as the beneficiary of the insurance benefit; such designation may be revocable or irrevocable. Where this condition is not met, only the policyholder may demand payment of the insurance benefit. The insurance policy need not be presented.

Section 195
Period of insurance

(1) Health insurance which may wholly or partially substitute for health and long-term nursing care insurance cover provided for in the statutory social insurance system (substitutive health insurance) is for an indefinite period, unless subsections (2) and (3), and sections 196 to 199, provide otherwise. Sentence 1 applies accordingly where the non-substitutive health insurance cover is provided in the manner of life insurance.
(2) A period of contract may be agreed in the case of vocational training, overseas, travel, and residual debt health insurance.
(3) Agreement may be reached in the case of health insurance for a person with a temporary residence permit for Germany to the effect that the insurance will expire after five years at the latest. If a shorter term has been agreed, a similar new contract may only be concluded with a maximum term that does not exceed five years when added to the term of the expired contract; this also applies if the new contract is concluded with another insurer.

Section 196
Time limit on daily sickness allowance insurance

(1) It may be agreed in the case of daily sickness allowance insurance that the insurance expires when the insured person reaches the age of 65. The policyholder may demand in such cases that the insurer accept an application to take out a new daily sickness allowance to commence after he or she reaches the age of 65, and to expire when he or she reaches the age of 70 at the latest. The insurer notifies the policyholder of this right in writing six months at the earliest before the insurance expires, enclosing the text of this provision. If the application is made before two months have elapsed after the policyholder reaches the age of 65, the insurer grants the insurance cover without risk assessment or qualifying periods, insofar as the insurance cover is not higher or more comprehensive than under the previous tariff.
(2) If the insurer has not informed the policyholder that the insurance will expire in accordance with subsection (1) sentence 3, and the application is made before the policyholder reaches the age of 66, subsection (1) sentence 4 applies accordingly, whereby the insurance begins when the insurer receives the application. If the insured event has already occurred before the insurer receives the application, the insurer is not obliged to effect payment.
(3) Subsection (1) sentences 2 and 4 apply accordingly if, immediately after an insurance policy is taken out in accordance with subsection (1) sentence 4, or subsection (2) sentence 1, an application for a new daily sickness allowance insurance is made which expires when the policyholder reaches the age of 75 at the latest.
(4) The contracting parties may agree a later age than that set out in the subsections.

Section 197
Qualifying periods

(1) If qualifying periods are agreed, these may not exceed three months as general qualifying periods in respect of cost-of-illness, daily hospital allowance insurance, and daily sickness allowance insurance, and eight months as special qualifying periods in respect of childbirth, daily sickness allowance in accordance with section 192 subsection (5) sentence 2 psychotherapy, dental treatment, dental prostheses and orthodontics. In the case of long-term nursing care insurance, the qualifying period may not exceed three years.
(2) As regards persons leaving the statutory health insurance system, or who have left another contract relating to cost-of-illness insurance, account is taken of their uninterrupted period of insurance when calculating the qualifying period, insofar as the application for the insurance is made at the latest two months after the end of the previous insurance to begin immediately thereafter. This also applies to persons leaving the public sector with an entitlement to the health care allowance for public servants.

Section 198
Supplementary insurance for children

(1) If at least one parent has health insurance cover on the day on which their child is born, the insurer is obliged to insure this person's new-born from the completion of the birth without risk premiums and qualifying periods, if the application for the insurance is made retroactively, at the latest two months after the day on which the child was born. This obligation only exists insofar as the insurance cover applied for in respect of the new-born is not higher, and is not more comprehensive, than that of the insured parent.
(2) Adoption is equivalent to the birth of a child insofar as the child is still under age at the time of the adoption. Where a greater risk exists, the agreement of a risk premium is permissible up to once the amount of the premium.
(3) A minimum period of insurance for the parent may be agreed as the precondition for the insurance cover for the new-born or the adopted child. This must not exceed three months.
(4) Subsections (1) to (3) do not apply to overseas and travel health insurance insofar as other private or statutory health insurance cover is available in Germany or overseas for the new-born or for the adopted child.

Section 199
Public servants entitled to sickness allowance

(1) In the case of cost-of-illness insurance of an insured person entitled to a sickness allowance in accordance with the principles of the public service, the contracting parties may agree that the insurance will expire to the extent of the increase in the allowance assessment rate when the insured person retires.
(2) If, in the case of an insured person entitled to a sickness allowance in accordance with the principles of the public service, the allowance assessment rate changes, or the entitlement to a sickness allowance lapses, the policyholder is entitled to demand that the insurer adjust the insurance cover within the framework of the existing cost-of-illness insurance tariffs so as to balance out the amended allowance assessment rate, or the discontinued entitlement to allowance. If the application is made within six months after the change, the insurer grants the amended insurance cover without a risk assessment or qualifying periods.
(3) Subsection (2) does not apply to granting insurance at the basic tariff.

Section 200
Prohibition of enrichment

If the insured person has the right to assert a claim against several parties obliged to effect payment on account of the same insured event, the total compensation may not exceed the total expenses.

Section 201
Causing an insured event

The insurer is not obliged to effect payment if the policyholder, or the insured person, intentionally causes his or her own illness or his or her own accident.

Section 202
Insurer's duty to provide information; costs of ascertaining the loss

The insurer is obliged, at the request of the policyholder or of the insured person, to give any information about, and the right to inspect, expert opinions or statements which he or she has obtained in examining his or her liability in respect of the need for a medical treatment. If the provision of information to, or inspection by, the policyholder or the insured person is opposed by significant therapeutic reasons, or for other material reasons, it is only possible to demand provision of information from, or inspection by, a designated physician or lawyer. The right may only be asserted by the person affected in each instance or by his or her legal representative. If the policyholder has obtained the expert opinion or the statement at the insurer's instigation, the insurer reimburses the costs arising.

Section 203
Adjustment of premium and conditions

(1) In the case of health insurance where the premium is calculated in the manner of life insurance, the insurer may only demand payment of a premium calculated in accordance with the technical bases of calculation under sections 146, 149 and 150 in conjunction with section 160 of the Insurance Supervision Act. Other than with contracts in the basic tariff in accordance with section 152 of the Insurance Supervision Act, the insurer may agree an appropriate risk premium or release from obligation to effect payment, taking account of an aggravation of the risk insured. A risk assessment is only permissible in the basic tariff insofar as it is necessary for purposes of equalisation in accordance with section 154 of the Insurance Supervision Act, or for subsequent tariff changes.
(2) If, in the case of health insurance, the insurer's statutory right of termination is ruled out by law or contract, the insurer is entitled, in the event of a not only temporary change to one of the bases of calculation necessary for calculating the premium, to also re-determine the premium in accordance with the adjusted bases of calculation for existing insurance agreements insofar as an independent trustee has reviewed the technical bases of calculation, and has agreed to the adjustment of the insurance premium. The amount of an excess may also be adjusted, and an agreed risk premium amended accordingly, insofar as this has been agreed. The relevant bases of calculation within the meaning of sentences 1 and 2 are the insurance benefits and the probabilities of death. As regards the adjustment of insurance premiums, additional premiums and excesses, as well as their review and approval by the trustee, section 155 of the Insurance Supervision Act applies in conjunction with a statutory ordinance enacted on the basis of section 160 of the Insurance Supervision Act.
(3) If, in the case of health insurance, the insurer's statutory right of termination is ruled out by law or contract within the meaning of subsection (1) sentence 1, the insurer is entitled to adjust the general terms and conditions of insurance and the conditions of the tariff to the new conditions in the case of a non-temporary change in the conditions in the health system if the changes appear necessary to sufficiently safeguard the policyholders' concerns, and an independent trustee has reviewed the conditions on which the change is based, and has confirmed their appropriateness.
(4) Section 164 applies if a provision in the insurer's general terms and conditions of insurance has been declared void by a decision of one of the highest courts, or by a final administrative act.

(5) The re-assessment of the premium, and the changes in accordance with subsections (2) and (3), become effective from the start of the second month after the policyholder has been informed of the re-assessment or of the changes and of the relevant grounds.

Section 204
Change of tariff

(1) In the case of an existing insurance agreement, the policyholder may demand that the insurer

1. accept applications to change to other tariffs with equivalent insurance cover, taking into account the rights acquired under the contract, and old-age reserves; insofar as the benefits payable according to the tariff to which the policyholder wishes to change are higher or more comprehensive than those in the previous tariff, the insurer may demand to be released from the obligation to effect payment for the additional benefit, or may demand an appropriate risk premium, and thus a qualifying period; the policyholder may avert the agreement of a risk premium and a qualifying period by agreeing release from the obligation to effect payment in respect of the additional benefits; in case of a change from the basic tariff into another tariff, the insurer may also demand the risk premium which was calculated on conclusion of contract; a change to the basic tariff of the insurer allowing for the rights acquired from the contract and of the old-age reserve is only possible if

   a) the existing cost-of-illness insurance was concluded subsequent to 1 January 2009, or

   b) the policyholder has reached the age of 55, or has not yet reached the age of 55, but meets the prerequisites for a claim to a pension from the statutory pensions insurance, and has applied for this pension, or draws a pension in accordance with civil service law or comparable regulations, or is in need of assistance in accordance with Book 2 or 12 of the Social Code, or

   c) the existing cost-of-illness insurance was concluded subsequent to 1 January 2009, and the change into the basic tariff was applied for prior to 1 July 2009;

   a change from a tariff in which the premiums are calculated on a unisex basis to a tariff in which this is not the case is ruled out;

2. in case of termination of the contract, and simultaneous conclusion of a new contract which can completely or partly replace the health insurance cover provided for in the statutory social insurance system, with another health insurer

   a) assign the calculated old-age reserve of the part of the insurance the benefits of which correspond to the basic tariff to the new insurer insofar as the terminated cost-of-illness insurance was concluded subsequent to 1 January 2009;

   b) in case of conclusion of a contract in the basic tariff assign, the old-age reserve calculated of the part of the insurance the benefits of which correspond to the basic tariff to the new insurer insofar as the terminated cost-of-illness insurance was concluded prior to 1 January 2009, and termination took place prior to 1 July 2009.

Insofar as the benefits according to the tariff from which the policyholder wishes to change are higher, or more comprehensive, than those in the basic tariff, the policyholder may require the previous insurer to agree an additional tariff in which the old-age reserve extending beyond the basic tariff is to be accounted for. It is not possible to waive the entitlements in accordance with sentences 1 and 2.

(2) If the policyholder has changed to the basic tariff in accordance with section 152 of the Insurance Supervision Act subsequent to 15 March 2020 owing to existing need of assistance within the meaning of Book 2 or 12 of the Social Code, and if the policyholder's need of assistance comes to an end within two years of the change, he or she may demand in text form, within three months of the need of assistance coming to an end, that the insurer continue the contract from the first day of the month after next in the tariff in which the policyholder was insured prior to changing to the basic tariff. At the request of the insurer, the policyholder proves commencement and coming to an end of the need of assistance through suitable documents; the certification of the competent funding organisation in accordance with Book 2 or 12 of the Social Code is deemed to constitute proof. With regard to the change, the policyholder is placed as he or she was prior to being insured in the basic tariff; the rights and old-age reserves acquired in the basic tariff are taken into account. Premium adjustments and amendments to the general terms and conditions of insurance in the tariff in which the policyholder was insured prior to changing to the basic tariff apply from the day of continuation of the contract in this tariff onwards. The sentences 1 to 4 apply accordingly to policyholders with regard to whom need of assistance within the meaning of Book 2 or 12 of the Social Code would arise solely from payment of the contribution. Section (1) sentence 1 no. 1 last clause does not apply.
(3) In the case of termination of the contract on private compulsory long-term care insurance and simultaneous conclusion of a new contract with another insurer, the policyholder may require the previous insurer to transfer the old-age reserve as calculated for him or her to the new insurer. It is not possible to waive this entitlement.
(4) Subsection (1) does not apply to time-limited insurance agreements. If this is a time limit in accordance with section 196, the right to change tariffs in accordance with subsection (1) no. 1 applies.
(5) Insofar as the health insurance is calculated in the form of a life insurance policy, the policyholders and the insured person have the right to continue a terminated insurance contract in the form of a coverage-retention policy.

Section 205
Termination of the contract by the policyholder

(1) Unless a minimum period of insurance has been agreed for the cost-of-illness and daily hospital allowance insurance, the policyholder may terminate a health insurance agreement which has been concluded for a period of more than one year to the end of the first year, or of each subsequent year, subject to a notice period of three months. The termination may be limited to individual insured persons or tariffs.
(2) If an insured person is obliged by operation of law to take out health or long-term nursing care insurance, the policyholder may terminate cost-of-illness, daily sickness allowance insurance and long-term nursing care insurance, as well as the prospective entitlement insurance which exists for these insurance policies, retroactively within three months of the day on which the obligation to take out the insurance arose. Termination of the contract is void if the policyholder does not provide proof to the insurer within two months of the obligation to take out insurance after the insurer has asked him or her to do so in writing, unless the policyholder is not responsible for missing this deadline. If the policyholder avails himself or herself of the right to terminate the contract, the insurer is only entitled to the premium up until that point in time. The policyholder may subsequently terminate the insurance agreement as per the end of that month in which he or she provides proof of his or her obligation to take out the insurance. The statutory right to family insurance, or the non-temporary right to a health care allowance for public servants resulting from a public service contract or similar employment status, is equivalent to the obligation to take out insurance.
(3) If the contract of insurance provides that, when the policyholder reaches a certain age, or when other preconditions referred to therein are met, the premium for another age or another age group applies, or the premium is calculated taking old-age reserves into account, the policyholder may terminate the insurance agreement with regard to the affected insured

person within two months after the change with effect from the time when it became effective, if the premium increases as a result.
(4) If the insurer increases the insurance premium, or reduces a benefit on account of an adjustment clause, the policyholder may terminate the insurance policy with regard to the affected insured person within two months after receipt of the communication of the change, with effect from such time as the increase in the premium or the reduction of the benefits is to take effect.
(5) If the insurer has reserved the right to limit the termination of a contract to individual insured persons or tariffs, and he or she avails himself or herself of this possibility, the policyholder may demand that the remaining share of the insurance be rescinded within two weeks after receipt of the termination to such time as the termination takes effect.
Sentence 1 applies accordingly if the insurer declares the avoidance or rescission of the policy possible only for individual insured persons or tariffs. The policyholder may demand in such cases that the contract be rescinded as per the end of the month in which he or she receives the insurer's declaration.
(6) In derogation from subsections (1) to (5), the policyholder may only terminate an insurance policy which complies with an obligation under section 193 (3) sentence 1 if he or she concludes a new contract with another insurer for the insured person which complies with this obligation. Termination only becomes effective if the policyholder proves, within two months after the declaration of termination, that the insured person is insured by a new insurer without interruption; if the time when termination was pronounced is more than two months after the declaration of termination, proof must be provided by this date.

Section 206
Termination by the insurer

(1) Any termination of cost-of-illness insurance which complies with an obligation under section 193 (3) sentence 1 is ruled out by the insurer. Over and above this, the insurer may not give statutory notice of termination on cost-of-illness, daily sickness allowance insurance and long-term nursing care insurance if the insurance can completely or partly replace the health insurance cover, or long-term nursing care insurance provided for in the statutory social insurance system. It is also ruled out for daily hospital allowance insurance taken out alongside full cost-of-illness insurance. In derogation from sentence 2, the insurer may terminate a daily sickness allowance insurance for which there is no statutory right to an allowance towards contributions from an employer as per the end of each insured year in the first three years, subject to a notice period of three months.
(2) If, in the case of daily hospital allowance insurance or partial cost-of-illness insurance, the preconditions under subsection (1) are not met, the insurer may only terminate the insurance agreement as per the end of the insurance year within the first three insurance years. The notice period is three months.
(3) Where cost-of-illness insurance, or long-term nursing care insurance, is effectively terminated by the insurer on account of delayed payment by the policyholder, the insured persons are entitled to declare that the insurance agreement will continue, and to name the future policyholder; the premium is payable from such time onwards as the insurance agreement continues. The insurer informs the insured persons in writing about the termination and the right under sentence 1. This right lapses two months after the time when the insured person learns of this right.
(4) The statutory notice of termination of a group contract of insurance which covers the risk of illness by the insurer is permissible if the insured persons can continue the health insurance, taking into account the rights acquired under the contract and the old-age reserve, insofar as it has been set aside, at the terms and conditions of the individual insurance. Subsection (3) sentences 2 and 3 apply accordingly.

Section 207
Continuation of the insurance agreement

(1) If the insurance agreement ends on the death of the policyholder, the insured persons are entitled to declare the continuation of the insurance agreement by appointing the future policyholder within two months following the death of the policyholder.
(2) Subsection (1) applies accordingly if the policyholder terminates the insurance agreement overall, or for individual insured persons. The termination is only effective if the insured person has learned of the declaration of termination. If the terminated contract is a group contract of insurance, and no new policyholder is designated, the insured persons are entitled to continue the insurance agreement, taking account of the rights acquired under the contract and the old-age reserves, insofar as they have been set aside, at the same terms and under the same conditions as the individual contract. The right under the third sentence lapses two months after the time when the insured persons learn of this right.
(3) If an insured person moves his or her habitual place of residence to another Member State of the European Union, or to another state party to the Agreement on the European Economic Area, the insurance agreement continues, with the proviso that the insurer only remain liable up to the maximum benefits which he or she would have had to pay were his or her place of residence still in Germany.

Section 208
Deviating agreements

Agreements deviating from section 192 (5) sentence 2, sections 194 to 199, and sections 201 to 207, to the detriment of the policyholder or the insured person are not permitted. As regards the termination of the contract by the policyholder in accordance with section 205, the contracting parties may agree that this must be made in writing.

Part 3
Concluding provisions

Section 209
Reinsurance, maritime insurance

The provisions of the present Act do not apply to reinsurance and to insurance against risks in shipping (maritime insurance).

Section 210
Jumbo risks, open policy

(1) The restrictions on the freedom of contract under the present Act do not apply to jumbo risks or to open policies.
(2) Jumbo risks within the meaning of this provision are:

1. risks of the transport and liability insurance indicated at nos. 4 to 7 and 10(b), as well as nos. 11 and 12, of Annex I to the Insurance Supervision Act,

2. risks of the credit and suretyship insurance indicated at nos. 14 and 15 of Annex I to the Insurance Supervision Act, where the policyholders exercise a commercial, mining or freelance activity, if the risks are relevant thereto, or

3. risks of the property, liability and other indemnity insurance indicated at nos. 3, 8, 9, 10, 13 and 16 of Annex I to the Insurance Supervision Act, where the policyholders exceed at least two of the following characteristics:

    a) 6,600,000 euros balance sheet total,

    b) 13,600,000 euros net turnover,

    c) an average of 250 employees per fiscal year.

If the policyholder belongs to a group of companies which must prepare a consolidated financial statement in accordance with section 290 of the Commercial Code, in accordance with section 11 of the Disclosure Act of 15 August 1969 (Federal Law Gazette I, p. 1189), in the respectively valid version, or in accordance with the law of another Member State of the

European Community or of another contracting state of to the Agreement on the European Economic Area that is in concordance with the requirements of Directive 2013/34/EU of the European Parliament and of the Council of 26 June 2013 on the annual financial statements, consolidated financial statements and related reports of certain types of undertakings, amending Directive 2006/43/EC of the European Parliament and of the Council and repealing Council Directives 78/660/EEC and 83/349/EEC **(**OJ L 182 of 29 June 2013, p. 19), the figures contained in the consolidated financial statement are material to the establishment of the size of the undertaking.

Section 210a
Electronic transport insurance policy document

An electronic transport insurance policy document in accordance with section 365a of the Commercial Code is deemed equivalent to the certificate in accordance with section 4 or section 55.

Section 211
Pension funds, small insurance associations, insurance policies with small contributions

(1) Insofar as other provisions have been agreed in the general terms and conditions of insurance with the consent of the supervisory authority, sections 37, 38, 165, 166, 168 and 169 do not apply to

1. insurance policies with pension funds within the meaning of section 233 (1) and (2) of the Insurance Supervision Act,
2. insurance policies taken out with an association recognised as a small association within the meaning of the Insurance Supervision Act,
3. life insurance policies with small contributions, and
4. accident insurance policies with small contributions.

(2) Furthermore, the following does not apply to pension funds referred to in subsection (1):

1. sections 6 to 9, 11, 150 (2) to (4) and section 152 (1) to (4); with regard to distance contracts in accordance with section 312c of the Civil Code, this does not apply to sections 7 to 9 and to section 152 (1) to (4);
2. section 153, insofar as other provisions have been agreed in the general terms and conditions of insurance with the consent of the supervisory authority; section 153 (3) sentence 1 does not apply to funds paying funeral benefits.

(3) Where other provisions have been agreed for insurance policies with small contributions within the meaning of subsection (1) nos. 3 and 4, their effectiveness may not be challenged by invoking the fact that they are not insurance policies with small contributions.

Section 212
Continuation of life insurance after parental leave

If an employment relationship continues during parental leave without payment in accordance with section 1a (4) of the Company Pensions Act (*Betriebsrentengesetz*), and a life insurance policy taken out by the employer for the benefit of the employee is converted into a fully paid-up insurance policy on account of the non-payment of insurance premiums due during parental leave, the employee may demand, within three months of the end of parental leave, that the insurance be continued under the terms and conditions agreed prior to the conversion.

Section 213
Acquiring personal health-related data from third parties

(1) The insurer may only acquire personal health-related data from doctors, hospitals and other health institutions, care homes and nursing staff, other insurers of persons and statutory health insurers, as well as social insurance providers for occupational accidents and public authorities; this is only permissible insofar as the knowledge of the data is necessary to assess the risk to be insured, or the liability, and the affected person has given his or her consent.
(2) The consent required in accordance with subsection (1) may be given prior to the submission of the contractual acceptance. The affected person is informed prior to the data referred to in subsection (1) being acquired; he or she may object to the data being acquired.
(3) The affected person may demand at any time that the data only be acquired if his or her consent has been given in each individual case.
(4) The affected person is notified of these rights, and is notified of the right to object in accordance with subsection (2) when being instructed.

Section 214
Conciliation board

(1) The Federal Office of Justice may authorise private-law institutions to act as conciliation boards for the extra-judicial settlement of disputes

1. in the case of contracts of insurance with consumers within the meaning of section 13 of the Civil Code,

2. between insurance intermediaries or insurance advisers and policyholders in connection with the mediation of contracts of insurance.

Those concerned may apply to these conciliation boards; the right to appeal to the courts remains unaffected.
(2) A private-law institution may be authorised to act as a conciliation board if it satisfies the requirements for authorisation as a consumer conciliation board in accordance with section 24 of the Consumer Dispute Settlement Act (*Verbraucherstreitbeilegungsgesetz*) of 19 February 2016 (Federal Law Gazette I, p. 254). A recognised conciliation board is deemed to be a consumer conciliation board in accordance with the Consumer Dispute Settlement Act. The Federal Office of Justice includes the consumer conciliation boards in accordance with subsection (1) in the list in accordance with section 33 (1) of the Consumer Dispute Settlement Act, and announces the authorisation and the revocation or withdrawal of the authorisation in the Federal Gazette.
(3) The authorised conciliation boards are obliged to respond to each complaint regarding an insurer or insurance intermediary, an intermediary in accordance with section 66, and an insurance adviser.
(4) The authorised conciliation boards may levy a fee from the insurance intermediary, intermediary in accordance with section 66, or insurance adviser. In the case of manifestly improper complaints, a small fee may also be levied from the policyholder. The amount of the fee must be proportionate to the recognised conciliation board's expenses.
(5) Conciliation boards recognised in accordance with subsection (1) inform the Federal Financial Supervisory Authority of the business practices of enterprises that have become known to them in their conciliation activities, if such business practices may have significant adverse effects on the interests of large numbers of consumers.
(6) Insofar as no private-law institution has been authorised to act as a conciliation board, the Federal Ministry of Justice and Consumer Protection, in consultation with the Federal Ministry of Finance and the Federal Ministry of Economics and Energy, assigns the tasks of the conciliation board to one of the higher federal authorities, or to a federal institute, by statutory ordinance without the consent of the Bundesrat, and regulates its procedures and the levying of fees and expenses. Section 31 of the Consumer Dispute Settlement Act applies accordingly. The conciliation board is deemed to be a consumer conciliation board in

accordance with the Consumer Dispute Settlement Act, and must satisfy the requirements in accordance with the Consumer Dispute Settlement Act.

Section 215
Place of jurisdiction

(1) In respect of actions brought on the basis of the contract of insurance or the mediation of a contract of insurance, that local court in whose district the policyholder has his or her place of residence at the time of the filing of the action also has jurisdiction, failing that, his or her habitual place of residence. Only this court has jurisdiction in respect of actions brought against the policyholder.
(2) Section 33 (2) of the Code of Civil Procedure does not apply to cross-actions brought by the other party.
(3) An agreement deviating from subsection (1) is permitted in the event that the policyholder moves his or her domicile or habitual place of residence outside of the scope of the present Act after signing the contract, or his or her domicile or habitual place of residence is unknown at such time as the action is filed.

Section 216
Derivative right of action with a majority of insurers

If an insurance contract with the individual insurers associated together with Lloyds has not been concluded via a branch office in the area of application of the present Act, and if there is a domestic venue, claims arising therefrom may be asserted against the authorised signatory of the syndicate named in the insurance policy first, or against an insurer designated by the latter; a title acquired thereby applies for and against all insurers which are party to the insurance contract.**Annex (re section 8 (5) sentence 1)**
Model notice regarding revocation
(Source: Federal Law Gazette I 2021, 1687-1690, cf. footnote with regard to the individual amendments)

Notice regarding revocation
Part 1 **Right of revocation, consequences of revocation and particular remarks** **Right of revocation** **You may revoke your contractual acceptance within [14] days in text form (e.g. letter, fax, e-mail) without stating reasons.** **The period begins after you have received** • **the insurance policy,** • **the terms of the contract,** including the general terms and conditions of insurance applicable to the insurance agreement, these in turn including the conditions of the tariff, • **this Notice,** • **the product information sheet on insurance products,** • **and the further information provided in Division 2,** **in each case in text form.** **Dispatching the revocation in good time suffices to meet the revocation deadline.** **The revocation is to be addressed to:** **Consequences of revocation** **If the insurance cover begins prior to the end of the revocation period, the insurance cover will be terminated in the event of effective revocation, and the insurer must refund to you only the share of the premiums accounted for by the period subsequent to receipt of the revocation notice. The insurer may in this case retain the share of the premium accounted for by the period until receipt of the revocation notice; this is [an amount of...]. [You may in this event retain insurance payments which you have claimed prior to exercising the right of revocation on the**

basis of an insured event from the insurance contract.] If the insurance cover does not begin prior to the end of the revocation period, the consequence of effective revocation is that payments that have been received are to be refunded.
Payments must be refunded promptly within 30 days at the latest. The period begins for the insurer on receipt of the revocation notice, and for the policymaker on submission of the revocation notice.

Particular remarks

If you do not exercise your right of revocation, you are bound by your contract.
Your right of revocation ceases to apply if, at your explicit request, the contract has been fully performed both by you and by the insurer prior to your exercising your right of revocation.
Your right of revocation ceases to apply at the latest [twelve months and 14 days] after conclusion of the contract.

Division 2
List of further information required for the commencement of the revocation period

The duties to inform are listed in detail as follows with regard to the further information provided in Division 1 sentence 2:

Subdivision 1
Duties to inform in all classes of insurance

The insurer must provide you with the following information:

1. the identity of the insurer, and of any branch office through which the contract is to be concluded; the commercial register with which the legal entity is registered, and the corresponding register number, must also be indicated;
2. the identity of a representative of the insurer in the Member State of the European Union in which you are resident, if there is such a representative, or the identity of a person other than the insurer who is operating commercially, if you have business dealings with such person, and the capacity in which that person is acting in vis-à-vis yourself;
3. a) the address of the insurer at which documents may be served, and any other address relevant to the business relationship between the insurer and yourself, in the case of legal entities, associations of persons or groups of persons, also the name of a person authorised to represent them; insofar as the notification is made by transmitting the contractual provisions, including the general terms and conditions of insurance, the information must be in a prominent, clear form;

   b) *any other address that is relevant to the business relationship between a representative of the insurer, or of another person operating commercially in accordance with No. 2, and yourself, in the case of legal entities, associations of persons or groups of persons, also the name of a person authorised to represent them; insofar as the notification is made by transmitting the contractual provisions, including the general terms and conditions of insurance, the information must be in a prominent, clear form;*
4. the main business activity of the insurer;
5. information concerning the existence of a guarantee fund or of other compensation arrangements; the name and address of the guarantee fund are indicated;
6. the essential features of the insurance benefit, in particular information on the

type, scope and due date of the benefit provided by the insurer;

7. the total price of the insurance, including all taxes and other price components, whereby the premiums are to be itemised if the insurance agreement is to comprise several separate insurance contracts, or, if an exact price cannot be indicated, information on the basis used for its calculation which enables you to verify the price;

8. a) any additional costs incurred, stating the total amount to be paid, as well as possible further taxes, fees or costs which are not paid via or billed by the insurer;

   b) all costs incurred by yourself for the use of means of distance communication, if such additional costs are billed;

9. details regarding payment and fulfilment, in particular the method of payment of the premiums;

10. any limitation of the period of validity of the information provided, for example the period of validity of time-limited offers, in particular with regard to the price;

11. an indication that the financial service relates to financial instruments which, due to their specific characteristics or to the operations to be carried out, are subject to specific risks, or the price of which is subject to fluctuations on the financial market over which the insurer has no control, and that amounts earned in the past are not indicative of future returns; the respective circumstances and risks are to be indicated;

12. information as to how the contract is established, in particular as to the beginning of the insurance and of the insurance cover, as well as to the duration of the period during which the applicant is to be bound by the application;

13. the existence or non-existence of a right of revocation, as well as the conditions, the details of its exercise, in particular the name and address of the person to whom such revocation is to be addressed, and the legal consequences of revocation, including information regarding the amount that you may be required to pay in the event of revocation; insofar as the notification is made by transmitting the contractual provisions, including the general terms and conditions of insurance, the information must be in a prominent, clear form;

14. a) information regarding the term of the contract;

    b) information regarding the minimum term of the contract;

15. information concerning the termination of the contract, *in particular regarding the contractual terms and conditions of termination, including any contractual penalties*; insofar as the notification is made by transmitting the contractual provisions, including the general terms and conditions of insurance, the information must be in a prominent, clear form;

16. the Member States of the European Union the law of which the insurer uses as a basis for establishing relations with yourself prior to the conclusion of the insurance contract;

17. the law applicable to the contract, a provision in the contract concerning the law applicable to the contract or the court having jurisdiction;

18. the languages in which the terms and conditions of the contract, and the preliminary information referred to in the present subdivision, will be communicated, as well as the languages in which the insurer undertakes, with your consent, to conduct communications during the term of this contract;

19. the possibility for you to have access to an out-of-court complaint and appeal procedure and, where applicable, the prerequisites for such access, expressly stating that the possibility for you to have recourse to the courts remains unaffected;

20. name and address of the competent supervisory authority, as well as the possibility of lodging a complaint with this supervisory authority.

Subdivision 2
Additional duties to inform with regard to this occupational disability insurance

The insurer must provide you with the following information with regard to this occupational disability insurance, in addition to the above information:

1. information in euros regarding the amount of the costs included in the calculation of the premium; the acquisition costs included in the calculation must be indicated as a uniform total amount, and the other costs included in the calculation must be indicated as a proportion of the annual premium, indicating the respective term; in the case of the other costs included in the calculation, the administrative costs included in the calculation must additionally be indicated separately as a proportion of the annual premium, indicating the respective term;

2. information in euros regarding possible other costs, in particular regarding costs that may arise on a one-off basis or for a special reason;

3. information regarding the principles of calculation and standards applicable to the calculation of surpluses and surplus sharing;

4. information in euros regarding the surrender values that can be considered;

5. information in euros regarding the minimum insurance amount for conversion to fully paid-up or premium-reduced insurance, and regarding the benefits from fully paid-up or premium-reduced insurance;

6. the extent to which the benefits referred to in nos. 4 and 5 are guaranteed; the information is to be given in euros;

7. information regarding the funds on which the insurance is based, and concerning the nature of the assets held therein;

8. general information regarding the tax regime applicable to this type of insurance;

9. a reduction in performance due to costs in percentage points (effective costs) until the start of the disbursement phase;

10. an indication that the term occupational disability used in the terms and conditions of insurance does not correspond to the term occupational disability or reduction in earning capacity within the meaning of social law, or to the term occupational disability within the meaning of the terms and conditions of insurance in daily sickness allowance insurance.

Subdivision 3
Additional duties to inform with this health insurance

The insurer must provide you with the following information with regard to this health insurance, in addition to the above information:

1. information in euros regarding the amount of the costs included in the calculation of the premium; the acquisition costs included in the calculation must be indicated here as a uniform total amount, and the other costs included in the calculation must be indicated as a proportion of the annual premium, indicating the respective term; in the case of the other costs included in the calculation, the

administrative costs included in the calculation must additionally be indicated separately as a proportion of the annual premium, indicating the respective term;

2. information in euros regarding possible other costs, in particular regarding costs that may arise on a one-off basis or for a special reason;
3. information on the effects of rising healthcare costs on future premium development;
4. information regarding the possibilities of limiting premiums in old-age, in particular the possibilities of changing to the basic tariff, or to other tariffs in accordance with section 204 of the Insurance Contract Act, and of agreeing on exclusions from benefits, as well as on the possibility of a reduction in premium in accordance with section 152 (3) and (4) of the Insurance Supervision Act;
5. an indication that it is generally impossible to switch from private to statutory health insurance at an advanced age;
6. information that switching within private health insurance at an advanced age may entail higher premiums, and may be limited to a change to the basic tariff;
7. a summary in euros of the premium development over the ten-year period preceding the offer; the monthly premium must be indicated that would have been payable in each of the ten years preceding the offer, if the insurance contract had been concluded at that time by a person of the same sex as you with a starting age of 35; if the tariff offered has not yet existed for ten years, the time of introduction of the tariff is to be taken into account, and it is to be pointed out that the authoritativeness of the summary is limited due to the short period of time that has passed since the tariff was introduced; in addition, the development of a comparable tariff is to be indicated that has already existed for ten years.

(Place), (date), (signature of the policyholder)

Notice on drafting:

The supplement in brackets for life insurance and for occupational disability insurance, to which section 152 of the Insurance Contract Act applies accordingly in accordance with section 176 of the Insurance Contract Act, reads as follows: “30”.

The words **“the key information document has been made available and”** are to be inserted with insurance products for which a key information document is to be drawn up in accordance with Regulation (EU) No 1286/2014. The words **“the PEPP key information document has been made available and”** are to be inserted with insurance products for which a PEPP key information document is to be drawn up in accordance with Regulation (EU) 2019/1238.

The item entitled **“the insurance policy”** is not to be included in the case of the instruction of the insured person of a contract in accordance with section 7a (5) sentences 3 and 4 of the Insurance Contract Act.

The item entitled **“the product information sheet on insurance products”** is only to be included if a product information sheet on insurance products is to be provided in accordance with section 4 of the Information Obligation Ordinance on the Insurance Contract Act. The words **“the product information sheet on insurance products”** are to be replaced by the words **“the product information sheet”** in the case of retirement provision and basic pension contracts for which an individual product information sheet is to be drawn up in accordance with section 7 (1) of the

Pension Contracts Certification Act (*Altersvorsorgeverträge-Zertifizierungsgesetz*).

(repealed)

The following is to be inserted here: name/firm name and address of the addressee of the revocation at which documents may be served. Additionally, the following may be stated: fax number and e-mail address. If you provide, or are obliged to provide, a function with which the policyholder may revoke his or her contractual acceptance, add the following sentence after that:
"You can also exercise your right of revocation online at … [State Internet address or other suitable indication of where the revocation function is available]. If you use this online function, we will promptly provide you on a permanent data carrier (such as via an e-mail) with a confirmation of receipt containing information on the content of the revocation notice, as well as the date and time of its receipt."

The amount may also be denominated in other documents, such as in the application; the supplement in brackets will then be worded as follows, depending on the structure: "the amount designated in the application/in ... on p. .../at no. ... ".

For life insurance, and for occupational disability insurance, to which section 152 of the Insurance Contract Act applies accordingly in accordance with 176 of the Insurance Contract Act, the supplement in brackets reads as follows for cases falling under section 152 subsection (2) number 2 of the Insurance Contract Act:
"The insurer must disburse to you the surrender value in this case, including surplus sharing."

If the insurance contract is concluded with an associated contract, the following sentence is added at the end of the paragraph on "Consequences of revocation":
"If you have made effective use of your right of revocation with regard to the insurance contract, you are also no longer bound by a contract associated with the insurance contract. An associated contract is deemed to exist if it is linked to the revoked contract and relates to a service of the insurer or of a third party on the basis of an agreement between the third party and the insurer. You may not incur any costs as a result of exercising the right of revocation."

In the case of life insurance and occupational disability insurance, to which section 152 of the Insurance Contract Act applies accordingly in accordance with section 176 of the Insurance Contract Act, the supplement in brackets is to read "24 months and 30 days".

The information listed and italicised under Division 2 subdivision 1 nos. (2), (3)(b), nos. (5), (8)(a) and (b), and nos. (10), (11) and (14)(b), is to only be included in the notice regarding revocation if it is relevant to this present contract. The italics are to be removed if it is included. Information is to be included in full even if it is only partially relevant, for example if in the case of no. 8(a) there are only additional costs, but not further taxes which are not paid via or billed by the insurer. If information is not included in accordance with the above stipulation, the sequential numbering is to be adjusted accordingly (for example, if no. 8 is not included, no. 9 becomes no. 8, etc.). Points (a) and (b) provided for in nos. 3, 8 and 14 are in each case only to be used if both the information in (a) and that in (b) is included. The words in italics "*, in particular regarding the contractual terms and conditions of*

termination, including any contractual penalties" in no. 15, and ", *a provision in the contract concerning the law applicable to the contract or the court having jurisdiction"* in no. 17, are in each case only to be included if they are relevant to the contract in question. The italics are to be omitted in the event of inclusion. If no further subdivisions follow, the heading "subdivision 1" is to be removed, and the word "subdivision" in no. 18 replaced by the word "Division".

This subdivision is only to be inserted for occupational disability insurance, life insurance and accident insurance with return of premiums. This applies to life insurance subject to the proviso that the words "occupational disability insurance" are to be replaced in each case by the words "life insurance", and the information in no. 10 is to be omitted. This applies to accident insurance with return of premiums, subject to the proviso that the words "occupational disability insurance" are to be replaced in each case by the words "accident insurance with return of premiums", and that only the information in nos. 3 to 8 is to be included.
The information under no. 7 is only to be inserted for unit-linked life or occupational disability insurance, or for unit-linked accident insurance with return of premiums.
The information under no. 9 is only to be inserted for life and occupational disability insurance contracts which provide insurance cover for a risk where the insurer's obligation is certain to occur. The italics are to be omitted if the information under no. 7 or no. 9 is included.
If information is not included in accordance with the above stipulations, the sequential numbering is to be adjusted accordingly (for example, if no. 7 is not included, no. 8 becomes no. 7, etc.). The last item of information included in the notice regarding revocation in this subdivision is to end with the punctuation mark ".".

This subdivision is only to be inserted in the case of substitutive health insurance. If it is the second subdivision, the heading **"subdivision 3"** is to be replaced by the heading **"subdivision 2"**.

In the case of instruction of the insured person of a contract in accordance with section 7a (5) sentences 3 and 4 of the Insurance Contract Act, the supplement in brackets is to read "of the insured person".

The place, date and signature line may not be necessary. In this case, the information is to be replaced either by the words "End of the revocation notice" or by the words "Yours, [insert: firm name of insurer]".