CONTRACT NO : MGENIB1100884NNP

INFORMATION NOTICE

Association Internationale des Interprètes de Conférence (AIIC)

Optional insurance cover

The Association Internationale des Interprètes de Conférence (AIIC) has arranged a Life and Invalidity insurance plan for eligible Conference Interpreting Agents (ACIs). This voluntary plan is intended for ACIs during periods when they are not working under contract with a European Institution or covered by the compulsory insurance policy provided by the European Commission (referred to as "Provision of sickness and accident insurance services for Conference Interpreting Agents (ACIs)").

This plan offers Life and Invalidity benefits from the first euro. Insured ACIs do not need to provide evidence of coverage under a national Social Security scheme to receive benefits. However, if applicable, any reimbursements received from national Social Security systems may be taken into account when calculating the benefits paid under this plan.

AIIC is responsible for negotiating and setting up the insurance plan with the Insurer. However, each Insured Member remains solely responsible for fulfilling all obligations under the plan, such as paying premiums and submitting the necessary documentation in case of a claim.

This insurance coverage is governed by French law and by the provisions set out in Tome II of the French Mutual Insurance Code (*Code de la Mutualité*).

The rights and responsibilities under this plan concern:

- The Policyholder : the Association Internationale des Interprètes de Conférence (AIIC),
- The Insured Members: individual members of AIIC who join the plan,
- The Insurer: MGEN, represented by VYV International Benefits.

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Lump sum in case of death all causes	
Amount	Three times the average number of days worked over the past three years, multiplied by the daily remuneration applicable at the time of death
Minimum	**50,000 EUR**
Maximum	**150,000 EUR**
Coverage	Coverage is provided during Inactive days.

Lump sum in case of permanent invalidity	
If the "T" invalidity rate is equal or exceeds 20%	Three times the average number of days worked over the past three years, multiplied by the daily remuneration applicable at the time of invalidity event **within the limit of 250,000 EUR x "T"**
If the "T" invalidity rate is below 20%, no lump sum will be paid.	
Coverage in case of Accident	Coverage is provided during Inactive days.
Coverage in case of Illness	Coverage is provided during Active and Inactive days.

Temporary incapacity all cause	
Daily benefits	**Amount**
Deductible period	60 days
Amount	**First 365 days of incapacity event (deductible period included):** daily benefit corresponding to 50 % of the Daily remuneration applicable at the time of the incapacity event **From 366th day to 730th days:** daily benefit corresponding to 35 % of the Daily remuneration applicable at the time of the incapacity event
Maximum duration	730 days
Coverage	Coverage is provided during Inactive days.

Coverage applicable to Conference Interpreting Agents (ACIs) with fewer than 50 days of work per year over the past three years and/or over the age of 65 – on condition that at least one day was worked in the 12 months preceding affiliation.

Lump sum in case of death all causes	
Amount	Three times the average number of days worked over the past three years, multiplied by the daily remuneration applicable at the time of death
Maximum	**50,000 EUR**
Coverage	Coverage is provided during Inactive days.

Temporary incapacity all cause	
Daily benefits	**Amount**
Deductible period	90 days
Amount	Daily benefit corresponding to 35 % of the Daily remuneration applicable at the time of the incapacity event
Maximum duration	365 days
Coverage	Coverage is provided during Inactive days.

Lump sum in case of permanent invalidity
No invalidity coverage offered

SECTION 1 - GENERAL PROVISIONS REGARDING THE COVERAGE

Article 1. Start, duration, renewal, and termination of coverage

1.1 Membership

Natural persons who meet the following conditions may join the coverage:

- **be accredited as a Conference Interpreting Agent (ACI) at the EU Institutions,**
- **must have worked at least one day during the rolling year preceding the date of enrolment in this coverage.**

Application for membership to this cover is made by an individual application form filled out, dated and signed by the insurance applicant.

This individual application form specifies the identity, the elements necessary to determine the coverage and to calculate the premium and must contain the Insured Member's consent to the insurance.

The Insured Member must acknowledge that he/she has read the pre-contractual documents and the information leaflet.

The Insured Member's membership to the insurance is established by a certificate of insurance, which mentions in particular:

- the membership number,
- the contract number,
- the effective date of membership,
- the last name(s) and first name(s) of the Insured Member,
- the nature and amount of the benefits,
- the amount of the corresponding premium and the terms of payment,
- any specific provisions.

1.2 Effective date and renewal

Eligible Conference Interpreting Agents (ACIs) may join the insurance coverage at any time. The sole condition for initial eligibility is that the individual must have been accredited and performed at least one day of interpreting duties during the rolling year preceding the date of enrolment in this coverage.

Insurance cover takes effect following receipt by the Administrator of the whole premium payment and receipt of the complete application file. The Administrator needs to receive the following completed forms:

- Application form,
- Designation of beneficiary's form.

The insurance coverage takes effect on the date mentioned on the certificate of insurance.

Thereafter, coverage shall be automatically renewed on January 1st of each year. The Administrator – Henner – shall verify that any individual whose coverage is renewed has performed at least one day of interpreting duties during the rolling year immediately preceding the renewal date.

1.3 Termination of coverage

Once admitted to the Insurance and subject to the penalties provided in the event of a misrepresentation, the Insured Member may not be excluded from the coverage as long as he/she meets the conditions to be covered by the benefits.

The Insured Member's membership may be terminated:

- **At the Insurer's initiative:**
  - if the Insured Member does not pay the premiums **(coverage will cease after applying the procedure stipulated in the event of non-payment of premiums indicated in Section 7),**
  - if the contract between MGEN and the European Commission for ACIs, referenced as "Provision of sickness and accident insurance services for Conference Interpreting Agents (ACIs)" is terminated,
  - on the date the Insured Member no longer meets the conditions to be covered,
  - in the event of reluctance to submit supporting documents or misrepresentation,
  - on the day of the Insured Member's death.

- **At the Insured Member's initiative:** on the annual expiry date of the membership, which is set on December 31st, by notifying

the Administrator at least two (2) months before this date, i.e. by October 31st at the latest. The termination is effective on December 31st, at midnight, of the year in which it is notified.

The Insured Member may notify his/her request for termination under the conditions provided for in Article L.221-10-3 of the *Code de la Mutualité* (the French Mutual Insurance Companies Code), in the following ways, at the Insured Member's discretion:

- either by simple letter or any other durable medium
- or by a declaration made at the head office or at one of the Insurer's branches,
- or by an extrajudicial act,
- or when the membership to this coverage is made by a remote communication method, by the same method of communication,
- or by any other means provided for in the contract between AIIC and the Insurer.

In addition, the Insured Member's membership is automatically terminated in the event of termination of the group insurance contract between AIIC and the Insurer.

Article 2. Insured Member's undertakings

The Insured Member is required to always justify the declarations made to the Insurer as part of the membership.

In the event of an omission or misrepresentation by the Insured Member, the Insurer is entitled, pursuant to articles L. 221-14 and L. 221-15 of the *Code de la mutualité* (the French Mutual Insurance Compagnies Code), either to invoke the nullity of the membership, or to continue its execution under new conditions it will set, or to request the termination of the membership in the event of refusal of the new conditions.

Article 3. Modifications

The terms and conditions of the agreement shall take into account the relevant legislation in force on the effective date of the contract between AIIC and the Insurer. However, should the legislation be modified, the Insurer reserves the right to modify the coverage as soon as possible from the effective date of the new provisions.

Nevertheless, the Insured Member has the possibility to request within thirty (30) days, the termination of the coverage without notice. The termination shall become effective on the first (1st) day of the calendar month following the request of the Insured Member, or from the date of the proposed modifications, if later.

In this latter case, all benefits and premium amounts are maintained until the termination date regardless of the proposed modifications.

Article 4. Limitation period

4.1 Time limit

All actions deriving from this coverage are limited to two (2) years after the event giving rise to them, in accordance with article L.221-11 of the *Code de la Mutualité* (the French Mutual Insurance Companies Code).

However, the two-year limit shall start:

- in the event of non-disclosure, omission, false or inaccurate statement as to the risk incurred from the Insured Member, as of the day on which the Insurer was informed of it;
- in the event of the occurrence of the risk, as of the day when the interested parties have been informed about it, if they can prove that they were not aware of it until then.

When the Insured Member's action against the Insurer is based on the recourse of a third-party, the limitation period only begins on the date this third party initiated legal action against the Insured Member or his/her Dependent or has been compensated by the Insured Member.

In the case of the group operations referred to in III of article L. 221-2 of the French Mutual Code, the limitation period is extended to five years for incapacity for work.

The limitation period is extended to ten (10) years when, in the case of undertakings whose performance depends on how long the human life lasts for, as provided for in b of 1° of I of article L.111-1 of the *Code de la Mutualité* (the French Mutual Insurance Compagnies Code), the beneficiary is not the Insured Member and, in operations relating to accidents affecting persons, when the beneficiaries are the deceased Insured Member's dependents.

For life insurance policies, the beneficiary's actions are limited to thirty (30) years after the death of the Insured Member, at the latest.

4.2 Reasons for suspension of the limitation period

The limitation period may be interrupted by one of the ordinary grounds for interruption of the limitation period provided for in articles 2240 et seq of the *Code Civil* (the French Civil Code) and by the appointment of experts following the occurrence of a risk.

The ordinary causes of interruption of prescription provided for by the Civil Code are:

- Recognition by the debtor of the right of the party against whom he was prescribing (article 2240 of the Civil Code),
- Legal action (articles 2241 to 2243 of the Civil Code),
- A precautionary measure taken in application of the Code of Civil Enforcement Procedures or an act of forced execution (article 2244 of the Civil Code),
- The interpellation made to one of the joint and several debtors by a legal demand or by an act of forced execution, or the recognition by the debtor of the right against the person against whom he was prescribing (article 2245 of the Civil Code),
- The interpellation made to the principal debtor or his acknowledgement for the cases of prescription applicable to sureties (article 2246 of the Civil Code).
- Sending a registered letter or an electronic registered letter, with acknowledgment of receipt, by the Insurer to the Policyholder, regarding the payment of the premium, and by the Insured Member, the beneficiary or the Dependent to the Insurer, regarding the payment of the claim, may interrupt the limitation period.

4.3 Mandatory application of the limitation period

In accordance with article L.221-12-1 of the French Mutual Code, and notwithstanding article 2254 of the French Civil Code, the parties to the insurance cover may not, even by mutual agreement, modify the duration of the limitation period, nor add to the causes of its suspension or interruption.

Article 5. Forfeiture of benefits

The beneficiary who has been convicted of intentionally causing the death of the Insured Member is forfeited from the benefits of the coverage, which shall be distributed to the other beneficiaries.

The Insured Member or the beneficiary of the benefit is also forfeited of any right to compensation for the related claim:

- if they intentionally make a false declaration regarding the claim or in connection with the claim, concerning the date, nature, causes, circumstances, or consequences of the claim;
- if they knowingly provide or use inaccurate, fabricated, or falsified information or documents as proof, or use other fraudulent means to obtain the payment of benefits.

They also risk criminal prosecution by the Insurer.

Article 6. Subrogation

For the payment of compensatory health benefits, the Insurer is subrogated, up to the amount of the said benefits, to the rights and actions of the Insured Members, the beneficiaries or their dependents against liable third parties.

This subrogation is limited to the expenses the Insurer incurred, up to the amount of the share of the compensation payable by the third party who compensates the injury to the victim's physical integrity. The personal compensation for the physical or moral injuries endured by the victim and the compensation for disfigurement and loss of amenity are excluded unless the benefits paid by the Insure compensates for these parts of the claim.

Similarly, in the case of accidents causing death, the part of the compensation corresponding to the moral prejudice of the Dependents remains theirs, subject to the same conditions.

For the payment of daily allowances and invalidity benefits, the Insurer is subrogated to the rights and actions of the Insured Members, the beneficiaries, or their Dependents against liable third parties, up to the amount of those said benefits.

The Insurer is automatically subrogated to the beneficiary of the benefits who is the victim of an accident, in its action against the liable third party, whether the third party is fully liable or not. If the beneficiary of the benefits has been directly compensated by the third party, he/she must reimburse the Insurer of the benefits paid by the latter.

The beneficiary of the benefits who, through negligence or voluntary renunciation, makes the reimbursement impossible, must reimburse the benefits received.

The Insurer waives any right of recourse against the Policyholder.

Article 7. Personal data protection

Pursuant to the Regulations (EU) 2016/679 of 27 April 2016 on the protection of individuals concerning the processing of personal data and on the free movement of such data (known as General Data Protection Regulation) and for the purpose of the management of the insurance coverage, the personal data of the Insured Member may be transferred to the Insurer and to its delegates, service providers, subcontractors or reinsurers. Insured Members are informed that processes concerning them, and their Dependents if any, are implemented for the signing, management and execution of this insurance coverage along its commercial management. Personal data may also be used for control operations, fight against fraud and money laundering and the financing of terrorism, search for beneficiaries of unpaid life contracts and the implementation of legal and regulatory provisions, with respect of the enforcement of this cover.

Collected Data are indispensable for the implementation of these processing and are intended for the relevant departments of the Insurer as well as its outsourced Administrator and where applicable, its subcontractors, providers or partners. The Insurer is liable to ensure that this data is accurate, complete, and up to date when necessary. The data collected will be kept for the entire duration of the coverage which may be increased by legal prescriptions or in order to be compliant with the periods provided for by the CNIL *Commission Nationale de l'Informatique et des Libertés* (the French National Commission for Data Protection).

These personal data may be transferred to service providers or subcontractors which are established in countries outside of the European Union. Only countries recognized by the European Commission as providing an adequate level of personal data security, or recipients who have appropriate assurances, are eligible for these transfers.

Insured Members and/or Dependents have a right of access, rectification or deletion, limitation of the processing of their data, portability, opposition to processing, along with the right to provide instructions on the outcome of the data after their death. They can exercise their rights towards the *Data protection officer of VYV International Benefits*, located 3 Square Max Hymans, 75748 Paris CEDEX 15 or at dpo@vyv-ib.com. When exercising their rights, a proof of identification may be requested. In the event of a persistent conflict, they have the right to appeal to the CNIL on **www.cnil.fr or at 3, place de Fontenoy - TSA 80715 - 75334 Paris Cedex 07, France.**

Data related to medical information on the Insured Members may be processed for the conclusion, the management and the execution of this coverage, as their processing is necessary to fulfil the obligations and to exercise the rights of the Insurer or the rights of the Insured Members to social protection. These data are exclusively intended for the medical department of the Administrator. The exercise of rights is carried out by mail, along with a proof of identity, to the medical advisor of medical@vyv-ib.com.

Article 8. Administrative agreement

A separate administrative agreement between the Insurer and **Henner 14 boulevard du Général Leclerc, 92200 Neuilly-sur-Seine, France** is established. It specifies the operations related to this coverage that the Insurer delegates to Henner and its obligations towards the Insurer with respect to:

- **Reimbursement and payment of incapacity benefits,**
- **Collection of the required documents for the payment of permanent invalidity and death benefits,**
- **Administration of memberships,**

- **Administration and collection of premiums.**

Administration Services, as defined above, shall in practice be carried out by GIE Henner-GMC, an economic interest group ('Groupement d'Intérêt Economique') governed by the provisions of Order n° 67-821 dated 23 September 1967, of which Henner is a member.

A separate administrative agreement between the Insurer and **VYV International Benefits (VYV-IB), 3/5/7 Square Max-Hymans - 75748 Paris Cedex 15, France** is established. It specifies the operations related to this coverage that the Insurer delegates to VYV-IB, and its obligations towards the Insurer with respect to:

- **Management and payment of permanent invalidity and death benefits,**
- **Production of statistics.**

Article 9. Control authority

The Insurer's control body is *Autorité de Contrôle Prudentiel et de Résolution* (ACPR – French Prudential Supervisory Authority), 4 place de Budapest 75436 Paris Cedex 09, France.

Article 10. Settlement of disputes

The parties agree to meet in the event of any dispute, litigation, contention or claim that may arise between them, in order to do everything in their powers to reach an amicable settlement. Any dispute related to the interpretation or the execution of this coverage and which cannot be settled by mutual agreement, will be under the jurisdiction of the competent French jurisdiction.

Article 11. Information - complaints - mediation

If Beneficiaries have any queries, they should contact the Administrator Henner, located 14 boulevard du General Leclerc, 92200 Neuilly-sur-Seine, France or via email at service.qualite@henner.fr for any request or complaint related to:

- insurance enrolment conditions,
- claims,
- payment of premiums.

Receipt of the complaint shall be acknowledged within ten (10) days of its receipt, unless the reply itself is provided during this period. In any event, in accordance with the relevant legislation, the reply shall be sent within two (2) months from the date of receipt of the complaint.

If the complaint has not been settled after the reply, the Insured Members may contact customer service and forward copies of the written replies made to them, at the following address: **VYV International Benefits – Customers Department, 3 Square Max Hymans 75 748 Paris Cedex 15, France** Email: clients@vyv-ib.com.

If all complaints handling procedures are exhausted, the claimant may contact the MGEN ombudsman by regular mail: **CNPM - MÉDIATION – CONSOMMATION, 27 Avenue de la Libération 42400 SAINT-CHAMOND** or on the dedicated website: https://www.cnpm-mediation-consommation.eu.

The Ombudsman's opinion is not binding and the parties can still proceed in the competent courts. The Ombudsman is not empowered to adjudicate on the conditions for admission to insurance. The terms and conditions of the Ombudsman interventions can be found on the dedicated website for mediation on: https://www.cnpm-mediation-consommation.eu.

Article 12. Language and jurisdiction

The competent courts are the courts of France. French language shall prevail for the purpose of this coverage. Insured members may communicate with the Insurer and the Administrator in French and in English.

Article 13. Limitation provision – International sanctions

The Insurer shall not be liable to provide insurance coverage or to pay a claim or provide benefits, if such coverage, payment or benefits would subject the Insurer to any sanction, prohibition or restriction under United Nations resolutions relating to economic or trade sanctions, or under the laws and regulations of the European Union, the United States of America or any other jurisdiction.

No payment shall be made directly or indirectly to any country subject to sanctions at the time of the event, as enacted by the United Nations, the Office of Foreign Assets Control (OFAC) of the U.S. Treasury or the European Union.

Article 14. Reluctance or misrepresentation

THE CONDITIONS OF THE COVER ARE BASED ON THE DECLARATIONS PROVIDED BY THE INSURED MEMBERS.

REGARDLESS OF THE ORDINARY CAUSES OF NULLITY, ANY INACCURACY OR INTENTIONAL OMISSION MAY LEAD THE INSURER TO DECLARE THE MEMBERSHIP NULL AND VOID.

THE PREMIUMS PAID WILL THEN BE KEPT BY THE INSURER, WHO WILL BE ENTITLED TO THE PAYMENT OF ALL OVERDUE PREMIUMS AS DAMAGES.

FOR OPTIONAL INDIVIDUAL OPERATIONS, OMISSION OR MISREPRESENTATION BY THE INSURED MEMBER, WHOSE BAD FAITH IS NOT PROVEN, DOES NOT INVALIDATE THE BENEFITS PROVIDED FOR IN THE INDIVIDUAL APPLICATION FORM.

IF THE OMISSION OR UNINTENTIONAL MISREPRESENTATION IS DISCOVERED BEFORE ANY CLAIM IS MADE, THE INSURER HAS THE RIGHT TO MAINTAIN THE MEMBERSHIP SUBJECT TO A PREMIUM INCREASE ACCEPTED BY THE INSURED MEMBER. IF THE INSURED MEMBER DOES NOT AGREE, THE APPLICATION FORM OR THE COVER WILL BE TERMINATED TEN (10) DAYS AFTER NOTIFICATION IS SENT TO THE INSURED MEMBER BY REGISTERED LETTER. THE INSURER WILL REFUND THE PORTION OF THE PREMIUM PAID FOR THE PERIOD DURING WHICH THE COVERAGE NO LONGER APPLIES.

IF THE OMISSION OR UNINTENTIONAL MISREPRESENTATION IS ONLY DISCOVERED AFTER THE RISK HAS OCCURRED, THE BENEFIT IS REDUCED IN PROPORTION TO THE AMOUNT OF THE PREMIUM PAID BY THE INSURED MEMBER COMPARED TO THE AMOUNT OF THE PREMIUM THAT WOULD HAVE BEEN DUE IF THE INSURED MEMBER'S STATEMENT HAD BEEN TRUE.

SECTION 2 - DEFINITIONS

Accident: a sudden, unforeseeable, unexpected, external (outside the victim's body) event that results, directly and independently of all other causes, in an Injury and meets all of the following conditions: (i) occurs at an identifiable time and place while the Insured Member is covered under this Agreement; (ii) is not contributed to by disease, illness, mental or bodily infirmity and (iii) is not otherwise excluded under the terms of this coverage.

Annual remuneration: used to calculate the compensation due in Lump sum in case of death (all-causes) and Lump sum in case of permanent invalidity. It is equal to the Insured's Daily remuneration at the time of the compensation payment multiplied by the Insured's "average remunerated days".

Administrator: legal entity that is entrusted for a limited period, which may be renewable, with the performance, on behalf of the Insurer, of administration acts (call for contributions, payment of benefits etc...).

Application form: Form to be completed by the Insured Members whereby they accept the relevant terms and conditions, and can enroll in the coverage.

Average remunerated days (*): the Insured Person's weighted yearly average number of remunerated days over the period of the last 3 rolling years preceding the coverage effective date. The result is rounded up to the nearest integer. For the calculation of the "average remunerated days":

- a paid contract day is equivalent to 1 remunerated day,
- a paid flat-rate travel allowance or a flat-rate compensatory allowance is equivalent to 0.5 of a remunerated day,
- a paid remuneration for days not worked is equivalent to 0.67 of a remunerated day.

For the calculation purposes, only those rolling years within the above-mentioned period where the Insured had at least one remunerated day are taken into consideration. In case of justified prolonged reduction of the number of days worked (for reasons of parental leave, pregnancy, caring for a family member, study break, etc.), the average shall be calculated over the last rolling 4, or 5 years, depending on the situation.

Regardless of their "average remunerated days" each Insured is guaranteed 21 calendar days of compensation in case of incapacity for the same accident or illness. Any claim covering a timespan equal or below this guaranteed duration and duly

attested by medical certificate must be honoured in its entirety unless it can be shown that the claim falls under a situation defined in the exclusions and limitations, as enumerated further in this document.

(*): The present definition originates from the main mandatory insurance policy, as referenced in 'Call for tenders EC-SCIC/2024/OP/0001 – Provision of sickness and accident insurance services for Conference Interpreting Agents (ACIs), Annex Ib, Tender Specifications, Part 2: Technical specifications.

Claim: any random event that may incur in benefits under this coverage.

Daily remuneration (*): means the daily gross remuneration, paid to the Insured by the European Commission on its own behalf or on behalf of the other European Institutions for each day contracted as an ACI.

As a guide, the Daily remuneration applicable is in 2025:

- 744,80 EUR for experienced interpreters,
- 536,26 EUR for beginning interpreters.

The above rates and compensation payments based thereon are subject to retroactive adjustments, in line with the adjustment of the remuneration of officials and other servants of the European Union. In case of negative adjustment of rates, the Insurer has the possibility to regularise the difference in compensation paid directly to the Insured. In case of such adjustments, the Insurer will have 60 days from the notification of the new rates by the European Commission to calculate and execute the payment of the retroactive adjustments due for the benefits already paid. Within the same timeframe, the Insurer will adjust the rate of compensation applied to new claims.

(*) : The present definition originates from the main mandatory insurance policy, as referenced in 'Call for tenders EC-SCIC/2024/OP/0001 – Provision of sickness and accident insurance services for Conference Interpreting Agents (ACIs), Annex Ib, Tender Specifications, Part 2: Technical specifications.

In the event of Death, Temporary Incapacity, or Permanent Invalidity benefits, the Insurer shall determine the amount of such benefits by reference to the applicable Daily Remuneration in effect on the date of the occurrence of the event giving rise to the entitlement.

Deductible period: by deductible, we mean the period of sick leave between the starting point of the sick leave and the starting point of the guaranteed service, during which the Insured Member cannot claim the service of the services.

Inactive days: pursuant to the Agreement on Working Conditions and the Pecuniary, Regime for Conference Interpreting Agents (ACIs) recruited by the Institutions of the European Union, days on which an Insured Member:

- (a) does not have a contract to supply services to the European Institutions;
- (b) does not receive a flat-rate travel allowance or a flat-rate compensatory allowance from a European Institution;
- (c) does not receive remuneration for days not worked from a European Institution. “Days not worked” means the period (which may be up to 3 days) between 2 assignments which is too short to allow an Insured Member to return to their professional domicile;
- (d) is not travelling to and from the place of their assignment;
- (e) for reasons of service, is not obliged, on days other than those referred to under points (a), (b), (c) and (d) above, to remain away from their domicile because of the requirements of their contract.
- (f) which must be proved by official documentation provided to the Insurer to enable appropriate calculations of benefits to be made.

Illness: a physical or mental illness confirmed by a medical doctor based on a medical examination, diagnostic tests (such as blood tests, scans, or psychological assessments), or other professional evaluations.

Insurer: the organization which covers the risk guaranteed under this coverage, i.e., MGEN, a mutual insurance company, governed by the provisions of Tome II of the Code de la mutualité (the French Mutual Insurance Companies Code) and located 3 square Max-Hymans – 75 748 PARIS Cedex 15.

As part of its activities, MGEN has granted a delegation of distribution, management, and

underwriting to VYV International Benefits, a simplified joint-stock company with a share capital of 1,000,000 euros, registered with the Paris Trade and Companies Register under number 813 361 441 RCS PARIS, listed as an insurance intermediary with ORIAS under number 16002500, and whose registered office is located at 3 Square Max-Hymans, 75748 Paris Cedex 15, France

Insured Member(s): individual ACIs insured under this Voluntary Plan who are accredited as an ACI at the EU Institutions who have applied for coverage.

Reluctance: in the context of insurance refers to an Insured member's deliberate hesitation or unwillingness to disclose relevant information. This reluctance may result in the intentional withholding or minimization of facts that are material to the Insurer's risk assessment.

Voluntary Plan: insurance coverage for the payment of a lump sum in the case of death, Permanent Invalidity and annuity in the case of Temporary Incapacity from Accident or Illness that is offered in this plan to Insured Members that are eligible according to the conditions set out in these terms and conditions.

SECTION 3 - BENEFITS

Article 15. Geographical and temporal scope of coverage

- **Geographical scope of coverage** : the coverage provided under this policy is valid worldwide.
- **Temporal scope of coverage :** The insured members are covered under this policy as of the effective date specified in their Certificate of Insurance, and according to the following provisions:
  - Death and Temporary All Causes Benefits:
    Coverage is provided during inactive days only.
  - Permanent Invalidity:
    - Coverage in case of accident is provided during inactive days only.
    - Coverage in case of illness is provided in all cases.

In all cases, the insured member shall not be entitled to receive double compensation resulting from concurrent coverage under both this optional insurance policy and the compulsory insurance policy provided by the European Commission, referred to as the "Provision of sickness and accident insurance services for Conference Interpreting Agents (ACIs)." Any benefits payable under this optional insurance policy shall be adjusted accordingly to prevent duplication of payments.

Article 16. Reference salary

16.1 Basis for calculating benefits

The benefits are based:

- For the Lump sum in case of death all-causes and the Lump sum in case of Permanent invalidity: on the Annual remuneration of the Insured Member.
- For the Temporary incapacity all-causes benefit: on the daily Remuneration of the Insured Member.

16.2 Benefits currency and payment terms

Benefits are payable in euros. If bank charges are billed due to the domiciliation of the Insured's bank account, they will remain at the latter's expense (deduction of the amount of the benefit due).

If a conversion is required from one currency to another, the Insurer will use the exchange rate set by the Bank of France on the last day of the month before the claim is settled.

Under no circumstances shall the Insurer be held liable for any damage that the Beneficiary(ies) or the Insured Member(s) may suffer as a result of fluctuations in exchange rates, nor for any bank charges they may incur when receiving payment of a benefit in a foreign currency or when receiving a bank transfer from the Insurer.

Article 17. Claims processing

The claim processing described herein follows the mains terms as those set out in the main mandatory insurance policy, as referenced in 'Call for tenders EC-SCIC/2024/OP/0001 – Provision of sickness and accident insurance services for Conference Interpreting Agents (ACIs), Annex Ib, Tender Specifications, Part 2: Technical specifications'.

The documents to be submitted in the event of a claim are detailed in Section 4 - 'Documents to be provided' of this information notice.

The procedures for medical examinations are defined in Section 5 - 'Medical examinations and litigations' of this information notice.

17.1 – Claim processing in case of temporary incapacity

The Insured shall send all documents as stated in Section 5 concerning the incapacity to work to the Insurer within 5 calendar days from the day following the occurrence of the accident or manifestation of the illness. The same deadline shall be valid in case of a relapse and extension of the incapacity period. The postmark, e-mail date or the automatic acknowledgement of receipt in case of online upload will act as proof of submission.

To assess the admissibility of the claim, apart from the medical certificate, the Insurer may request the Insured to supply any other certificates and proofs which he may reasonably require.

Claims relating to temporary incapacity arising from accidents or illnesses should be handled by the Insurer and the decision transmitted to the Insured within one month of receipt of the complete claim. A complete claim consists of medical certificate and a claim form.

The one-month period can be prolonged by another month when an external medical examination is requested by the Insurer.

17.2 – Claim processing in case of permanent invalidity

For claims relating to permanent invalidity the Insurer shall endeavor to send a settlement proposal to the Insured within one month of receipt of the Insured filing for invalidity compensation. If the Insurer is not able to send the settlement proposal within the time specified above, it will inform the Insured about the precise reasons for the delay and the deadline will be extended by one month.

17.3 – Claim processing in case of death

For claims relating to death the Insurer shall endeavor to send a settlement proposal to the Insured's beneficiaries within one month of receipt of the death certificate. If the Insurer is not able to send the settlement proposal within the time specified above, it will inform the Insured's beneficiaries about the precise reasons for the delay and the deadline will be extended by one month.

The Insurer shall not be held liable for delays caused by the Insured / the Insured's beneficiaries to deliver the documents or information required.

Payments are to be made within 14 calendar days of the Insurer's decision / the acceptance date of the settlement proposal.

17.4 – General provisions regarding claims processing

The Insurer shall pay compensation directly to the Insured or, in the event of death to the Beneficiaries as detailed in article 23 "Beneficiaries in case of the Insured Member's death".

In the event of an uninterrupted period of temporary incapacity, provisional payments to the Insured (compensation and reimbursement of medical expenses) shall be made every four weeks, provided a medical certificate attests that the incapacity will continue beyond the four-week period.

Any sum overpaid can be recovered. The request for recovery must be made no later than five years from the date on which the sum was paid. Where the Insurer is able to establish that the Insured deliberately misled the Insurer with a view of obtaining the sum concerned, the request for recovery shall not be invalidated even if this period has elapsed.

Any tax liability or other consequences resulting from a compensation or reimbursement paid under this policy are the sole responsibility of and are borne entirely by the Insured. Upon request and up to 48 months from the payment date, the Insurer will provide a statement confirming the amounts paid to the Insured for the requested fiscal year.

Upon written request and within 30 days from the receipt of the payment, the Insured is entitled to interest on late payment at the rate applied by the European Central Bank for its main refinancing operations in Euros (the reference rate), plus eight points. The reference rate shall be the rate in force on the first day of the month in which the payment period ends, as published in the C series of the Official Journal of the European Union.

Interest on late payment shall cover the period running from the day following the due date for payment up to and including the date of actual payment.

Article 18. Beneficiaries in case of the Insured Member's death

The Insured Members designate one or more beneficiary (ies) either by means of the beneficiary designation form, or by authentic instrument, or by private deed. When the beneficiary is designated by name, the Insured Member must mention the contact details of this person/these persons in order to facilitate the lump sum payment in case of death.

In the absence of written designation of beneficiary or in case of prior death of the designated beneficiaries, the lump sum shall be allocated as follows:

- **to the Insured Member's spouse if not judicially separated,**
- **fail him/her, to the civil union partner or any other equivalent civil union,**
- **fail him/her, to the born or unborn children of the Insured Member, in equal shares between them, the share of any predeceased children returning to their own children or their siblings if they are childless,**
- **fail them, to the father and mother, in equal shares between them, or to the surviving parent in the event one is predeceased,**
- **fail them, to any other heirs.**

In case of death of the Insured Member and of one or several designated beneficiaries during a single event without the possibility to determine the order of deaths, the Insured Member is presumed to have survived for the purposes of determining the beneficiaries of the lump sum.

SECTION 3.1 - Coverage applicable to Conference Interpreting Agents (ACIs) with an average of 50 days of work minimum over the past three years and under the age of 65

Article 19. Lump sum in case of death (all-causes)

In the event of the death of the Insured Member, a lump sum be paid to the designated beneficiary(ies), if applicable, as detailed below:

Lump sum in case of death all causes	
Amount	Three times the average number of days worked over the past three years, multiplied by the daily remuneration applicable at the time of death
Minimum	**50,000 EUR**
Maximum	**150,000 EUR**
Coverage	Coverage is provided during Inactive days.

The Insurer pays the benefits in accordance with the information provided when the claim is processed. This payment releases the Insurer from any obligation in the event that it is subsequently notified of a specific designation of beneficiary(ies).

Article 20. Lump sum in case of permanent invalidity

The Insured Member is entitled to the payment of a lump sum in case of invalidity when the Insurer recognizes that the invalidity rate "T" is equal or exceeds 20%.

The nature and degree of invalidity are determined by the Insurer's Medical Advisor. The invalidity rate "T" is established in accordance with the provisions set out in Annex 1."

The amount of the lump sum – paid in a single instalment – is determined based on the Annual remuneration and the invalidity rate set by the Insurer's Medical Advisor:

Lump sum in case of permanent invalidity	
If the "T" invalidity rate is equal or exceeds 20%	Three times the average number of days worked over the past three years, multiplied by the daily remuneration applicable at the time of invalidity event **within the limit of 250,000 EUR x "T"**
If the "T" invalidity rate is below 20%, no lump sum will be paid.	
Coverage in case of Accident	Coverage is provided during Inactive days.

Coverage in case of Illness	Coverage is provided during Active and Inactive days.

Specific provisions regarding hearing loss:
In the event that the functional invalidity rate related to total hearing loss in one ear reaches or exceeds T = 18%, such impairment shall be automatically deemed to constitute a T=100% permanent invalidity rate for the purposes of this coverage.
In the event that a partial hearing loss of at least 30% affects both ears, such impairment shall be automatically deemed to constitute a T=100% permanent invalidity rate for the purposes of this coverage.

Payment of the invalidity lump sum will result in the cessation of Temporary incapacity all causes benefit. If the Lump Sum in Case of Permanent Invalidity has already been paid to the Insured Person, they shall no longer be eligible for coverage under the Temporary Incapacity All Causes benefit for this event.

The amounts already paid under the "Temporary incapacity all causes" benefit will not be deducted from the lump sum paid in the event of permanent invalidity.

Article 21. Temporary incapacity all causes

21.1 Deductible period

In the event of total incapacity for work of an Insured Member, the right to daily indemnities takes effect after a waiting period of **60 days for the temporary incapacity coverage**.

This period begins on the first day of each incapacity event and consists of an uninterrupted sequence of days of total incapacity for work.

21.2 Implementation

In the event of cessation of work of an Insured Member following total work incapacity due to an illness or an accident, recognized by the Insurer, the latter pays to the Insured Member daily benefits calculated in accordance with the terms set out in this information notice.

Daily benefits cease to be payable:

- **on the date on which the Insurer or a Social Security scheme awards a disability pension, a disability annuity or an old-age pension from a basic scheme,**
- **in case of permanent invalidity,**
- **on the date on which the cumulative duration of daily benefits paid by the Insurer reaches 730 days,**
- **on the date of the Insured Member's death.**

Legal maternity or paternity leave are excluded from this benefit.

In the event of invalidity, any benefits payable under this policy shall act as a top-up to any amounts received from other sources, including but not limited to social security schemes. The total compensation received by the Insured Member shall not exceed the covered amount under this policy.

21.3 Amount

The amount is set out below, as from the **61st day of the incapacity event** (deductible period):

Temporary incapacity all cause	
Daily benefits	**Amount**
Deductible period	60 days
Amount	**First 365 days of incapacity event (deductible period included):** daily benefit corresponding to 50 % of the Daily remuneration applicable at the time of the incapacity event **From 366th day to 730th days:** daily benefit corresponding to 35 % of the Daily remuneration applicable at the time of the incapacity event
Maximum duration	730 days
Coverage	Coverage is provided during Inactive days.

21.4 Relapse

In the event of a new incapacity event occurring within two (2) months of resumption of work, justified by the same cause and recognized as such by the Insurer, the benefits will resume on the same

basis, without application of the deductible period, if the policy is still in force.

No deductible is then applied and benefits are paid and calculated as for the initial incapacity event. The coverage in effect on the date of the initial incapacity event is retained.

SECTION 3.2 - Coverage applicable to Conference Interpreting Agents (ACIs) with fewer than 50 days of work per year over the past three years and/or over the age of 65

Article 22. Lump sum in case of death (all-causes)

In the event of the death of the Insured Member, a lump sum be paid to the designated beneficiary(ies), if applicable, as detailed below:

Lump sum in case of death all causes	
Amount	Three times the average number of days worked over the past three years, multiplied by the daily remuneration applicable at the time of death
Maximum	**50,000 EUR**
Coverage	Coverage is provided during Inactive days.

The Insurer pays the benefits in accordance with the information provided when the claim is processed. This payment releases the Insurer from any obligation in the event that it is subsequently notified of a specific designation of beneficiary(ies).

Article 23. Temporary incapacity all causes

23.1 Deductible period

In the event of total incapacity for work of an Insured Member, the right to daily indemnities takes effect after a waiting period of **90 days for the temporary incapacity coverage**.

This period begins on the first day of each incapacity event and consists of an uninterrupted sequence of days of total incapacity for work.

23.2 Implementation

In the event of cessation of work of an Insured Member following total work incapacity due to an illness or an accident, recognized by the Insurer, the latter pays to the Insured Member daily benefits calculated in accordance with the terms set out in this information notice.

Daily benefits cease to be payable:

- **on the date on which the Insurer or a Social Security scheme awards a disability pension, a disability annuity or an old-age pension from a basic scheme,**
- **in case of permanent invalidity,**
- **on the date on which the cumulative duration of daily benefits paid by the Insurer reaches 365 days,**
- **on the date of the Insured Member's death.**

Legal maternity or paternity leave are excluded from this benefit.

In the event of invalidity, any benefits payable under this policy shall act as a top-up to any amounts received from other sources, including but not limited to social security schemes. The total compensation received by the Insured Member shall not exceed the covered amount under this policy.

23.3 Amount

The amount is set out below, as from the **91st day of the incapacity event** (deductible period):

Temporary incapacity all cause	
Daily benefits	**Amount**
Deductible period	90 days
Amount	Daily benefit corresponding to 35 % of the Daily remuneration applicable at the time of the incapacity event
Maximum duration	365 days
Coverage	Coverage is provided during Inactive days.

23.4 Relapse

In the event of a new incapacity event occurring within two (2) months of resumption of work, justified by the same cause and recognized as such by the Insurer, the benefits will resume on the same bases, without application of the deductible period, if the policy is still in force.

No deductible is then applied and benefits are paid and calculated as for the initial incapacity event. The coverage in effect on the date of the initial incapacity event is retained.

Article 24. Indexation of the death benefits from the date of death of the Insured

According to Loi n° 2014-617 du 13 juin 2014 relative aux comptes bancaires inactifs et aux contrats d'assurance vie en déshérence (law related to inactive bank accounts and unclaimed life insurance contracts) called « Loi Eckert » and according to R.132-3-1 of Code des assurances, which became effective on January 1st, 2016, the death benefits which are due to natural persons beneficiaries will be indexed on an annual basis.

This death benefit must be indexed from the date of death of the Insured Member and until the Insurer has received all necessary documents for the payment of the death benefits or failing this, until the transfer of the funds to the Caisse des dépôts et consignation.

Between the date of death of the Insured and the information of said death by the Insurer, the death benefits are indexed and generate interests, free of charge and for each calendar year with a minimum rate equal to the lowest of the two following rates as per decree of Conseil d'Etat;

- The average of the last twelve (12) months of the average rate of the loans of France
- The latest average rate of the loans of the France available as of November of the previous year

SECTION 4 - DOCUMENTS TO BE PROVIDED

The supporting documents to be provided in the event of a claim for the payment of benefits are:

Article 25. Documents to be provided in case of Death

Benefits in relation with the death of the Insured Member are paid provided the following documents are transmitted:

- a death certificate,
- a medical certificate attesting to the death,
- documents proving the status of the beneficiary(ies) as well as any designation of beneficiary(ies),
- a copy of the family record book, if applicable,
- a bank statement of the beneficiary(ies),
- a dated and signed photocopy of both sides of the beneficiary(ies)' valid ID and, if applicable, that of his/her representative(s).

In addition, Henner, as the administrator, shall provide the Insurer with proof of the average number of days worked along with the remuneration applicable to each year worked.

Article 26. Documents to be provided in case of Permanent invalidity

Benefits in relation with the Permanent invalidity of the Insured Member are paid provided the following documents are transmitted:

- medical certificates issued by the attending physician specifying the rate of the permanent invalidity,
- a bank statement of the Insured member,
- a dated and signed photocopy of both sides of the Insured Person's ID.

In addition, Henner, as the administrator, shall provide the Insurer with proof of the average number of days worked along with the remuneration applicable to each year worked.

Article 27. Documents to be provided in case of temporary incapacity

In the event of temporary incapacity:

- an incapacity for work form completed and signed by the Insured member,
- medical certificates issued by the attending physician specifying the start and end dates of the incapacity event,
- any other document required for the settlement of benefits due,
- a bank statement from the Insured member.

SECTION 5 - MEDICAL EXAMINATIONS AND LITIGATIONS

Article 28. Medical examinations

The Insurer may arrange for a physician designated by it to carry out a medical examination of an

Insured member making a claim or receiving benefits under the coverage.

In the event of temporary incapacity all causes (permanent invalidity is excluded from this clause), the Insurer's medical advisors must have free access to the insured member, either at their place of treatment or at home, every working day, with a prior notice of 15 days, to assess their state of health.
Likewise, the Insured member must attend the summonses of the doctors appointed by the Insurer. If the Insured member refuses to undergo this medical check-up, cover and benefits will be suspended after formal notice has been sent to the last known address in the Insured member's file, or by sending formal notice by e-mail to the Insured member's e-mail address if known to the Insurer.

During the medical examination, the Insured member may be assisted by his or her attending physician, or any other physician of his or her choice. The Insurer reserves the right, based on the conclusions of the medical examination, to modify or suspend the provision of the benefits concerned. Prior to any modification or interruption, the Insurer will notify the Insured member by registered letter of the results of the medical examination and the consequences for the payment of the benefits concerned.

The Insurer's decisions based on the conclusions of the Medical Examiners are notified to the Insured member by registered mail; the Insured member may contest the validity of these decisions within twenty (20) days of their dispatch, by means of a detailed medical certificate sent by registered mail in a confidential envelope to the Insurer's Medical Department.

Article 29. Medical litigation

In case of disagreement on the health status of the Insured member, an amicable cross-examination may be carried out by the doctor designated by the Insured Member and the doctor appointed by the Insurer.

A medical arbitrator will be appointed, at the request of the two doctors, by the president of the court of the Insured's home.

The fees of the medical advisor or the expert doctor chosen by the Insurer to represent him during the arbitration shall be borne by the Insurer as well as the fees and costs of appointment of the medical arbitrator. However, in the event that the third-party expert confirms a decision taken against the situation of the Insured, the fees and expenses of appointment of the medical arbitrator would be borne by the Insured.

SECTION 6 - EXCLUSIONS

The general exclusions listed under this section shall apply and, consequently the cover described in information notice does not extend to:

1. **benefits are excluded for any incapacity for work, invalidity, or death resulting directly or indirectly from an illness, condition, or medical disorder that was diagnosed or evident before the effective date of the coverage,**
2. **any condition related to psychological or psychiatric disorders is excluded;**
3. **any condition related to back pain is excluded, unless it requires surgery;**
4. **the consequences of active participation in war, invasion, act of terrorist activities, rebellion (whether war be declared or not), civil war, commotion, military or usurped power, martial law, riot or the act of any lawfully constituted authority, or while the Insured Member is carrying out army, naval or air service operations, whether or not war has been declared;**
5. **the consequences of acts that constitute a commission or attempt to commit a felony, criminal offence or assault by the Insured Member;**
6. **the consequences of self-mutilation, self-inflicted injury, suicide or any attempt thereat while sane or insane;**
7. **the consequences of Illnesses, injuries or Accidents, intentionally caused by the Insured Member;**
8. **the consequences of Illnesses, injuries or Accidents, caused by bets or challenges;**
9. **the consequences of any Accident resulting from the Insured Member's use (including as a passenger) of delta-winged craft, paragliding, parachuting, bungee jumping, hot air balloon, and all other forms of aircraft**

which are not generally accepted or authorized for public transportation use;

10. the consequences of the Insured Member's participation in any sports, competitions, trials or demonstrations, which involve the use of motorized vehicles (including aircraft and boats);
11. the consequences of practicing sports in case the Insured Member is paid/remunerated for performing the sports activities and/or is practicing the sport as a professional sportsperson;
12. the consequences of the practice of any sporting activity in breach of the safety rules defined by the public authorities or by the relevant sports federation in such a way that the Insured Member could not have been unaware of the risk;
13. the consequences of an Illness, injury or Accident caused directly or indirectly from the disintegration of an atomic core, including explosions, heat release or irradiations caused by transmutation of the atomic nucleus or resulting from radiations produced by artificial acceleration of nuclear particles;
14. the consequences of Accidents with aircrafts that have no valid certificate of airworthiness in their country of operation. Aircraft Accidents are only covered if the Insured Member is on board an aircraft with a valid certificate of airworthiness, piloted by a person in possession of a valid license for the type of aircraft in question (but for the avoidance of doubt, this exclusion shall not apply to air travel by an Insured Member on a commercial airline as a fare paying passenger);
15. any and all consequences of a voluntary or intentional act of the Insured Member to commit fraud or to submit false reimbursement claims are excluded from the cover.
16. no benefits shall be payable under this policy in cases where the insured member is already entitled to receive compensation under the compulsory insurance scheme provided by the European Commission, known as the "Provision of sickness and accident insurance services for Conference Interpreting Agents (ACIs)." This policy shall not result in any duplication of payments.

The Insurer will not provide cover under the Life Benefit in respect of an Insured Member:

1. whilst the Insured Member is a detainee in a prison establishment;
2. where claim payments are prohibited under applicable law.

The Insurer will not pay a sum insured under this Life Benefit in respect of an Insured Member's death which in any way results directly or indirectly from any of the following:

1. Accidents resulting from the Insured Member's own act or omission, being a deliberate or reckless exposure to danger (except in an attempt to save human life);
2. suicide, attempted suicide or any injury or Illness that the Insured Member inflicts upon himself;
3. the influence of, or due wholly or partly to the effect of, alcohol or drugs taken by the Insured Member (other than drugs taken in accordance with the treatment prescribed and directed by a medical doctor but excluding drugs used in the treatment of drug addiction);
4. the Insured Member's voluntary participation in fights, except in the case of legitimate self-defense;
5. claims directly or indirectly attributable to chemical or biological substances which are not used for peaceful means;
6. travel or flight in, or getting in or out of: an aircraft being used for test or experiment; an aircraft the Insured Member is flying, is learning to fly, or is part of the crew of; a military aircraft or a similar air transport service of another country; an aircraft owned or leased by or for the Policyholder, its subsidiaries or

affiliates, or the Insured Member or a member of his or her household; an aircraft that does not have a transport type certificate of airworthiness; or an aircraft that is not flown by a pilot with a valid license (but for the avoidance of doubt, this exclusion shall not apply to air travel by an Insured Member on a commercial airline as a fare paying passenger);

7. death directly or indirectly caused or contributed to whilst engaging in or taking part in war, invasion, act of terrorist activities, rebellion (whether war be declared or not), civil war or unrest, demonstrations, commotion, military or usurped power, martial law, riot or the act of any lawfully constituted authority, or while the Insured Member is carrying out army, naval or air services operations, whether or not war has been declared.

The Insurer and/or the Administrator will not pay a sum insured under this Life Benefit if an Insured Member dies whilst, or as a direct or indirect result of, the Insured Member:

1. driving or riding any vehicle without a current valid license;
2. driving or riding any vehicle while the alcohol level in their blood is higher than the legal limit in the jurisdiction in which the Insured Member is driving or riding the vehicle;
3. motorcycling (including riding mopeds and motor tricycles) as a driver or passenger;
4. engaging in hazardous sports including but not limited to diving (including scuba diving), mountaineering, rock or cliff climbing, pot holing, parachuting, all professional sporting activity such as boxing, racing (other than on foot) or flying or training or practicing for any of these activities;
5. being resident in (whether on a permanent or temporary basis) or visiting a country, region or area of conflict and the Insured Member dies as a result of: war, invasion, act of terrorist activities, rebellion (whether war be declared or not), civil war or unrest, demonstrations, commotion, military or usurped power, martial law, riot, the act of any lawfully constituted authority, murder, attempted murder, kidnapping, assault or any other act of violence (including, without limitation, where the Insured Member is an innocent bystander). In the event the Insured Member, whilst abroad, is faced with the sudden, unanticipated occurrence of a new (outbreak of) war or warlike situations and acts, the insurance cover remains valid for fourteen (14) days starting from the beginning of the hostilities. In case of a dispute about whether a given country is known to be in state of war or civil war, the list of countries for which the UK Foreign and Commonwealth Office (FCO) advises not to travel to (advise against all travel to these countries/parts of these countries), as published on its official website www.fco.gov.uk), will be decisive.

The Insurer will not provide cover under this Permanent Invalidity Benefit in respect of an Insured member:

1. whilst the Insured member is a detainee in a prison establishment;
2. where claim payments are prohibited under applicable law.

The Insurer will not pay benefits under this Permanent Invalidity Benefit if an Insured member is affected by a Permanent Invalidity as a direct or indirect result of:

1. accidents resulting from the Insured member's own act or omission, being a deliberate or reckless exposure to danger (except in an attempt to save human life);
2. the influence of, or due wholly or partly to the effect of, alcohol or drugs taken by the Insured member (other than drugs taken in accordance with the treatment prescribed and directed by a medical doctor but excluding drugs used in the treatment of drug addiction);

3. **the Insured member's voluntary participation in fights, except in the case of legitimate self-defence;**
4. **claims directly or indirectly attributable to chemical or biological substances which are not used for peaceful means;**
5. **travel or flight in, or getting in or out of: an aircraft being used for test or experiment; an aircraft the Insured member is flying, is learning to fly, or is part of the crew of; a military aircraft or a similar air transport service of another country; an aircraft owned or leased by or for the Insured member or a member of his or her household; an aircraft that does not have a transport type certificate of airworthiness; or an aircraft that is not flown by a pilot with a valid license (but for the avoidance of doubt, this exclusion shall not apply to air travel by an Insured Member on a commercial airline as a fare paying passenger);**

The Insurer will not pay benefits under this Permanent Invalidity Benefit if an Insured Member is affected by a Permanent Invalidity as a direct or indirect result of, the Insured Member:

1. **driving or riding any vehicle without a current valid license;**
2. **driving or riding any vehicle while the alcohol level in their blood is higher than the legal limit in the jurisdiction in which the Insured Member is driving or riding the vehicle;**
3. **motorcycling (including riding mopeds and motor tricycles) as a driver or passenger;**
4. **engaging in hazardous sports including but not limited to diving (including scuba diving), mountaineering, rock or cliff climbing, pot holing, parachuting, all professional sporting activity such as boxing, racing (other than on foot) or flying or training or practising for any of these activities;**
5. **being resident in (whether on a permanent or temporary basis) or visiting a country, region or area of conflict suffers a Permanent Invalidity as a result of: war, invasion, act of terrorist activities, rebellion (whether war be declared or not), civil war or unrest, demonstrations, commotion, military or usurped power, martial law, riot, the act of any lawfully constituted authority, murder, attempted murder, kidnapping, assault or any other act of violence (including, without limitation, where the Insured Member is an innocent bystander). In the event the Insured Member, whilst abroad, is faced with the sudden, unanticipated occurrence of a new (outbreak of) War or warlike situations and acts, the insurance cover remains valid for fourteen (14) days starting from the beginning of the hostilities. In case of a dispute about whether a given country is known to be in state of war or civil war, the list of countries for which the UK Foreign and Commonwealth Office (FCO) advises not to travel to ('advise against all travel to these countries/parts of these countries'), as published on its official website "http://www.fco.gov.uk", will be decisive.**

The Insurer will not provide cover under this Temporary Incapacity Benefit in respect of an Insured Member:

1. **whilst the Insured Member is a detainee in a prison establishment;**
2. **where claim payments are prohibited under applicable law.**

The Insurer will not pay benefits under this Temporary Incapacity Benefit if an Insured Member is unable to perform his/her professional occupation as a direct or indirect result of:

1. **Accidents resulting from the Insured Member's own act or omission, being a deliberate or reckless exposure to danger (except in an attempt to save human life);**
2. **the influence of, or due wholly or partly to the effect of, alcohol or drugs taken by the Insured Member (other than drugs taken in accordance with the treatment prescribed and directed by a medical doctor but excluding**

drugs used in the treatment of drug addiction);

3. the Insured Member's voluntary participation in fights, except in the case of legitimate self-defence;
4. claims directly or indirectly attributable to chemical or biological substances which are not used for peaceful means;
5. travel or flight in, or getting in or out of: an aircraft being used for test or experiment; an aircraft the Insured Member is flying, is learning to fly, or is part of the crew of; a military aircraft or a similar air transport service of another country; an aircraft owned or leased by or the Insured Member or a member of his or her household; an aircraft that does not have a transport type certificate of airworthiness; or an aircraft that is not flown by a pilot with a valid license (however, for the avoidance of doubt, this exclusion shall not apply to air travel by an Insured Member on a commercial airline as a fare paying passenger).

The Insurer will not pay benefits under this Temporary Incapacity Benefit if an Insured Member is unable to perform his/her professional occupation as a direct or indirect result of, the Insured Member:

1. driving without a current valid license;
2. driving or riding any vehicle while the alcohol level in their blood is higher than the legal limit in the jurisdiction in which the Insured Member is driving or riding the vehicle;
3. motorcycling (including riding mopeds and motor tricycles) as a driver or passenger;
4. engaging in hazardous sports including but not limited to diving (including scuba diving), mountaineering, rock or cliff climbing, pot holing, parachuting, all professional sporting activity such as boxing, racing (other than on foot) or flying or training or practising for any of these activities;
5. being resident in (whether on a permanent or temporary basis) or visiting a country, region or area of conflict and the Insured Member suffers Illness or Accidental Bodily Injury as a result of: war, invasion, act of terrorist activities, rebellion (whether war be declared or not), civil war or unrest, demonstrations, commotion, military or usurped power, martial law, riot, the act of any lawfully constituted authority, murder, attempted murder, kidnapping, assault or any other act of violence (including, without limitation, where the Insured Member is an innocent bystander). In the event the Insured Member, whilst abroad, is faced with the sudden, unanticipated occurrence of a new (outbreak of) War or warlike situations and acts, the insurance cover remains valid for fourteen (14) days starting from the beginning of the hostilities. In case of a dispute about whether a given country is known to be in state of war or civil war, the list of countries for which the UK Foreign and Commonwealth Office (FCO) advises not to travel to ('advise against all travel to these countries/parts of these countries'), as published on its official website www.fco.gov.uk), will be decisive.

SECTION 7 - PREMIUMS

Article 30. Payment of premiums by the Insured Member

30.1 Payment terms

Premiums are due from the Insured Member, via the Administrator, and are payable in euros, yearly and in advance.

30.2 Default in payment of premiums

In the event of non-payment of premiums or any portion thereof, a registered letter shall be sent to the Insured Member at least ten (10) days after the due date, informing them that, upon the expiration of a period of forty (40) days following the sending of the registered letter, non-payment of the premium will result, without further notice, in the

cancellation of their membership under this coverage.

ANNEX 1 : ASSESSMENT OF THE INVALIDITY RATE

The degree "T" of invalidity is determined by medical expertise.

The Insurer designates a medical doctor to evaluate the degree of invalidity of the Insured Member, who may be assisted by his family doctor.

In case of disagreement between the physician of the Insured Member and the Insurer's Medical Advisor of the Insurer, an arbitration must be arranged as per Section 5.

The degree "T" of invalidity which gives rise to benefits is determined according to:

- the functional, physical or mental incapacity,
- the occupational incapacity.

The functional incapacity rate is determined from 0 to 100% regardless of any professional criteria, based on the reduction in physical or mental capacity resulting from an accident or illness.

The occupational incapacity rate is further determined from 0 to 100% according to the rate and the type of the functional incapacity in relation with the occupation, regarding how the profession was performed before the illness or the accident, the normal working conditions and the potential remaining abilities to work, putting aside the income of the concerned person.

Combining both functional and occupational rates, the invalidity rate is determined according to the following table.

This rate can be revised according to the evolution of the invalidity of the Insured.

	Functional incapacity rate								
Occupational incapacity rate	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**
10%				29.24	33.02	36.59	40.00	43.27	46.42
20%			31.75	36.94	41.60	46.10	50.40	54.51	58.48
30%		30.00	36.54	42.17	47.62	52.78	57.69	62.40	66.94
40%	25.20	33.02	40.00	46.42	52.42	58.09	63.50	68.68	73.68
50%	27.14	35.57	43.09	50.00	56.46	62.57	68.40	73.99	79.37
60%	28.85	37.80	45.79	53.13	60.00	66.49	72.69	78.62	84.34
70%	30.37	39.79	48.20	55.93	63.16	70.00	76.52	82.79	88.79
80%	31.75	41.60	50.40	58.48	66.04	73.19	80.00	86.54	92.83
90%	33.02	43.27	52.42	60.82	68.68	76.12	83.20	90.00	96.55
100%	34.20	44.81	54.29	63.00	71.14	78.84	86.18	93.22	100.00