HENNER SAS
INDIVIDUAL INSURANCE CONTRACT
LIFE & DISABILITY -1st USD/ 1st EURO

Policy No. 080719/001 (1st USD) 080719/002 (1st EURO)

SUMMARY PLAN DESCRIPTION

PREAMBLE

HENNER SAS has subscribed to, on behalf of its Clients Members a Group Life and Disability Insurance Policy (INTERNATIONAL EXPAT INSURANCE) with AWP Health & Life SA.
This contract has been based on the International Expat Insurance product of Joho, previously insured by Allianz Luxembourg and reinsured by AWP Health & Life SA. In the current agreement between Henner SAS and AWP Health & Life SA, the Parties has agreed that no modifications to the benefits have been made.

This Policy consists of the guaranteed benefits in the event of Death, Accidental death and Invalidity, Temporary Incapacity and permanent Disability in professional life for all eligible Members with the coverage stipulated in Title III of this policy.

The rights and obligations resulting therefrom,

- For HENNER SAS hereinafter referred to as "Policyholder" or "HENNER SAS" ;
- For the Member, who is a natural person having become a member of the Policyholder, who acquire the status of « Covered Person» or "Member; and
- For the insurer AWP Health & Life S.A., referred to as the « Insurer »;

are established under the terms and conditions herein which is governed by and interpreted in accordance with French law.

GENERAL CONDITIONS

PURPOSE

As **Clients Members** of HENNER, you benefit from the individual Insurance subscribed to by your employer, hereinafter referred to as the "Policyholder", with AWP Health & Life SA, hereinafter referred to as the "Insurer", under the master contract number **080719/001 (1st USD) 080719/002 (1st EURO)**.

This Policy consists of the guaranteed benefits in the event of Death, Accidental death and Invalidity, Temporary Incapacity and permanent Disability in professional life for all eligible Members.

The terms and conditions of the master contract covering you from the effective of the contract 1st of January 2022, the procedures for implementing the guarantees and the details of the benefits to which you are entitled, their effective date, and the claims procedures are defined in this Summary Plan Description.

The Group Insurance contract is governed by and interpreted in accordance French Insurance Code, in particular the provisions stipulated in Title IV of Book I of the Code, relating to group insurance.

The statements from both the Policyholder and the Covered Persons form the basis of the contract.

EFFECTIVE DATE DURATION, AND RENEWAL DATE OF THE MASTER POLICY

The contract takes effect on **1st January 2022** for a period of one year expiring on **31st December 2022**.

The contract shall then be renewed subsequently by tacit agreement from 1st January of each successive year for a one-year period, unless otherwise terminated by one of the parties by registered letter sent at the latest by 30st June of the current plan year.

The present contract may also be terminated on the Insurer's initiative:

- In the event of the a compulsory liquidation (or equivalent proceedings) of the Policyholder;
- in the event of non-payment of the premium in accordance with the terms defined in Title V;

The contract may also be terminated, on the initiative of the Policyholder, at any time , without fees or penalties at the expiration of a period of 1 year, starting from the first subscription.
The termination takes effect 1 month after the Insurer has received notification by registered letter, single letter, e-mail or other durable medium.

EFFECTIVE DATE DURATION, AND RENEWAL DATE – MEMBERSHIP CERTIFICATE

For the Covered Person, the insurance membership is established by **a membership certificate signed by the Policyholder,** which includes in particular:

- the membership number,
- the effective date of the policy
- the identity of the Member and his dependants
- the geographical area of coverage
- the type and the amount of coverage

For the Covered Person, the insurance policy shall take effect on the date specified on the membership certificate.

The Membership Certificate shall then be renewed subsequently by tacit agreement for each successive year for a one-year period, unless otherwise terminated by the Member by the registered letter with acknowledgment of receipt sent to the Policyholder at the latest 1 month before the policy renewal date. The Policyholder must inform the insurer.

The membership certificate may also be terminated in any of the following cases:

- on the date on which the Covered Person ceases to be a member of the Policyholder,
- on the date of termination of the present contract.
- in case of non-payment of premium to the Policyholder ;
- following a recovery plan or a compulsory liquidation of the Policyholder.

Withdrawal within the Cooling-off Period

The Policyholder commits to communicating the information relating to the right of withdrawal within the cooling-off period to the Covered Person.

The Covered Person may withdraw from insurance coverage within the cooling-off period of 30 calendar days from the date on which he/she is notified that the policy has been signed, by sending a registered letter with acknowledgement of receipt to:

AWP Health & Life S.A.
Client Service Relations
Eurosquare 2
7 rue Dora Maar
93400 Saint Ouen
France

The Insurer shall repay in full all sums paid by the covered Person within 30 days from the date of receipt of the registered letter.

Sample letter of Withdrawal (within the cooling-off period)

> *«I, the undersigned, Mr/Mrs/Ms. (Full name of the person concerned), residing at (Full address of the person concerned)..., withdraw from membership to the policy number. ... subscribed to by ... with AWP Health & Life S.A., in accordance with Article L.132-5-1 of the French Insurance Code.*
>
> *I hereby certify that, on the dispatch date of this letter, I have not been aware of any claim invoking the policy coverage since the policy was concluded.*
>
> *Date:*
> *Signature*

COVERED PERSONS

ELIGIBILTY

All members of the Policyholder defined in the present contract shall be enrolled for benefits described herein.
All individual Expats (private persons) working abroad (and their Dependents) and Local Employees who are not eligible and not affiliated to Dutch Basic Healthcare from the age of 18 onwards of the Policyholder must be covered .

The members of the category of persons to be covered must, at the time of the effective date of coverage fill out and sign an Individual Application for Enrolment for Coverage consisting in a health questionnaire provided by the Policyholder indicating

- the level of benefits subscribed by the covered person; and
- the Dependent beneficiaries defined herein of the insurance coverage.

The Insurer reserves the right to request any additional information it deems necessary.

When the Individual Application for Enrolment includes a health questionnaire, the Insurer may, if necessary, request the completion of medical formalities or production of any additional information.

The Insurer reserves the right, on the basis of the aforementioned documents and information, to limit the coverage, to reassess the policy premium indicated on the application for enrolment, or to refuse Membership.

In the event, the policy covers any Dependents, as defined herein, of the category of covered persons to be covered, the Data Privacy Notice must be equally communicated by the Policyholder to the Covered Person to provide said Notice to such third parties.

The Insurer shall inform the Policyholder of the new premium rates applicable by sending it an endorsement.

The Policyholder may refuse this increase and terminate the policy by sending the Insurer a registered letter with acknowledgement of receipt within 30 (thirty) days from the date of receipt of the endorsement sent by the Insurer. The termination shall take effect on the first day of the calendar quarter following the refusal notification.

The Policyholder shall inform the Covered Person of the termination.

In the event the Policyholder fails to inform the Insurer within 30 (thirty) days of its right to terminate the policy, the increase shall be deemed to have been accepted by the Policyholder.

Moreover if there any modification of the level of benefits/plan can only be taken into account every 1st January with previous written approval from the Insurer.

The same condition shall apply if the revaluation of annuities paid by the previous Insurer, following the death of a covered person , must be paid.

EFFECTIVE DATE OF COVERAGE

Once the contract has come into effect, the coverage becomes effective for each member who acquires the status of Covered Person as defined herein on the following dates:

- Eligible Members enrolled on the effective date of the contract:
  - from this date

- Eligible Members enrolled after the effective date of the contract:
  - on the date they join the category of members to be covered, and after they are medically accepted by the Policyholder

DURATION OF COVERAGE

Except in the event of concealment, omission or misstatement made in bad faith, the Covered Person, once accepted, cannot be excluded from the Insurance against his/her will as long as he/she belongs to the category of persons to be covered, subject to the provisions of Article L.141-3 of the Insurance Code.

Unless otherwise provided herein, coverage ceases in any event:

- For each Covered Person:
  - for each benefit, on the date on which the Covered Person ceases to belong to the category of person to be covered,
  - At the latest on the date of their 66th Birthday

- For all Covered Persons belonging to the Category of Covered Person:
  - upon the date of the termination of the present contract.

- Continuation of Cover

The coverage can be extended for maximum three(3) months in respect a Member who has been on cover at least 12 months prior to this additional three (3)-month continuation period, and ceases to earn an income due to one of the following reasons:

- Member has an employment contract that ended for any reason other retirement, or retrenchment due to illness; or
- Member is a freelancer but is not actively working; or
- Member - whether previously employed or a freelancer - is going on a sabbatical.

During this period, the Policyholder may reside in their current or a new host country, or may return to their home country.

The Member has to request the extension of coverage - in writing and before the termination date - cover for one additional three (3)-month period (without interruption of cover), at the terms and conditions prevailing prior to this additional three (3)-months period i.e. without the possibility to amend (upgrade/downgrade).

The insurer reserves the right to decline the continuation request or restrict the requested covers.

The premiums will continue to be paid in full by the insured in respect of the continuation period.

COVERAGE AND BENEFITS

Scope of coverage

Unless otherwise stipulated in this policy, the coverage may be invoked 24 hours a day, both in professional and private life, in the event of illness or accident and in the geographical area as indicated in herein.

This Policy can only be taken out if your policy is domiciled (policy address) in one of the following EEA countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden

PRELIMINARY DEFINITIONS

'BASE SALARY'

Definition

Unless otherwise stipulated in the present contract, the benefits and premiums amounts are determined according to the base salary declared and paid by the Covered Person for the period selected for the calculation of the benefits and premiums.

Benefits basis

When the benefit amount is calculated on the basis of the base salary declared and paid by the Policyholder, the benefit amount shall be equal to the amount of salary used as a basis for the payment of premiums over the past twelve consecutive calendar months prior to the date of the event giving rise to the entitlement to the benefits.

If this amount is reduced or at zero due to illness, accident, maternity leave or paternity leave, the amount shall be calculated up to the limit of the amount corresponding to the Covered Person's normal working hours over the twelve consecutive calendar months prior to the absence. The Salary does not include any benefits in kind such as car, living accommodation, bonuses or overtime. In the event of a claim, satisfactory proof of income will be required.

When the Policyholder has not paid twelve consecutive months of premiums for the Covered Person on the date of the event (due to employment or establishment of the plan), the base salary shall be equal to twelve times the average monthly salary received from the effective date of the coverage.

If the base salary includes sums that have become payable due to termination of the employment contract, these sums shall not be taken into account by the Insurer.

When the calculation of benefits takes in consideration family status or the dependents of the Covered Person, such consideration will be take into account on the date giving rise to the entitlement to benefits.

'Dependents'

For purposes of the present contract, each reference made to the guarantees and/or the amount of the benefits herein, it shall be understood by:

'Spouse/Civil Union Partner '

The spouse not legally separated from the Covered Person, or his/her registered civil union partner (PACS or local equivalent), or cohabiting partner, as registered with the appropriate regulatory authority.

'Cohabitation (Common Law/Life partner)'

Cohabitation/Partner means the person cohabiting with the Covered Person in a legally recognised marital/conjugal relationship and who together fulfil both of the following conditions:

- both individuals are free from matrimonial ties; and
- Cohabitation has been declared by the Covered Person to the Policyholder, who shall communicate such information to the Insurer, at the time of enrolment and the Covered Person provides a legal certificate attesting to this status.

If the cohabitation is declared subsequent to the enrolment date of the Covered Person, the person shall only be taken into account as a cohabiting partner after a 6 (six)-month period. This period is not required if a child born of this union is dependent on the Covered Person. The end of the state of cohabitation must be declared in writing by the Covered Person to the Policyholder who shall communicate this information to the Insurer.

In addition, in order to determine the lump sum in the event of death, the evidence of a marital relationship or otherwise legally recognised partnership as described hereinabove must be dated more than 1 (one) year from the date of the claim.

Only one person of the above persons shall be considered as beneficiary.

'Child/Children'
The unmarried Child/Children of the Covered Person and those of his/her spouse (or civil union partner PACS or local equivalent or cohabitating life partner), living in the household of the Covered Person, whether legitimate, recognized, adopted or taken in, those minors who are under the protection of the Covered Person under pre-adoptive care, are considered dependent, for tax purposes, on the Covered Person:

- Born alive at least 300 days after the death of the Covered Person; or
- if they are a legal minor; or
- no matter the age in the event they qualify and are officially recognised as handicapped/disabled in accordance with Article L.241-3 of the Family and Social Action Code; or
- if they fulfil the following conditions:
  - under the age of 28;
  - benefit from a French social security system or local equivalent; and
  - unemployed but employed as a volunteer (unless, in the case of full-time schooling they pursue a temporary employment with a duration inferior of 3 months or employment for the training for their career with a monthly salary inferior to 80% of the French minimum wage).

Children are considered dependent on the Covered Person for tax purposes if they are:

- taken into account for at least a half-share in the calculation of the Covered Person's income tax payable in the year of the event invoking the coverage;
- students who have not chosen to be attached to the tax household and who receive a living allowance from the Covered Person which is deductible when calculating the Covered Person's taxes payable in the year of the event invoking the coverage; and
- recognised, adopted or taken in by the Covered Person, if they are dependent for tax purposes on his/her civil union partner (PACS or local equivalent) or cohabitating life partner.

The benefits are only payable for claims occurring within the period during which the beneficiary belongs to the category defined hereinabove.

'Beneficiaries in the Event of the Covered Person's Death '

The lump sum in the event of the death of the Covered Person shall be provided to the beneficiary (ies) designated by the Covered Person or, in the event no beneficiary is designated, shall be allocated in accordance with the following order of priority:

- the Spouse, if not legally separated or divorced from the Covered Person ;
- failing him/her, to the Civil Union Partner (PACs or local equivalent) or Common Law/Life partner in cohabitation as declared to the Policyholder ;
- failing him/her, to the born or unborn child/children of the Covered Person, in equal shares between them, the share of any predeceased children returning to their own children or their siblings if they are childless;
- failing them, to the father and mother of the Covered Person, divided into equal shares between them, or to the surviving parent in the event one is deceased; or
- failing them, to the legally recognised heirs.

The Covered Person may modify the aforementioned order of priority at any time and designate any natural or legal person(s) of his/her choice by private or official notarial declaration. He/she must inform the Policyholder who shall inform the Insurer in writing of the designation of the beneficiary (ies).

A modification or modifications to the designation of beneficiaries must be equally notified to the Insurer in the same manner, the beneficiary clause may also be modified when it is no longer appropriate.

Once the beneficiary(ries) has been designated by name, the Covered Person must provide his/her contact details to the Insurer to be used in the event of death of the Covered Person.

The designation of a beneficiary becomes irrevocable with the beneficiary's acceptance subject to the conditions as stipulated in Article L.132-9 of the Insurance Code. Upon acceptance as beneficiary by private or official notarial declaration signed by the Covered Person and the beneficiary, the Insurer must be notified of said acceptance in order to take effect.

In the event the personal designation lapses or becomes, the aforementioned order of priority designation is applicable.

In the event of death of the Covered Person and of one or several designated beneficiaries during the same event, without the possibility to determine the order of deaths, the Covered Person is presumed to have survived for the purposes of determining the beneficiaries of the lump sum.

Personal data and/or other sensitive data are required for the underwriting, administration, and management of the present contract. Dependents and/or beneficiaries in the event of death as defined hereinabove shall be considered "Data Subjects" for purpose of the application of the Regulation as defined herein and in the annex hereto.

'Accident'
A sudden, unexpected event, the cause of which is situated outside the victim's body, which results in bodily Injury. Following events are also considered to be Accidents:
- a rescue attempt of persons or goods in peril;
- gas or vapour inhalation and the absorption of poisonous or corrosive substances;
- dislocations, distortions, ruptures and muscular lacerations provoked by a sudden effort;
- freezing;
- drowning.

'Social Security'
Social Security refers to any national Social Security scheme in which the Covered Person may be enrolled or dependent upon.

'The International Expat Insurance Life Insurance'
The Life/Disability plan proposed by HENNER SAS to its members namely individual expatriates. The plan is subject to payment of premiums.

'Annual Renewal Date'
For individual contracts only, 1 January.

'Chronic Conditions'
Illness or Injury which has one or more of the following characteristics:
is recurrent in nature;
is without a known, generally recognised cure;
is not generally deemed to respond well to Treatment;
requires palliative Treatment;
requires prolonged supervision or monitoring;
leads to permanent Invalidity.

'Deductible'
The (first) part of the (eligible) medical expenses, not reimbursed by the Insurer and deducted from the amount (of Eligible Medical Expenses) on which the reimbursement is calculated.

'Dependent'
The legal spouse (or legal partner) and/or unmarried children, until the thirty-first (31st) of December of the year of the twenty-eighth (28th) birthday of the insured child, who are financially dependent on the Insured.

'Doctor'
A person who graduated from a recognised medical school as listed in the WHO World directory of medical schools and who is licensed to practise medicine in the country where the Treatment is received.

'Expat (or Expatriated person)'
A person living and working abroad (outside his/her Home Country).

'Family Doctor or GP (General Practitioner)'
A Doctor providing Medical Treatment not requiring a specialist Doctor's training.

'GP (General Practitioner)'
See definition of 'Family Doctor'.

'Home Country'
The country where the Insured normally resides or used to reside and out of which he/she is expatriated to another country (as declared in the Application form). If the Home Country cannot be named according to this definition, it is the country of which the Insured has the nationality and is holding a passport from.

'Host Country'
The country where the Insured is expatriated to, as declared in the Application form.

'Illness'
A condition marked by a pathological deviation from the normal healthy state confirmed by a Doctor.

'Injury'
Bodily Injury caused solely by Accident.

'Insurance Year'

A twelve (12)-month period, starting on the effective date on the 1st January and terminating on the 31st December of each year.

'Insured'
The person(s) covered by the International Expat Insurance Package and whose name(s) is(are) mentioned in the Membership Certificates.

'Insurer'
The insurance company underwriting the risks set forth in the International Expat Insurance : AWP Health & Life SA

'Invalidity'
Incapacity of permanent nature, caused by a chronic Illness or Injury.

'Local employee'
A person living and working in the Netherlands who is not eligible and not affiliated to Dutch Basic Healthcare.

'Medical Emergency'
An accidental Injury or a sudden and unexpected onset of a change in a person's physical or mental condition which, if the procedure or Treatment was not performed immediately could reasonably be expected to result in loss of life or limb or significant impairment to bodily function or permanent dysfunction of a body part, as determined by the Doctor in attendance.

'Medically Necessary'
A medical service which is:
consistent with the diagnosis and customary Medical Treatment for a covered Illness or Injury;
in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits;
not for the convenience of the Insured or the Physician, and unable to be reasonably rendered out of hospital (if admitted as an inpatient);
not of an experimental, investigational or research nature, preventive or screening nature;
for which the charges are fair and reasonable for the Treatment.

'Member' is the expatriate individual that has been accepted as a member of HENNER SAS.

'Physician'
See definition of 'Doctor'.

'Policy Renewal Date'
1st January of each year

'Pre-existing Conditions'
Medical conditions or any related conditions, for which symptom(s) has/have been shown at some point during the five (5) years prior to commencement of cover, irrespective of whether any Medical Treatment or advice was sought. Any such condition or related condition, about which the Insured or his/her Dependents know, knew or could reasonably have been assumed to have known, will be deemed to be pre-existing.

'Permanent Disability'
Permanent Disability means that the continuation of the Medical Treatment will not lead to any significant improvement of the person's state of health, and that the Disability will therefore be definitive and irreversible.

'Salary'
The gross Salary being paid to an individual expatriate or expatriated employee at the commencement of his/her insurance, before deduction of any income tax. Gross Salary does not include any benefits in kind such as car, living accommodation, bonuses or overtime. In the event of a claim, satisfactory proof of income will be required.

The Salary for a self-employed person shall mean the gross average Salary during each of the three (3) years leading up to the date of the event entitling to benefits. In order to be eligible for a self-employed to apply for Temporary Incapacity and Permanent Disability benefits, proof of a steady income of 2500 euros per month (or the equivalent in dollar) six months prior to he date they applied is required.

During the application procedure for Temporary Incapacity and Permanent Disability insurance a self-employed person needs to provide official proof of income provided by an accountant or tax representative. Starting self-employed persons can opt for a maximum insured amount of 4166 euros per month (or the equivalent in dollar) for Temporary Incapacity and Permanent Disability insurance if they have 4166 euros per month income or higher accordingly.

'Self-employed person'
A person who owns a company and works for him/herself rather than for an employer.

'Sickness, disease or illness'
shall mean a condition marked by a pathological deviation from the normal healthy state confirmed by a doctor.

'Specialist Doctor'
A Doctor having a specialised qualification in the field of, or expertise in, the Treatment of the Illness or Injury.

'Starting self-employed person'
A person who owns a company for less than three years and works for him/herself rather than for an employer.

LUMP SUM IN THE EVENT OF DEATH

The amount of the sum insured is specified in the Membership Certificate. However, the minimum sum insured shall be 50,000 EUR/65,000 USD and can be increased up to a maximum sum insured of 500,000 EUR/625,000 USD. Premiums and benefits (lump sum) are calculated on the basis of the sum insured. Benefits will be paid insofar as the Insured's decease occurs before the day of his/her sixty-sixth (66th) birthday. If the policy ends before the decease of the insured, no payments will be effected.

LUMP SUM IN THE EVENT OF DEATH OR INVALIDIDTY RESULTING FROM AN ACCIDENT (OPTIONAL)

In the event of the accidental death or permanent Invalidity incurring before the Insured 66th birthday, of at least 20% of the Covered Person results from an accident, subject to the condition that the death or the permanent Invalidity occurred within 1 (one) year from the date of the Accident a lump sum will be paid to the beneficiaries.

The amount of the sum insured is specified in the Membership Certificate. However, the minimum sum insured shall be 50,000 EUR/62,500 USD and can be increased up to a maximum sum insured of 500,000 EUR/625,000 USD. Premiums and benefits (lump sum) are calculated on the basis of the sum insured.

The lump sum shall be paid in advance directly to the Covered Person, if the Insurer recognizes that the Covered Person suffers from irreversible loss of autonomy within 1 (one) year following the date of the accident which occurred under the aforementioned conditions.

To give rise to the entitlement to benefits, any accident likely to result in the early payment of the lump sum must be declared within 6 (six) months from the date of the occurrence of the accident.

When this lump sum is paid in advance, the Covered Person no longer benefits from the death coverage stipulated in the present article.

Accident Invalidity

In case of permanent Invalidity of the Insured caused by an Accident, the lump sum payable by the Insurer (to the Insured) will be equal to the amount of the sum insured multiplied by the degree of Invalidity (percentage), the latter being determined in accordance with the Table of Invalidity hereafter. Permanent Invalidity of a degree of less than twenty (20)% will not qualify for payment of any benefit. If the permanent Invalidity caused by the Accident amounts to twenty (20)% or more than 20% according to the Table of Invalidity hereafter, the benefit amounts to the corresponding percentage of the sum insured.

Assessment of the degree of permanent Invalidity

1/ Table of Invalidity

The following Table of Invalidity will be used to determine the degree of Invalidity:

Table of Invalidity	
Total paralysis	100%
Total blindness	100%
Incurable and total mental disability	100%
Amputation or the permanent loss of the use of:	
a) both arms or both hands	100%
b) both legs or both feet	100%
c) one arm or hand and one leg or foot	100%
Total loss of sight of one eye with removal of the eye	50%
Total loss of sight of one eye	45%
Loss of bone of the skull forming a hole in the skull over:	
a) an area of at least 6 cm^2	40%
b) an area of 3 to 6 cm^2	20%
c) an area of less than 3 cm^2	10%
Incurable total loss of hearing in both ears	100%
Incurable total loss of hearing in one ear	50%
Amputation of the lower jaw	
a) total	70%
b) partial (upright branch plus the whole or half of the up toillary bone)	40%
Loss of top and bottom teeth and their sockets	
a) impossibility of fitting dental prosthesis	10 to 30%
b) In the case of possible prosthesis with established functional improvement	1 to 10%
Right	**Left**

Loss of arm or hand	75%	60%
Total paralysis of an upper limb	65%	55%
Total paralysis of the circumflex nerve	20%	15%
Total paralysis of the median nerve	45%	35%
Total paralysis of the cubital nerve at the elbow	30%	25%
Total paralysis of the nerve of the hand	20%	15%
Total paralysis of the radial nerve above the triceps	40%	30%
Complete ankylosis of the shoulder:		
a) with immobilisation of the shoulder-blade	65%	55%
b) with mobility of the shoulder-blade	35%	25%
Non-consolidated fracture of the upper arm: *(constitution of pseudoarthrosis)*	30%	25%
Total loss of movement of the elbow:		
a) in an unfavourable position	40%	35%
b) in a favourable position	25%	25%
Non-consolidated fracture of the fore-arm: *(constitution of pseudo-arthrosis)*		
a) both bones	25%	20%
b) a single bone	10%	8%
Total loss of movement of the wrist		
a) in an unfavourable position *(flexion, forced extensions or supination)*	40%	30%
b) in a favourable position *(straight or prone)*	20%	15%
Amputation of a thumb		
a) total	20%	18%
b) partial (ungual phalanx)	10%	8%
Ankylosis of a thumb		
a) total	15%	12%
b) partial (ungual phalanx)	10%	8%
Amputation of index-finger		
a) total	16%	14%
b) two phalanxes	12%	10%
c) one phalanx	6%	5%
Amputation of second finger	12%	10%
Amputation of third finger	10%	8%
Amputation of fourth finger	8%	6%
Total paralysis of a lower limb		60%
Complete paralysis of the internal popliteal sciatic nerve		30%
Complete paralysis of the external popliteal sciatic nerve		30%
Complete paralysis of both popliteal sciatic nerves		40%
Shortening of a lower limb		
a) at least 5 cm		30%
b) from 3 to 5 cm		20%
c) from 1 to 3 cm		10%
Complete ankylosis of the hip:		
a) in a bad position *(flexion, adduction or abduction)*		60%
b) in a straight position		40%
Amputation of the thigh:		
a) upper half and leg		60%
b) lower half and leg		50%
Non-consolidated fracture of the thigh or both bones of the leg *(constitution of pseudoarthrosis)*		50%
Complete ankylosis of the knee:		
a) in flexion (from 130 degrees)		50%
b) straight or almost straight		25%
Chronic gonarthrosis according to the degree of muscular atrophy		3 to 20%
Non-consolidated fracture of the knee-cap with wide separation of the fragments and considerable difficulty in extension of the leg from the thigh		40%
Amputation of a leg		50%
Tibio-tarsian ankylosis		15%
Amputation of a foot:		

a) total (tibio-tarsian disarticulation) b) sub-astragalian c) media-tarian d) tarso-metatarsian	50% 40% 35% 30%
Amputation of all toes	20%
Amputation of big toe	10%
Amputation of a toe other than big toe	3%
Ankylosis of the big toe	3,5%

2/ Permanent nature of the Invalidity
In order to qualify for payment of the insured benefit, the Invalidity has to be of a permanent nature, meaning that it has been medically determined that continuation of the Medical Treatment will not lead to any significant improvement of the person's state of health, and that the Invalidity will therefore be definitive and irreversible.

3/ Pre-existing state of infirmity
A pre-existing state of infirmity of limbs or organs, cannot be taken into account for the assessment of the Injuries that are caused by the Accident.

4/ Maximum degree of Invalidity
The degree of permanent Invalidity can never exceed 100%. Under no circumstances the sum payable by the Insurer will exceed 100% of the sum insured.

5/ Several Injuries affecting the same limb
In case of several Injuries or infirmities resulting from the same Accident or from successive Accidents, each Injury or infirmity will be assessed separately, but the sum of Injuries or infirmities affecting a limb may not lead to a degree of Invalidity exceeding the degree of Invalidity corresponding to the full loss of the limb concerned.

6/ Events or infirmities not listed in the table of Invalidity
For events or infirmities not listed in the Table of Invalidity, the degree of Invalidity shall be determined by reference to the listed events or infirmities: the Table of Invalidity will be used as a guide to assess the degree of Invalidity by analogy with listed items. The sum payable will in no case be less than the amount payable for any reasonably analogous event or infirmity, listed in the Table of Invalidity.

7/ Total loss of use of a limb
Total loss of use of a limb will be considered being equal to the loss of the limb itself.

8/ Left-handed persons
Left-handed persons, upon declaration of left-handedness in the place indicated on the declaration of state of health, shall receive scaled benefits related to the upper right limb instead of upper left limb, and vice versa.

9/ Aggravating facts
In the case of aggravation of the consequences of an Accident as a result of infirmities, Illness or circumstances independent of the accidental cause, the degree of Invalidity cannot be superior to the one that would have been determined if the Accident had struck a healthy organism.

TEMPORARY TOTAL INCAPACITY (OPTIONAL)

- Common Terms and Conditions

Purpose

The purpose of the Temporary Total Incapacity cover is to guarantee to the Insured, after the waiting period as defined hereafter, the payment of a monthly allowance (maximum up to age of sixty-five (65)), during a maximum period of two (2) years, in case the Insured is totally unable to perform his/her professional occupation.

Waiting Period

The right to benefits shall take effect at the end of a **waiting period of 90 days**.

This period starts on the first day of each sick leave and consists of an uninterrupted series of days of total incapacity from work.

Notification Period

The Insurer must be notified of the duration of sick leave, no later than within 2 (two) months after the expiration of the aforementioned waiting period.

If such notification occurs after this 2 (two)-month period the duration of sick leave shall be deemed to have started on the day of notification to the Insurer.

The Covered Person, through the Policyholder, shall provide the supporting documents as provided for in the Summary Plan Description booklet.

Except in the event of force majeure, illnesses or accidents not declared within six months following the beginning of the sick leave shall be excluded from the coverage and therefore be not subject to compensation, provided that the absence or delay in declaring the claim has resulted in prejudice to the Insurer.

Amount and duration of the benefit

The amount of the monthly allowance in case of total incapacity of the Insured to perform his/her own professional occupation is mentioned in the Membership certificate. The minimum amount to be insured is 1,250 USD or 1,000 EUR(monthly allowance). The amount insured cannot exceed 80% of the gross (monthly) Salary of the Insured, nor can it exceed an amount of 12,500 USD or 1,000 EUR per month. The Policyholder shall submit to the Administrator a copy of the latest Salary statement of the Insured. After the waiting period of ninety (90) days, the allowance will be paid as long as the Insured is totally unable to perform his/her occupation, limited however to a maximum period of two (2) years.

Once the period of two (2) years is over, the Insured cannot claim another time the total incapacity benefit for the same cause unless provided in the article 14.1.7.

Assessment of Declared Claims by the Insurer

Nevertheless the Insurer reserves the right to assess the validity of the state of incapacity or disability of the Covered Person with a medical assessment pursuant to Article 17 hereinafter.

Partial resumption of work

Persons who (after the ninety (90)-day waiting period) are benefiting from the monthly allowance and whose condition is improving to such an extent that they are capable of partially resuming work, may continue (within the limits of the maximum period of two (2) years after the waiting period) to

receive an allowance. The amount of this allowance will however be reduced, and will be calculated by multiplying the (total monthly) sum insured by the percentage of the (remaining) incapacity. In case the incapacity would become less than thirty (30)%, the allowance will be discontinued.

Relapse

In the event the Covered Person returns to work for his employer and within the first 2 (two) months of the return to work, returns on sick leave again for the same cause and is recognized as such by the Insurer, the payment of benefits may continue on the same basis, without application of the waiting period, provided:

- the contract is still in force; and

PERMANENT DISABILITY (OPTIONAL)

The purpose of the Permanent Disability cover is to guarantee payment of a monthly Disability allowance, (maximum up to age of sixty-five (65)) to the Insured who is affected by a Permanent Disability caused by an Illness or Accident, prohibiting him/her from fully or partially continuing his/her professional occupation, therefore leading to a total or partial loss of income.
The insurance covers Permanent Disability caused by an Illness or Accident and amounting to a degree exceeding thirty-three point thirty-three (33.33)%. Moreover, in case the degree of Disability exceeds sixty-six point sixty-seven (66.67)%, and if the Insured needs the assistance of a third person to perform the basic activities of daily living, the insurance guarantees an additional lump sum benefit, in accordance with the provisions as set out below.

Waiting period

The Permanent Disability cover is a supplement to the Temporary Total Incapacity cover. Benefit payment will therefore start at the earliest after the allowances paid by the Insurer within the framework of the Temporary Incapacity cover have come to an end.

Assessment of Disability

The degree of Permanent Disability will be determined by means of a medical examination. To this end, the Insurer will designate a Doctor to determine the degree of Disability in accordance with the Table of Disability hereafter.

	Degree of functional disability								
Degree of occupational disability	20%	30%	40%	50%	60%	70%	80%	90%	100%
10%						36,59%	40,00%	43,27%	46,42%
20%				36,94%	41,60%	46,10%	50,40%	54,51%	58,48%
30%			36,54%	42,17%	47,62%	52,78%	57,69%	62,40%	66,94%
40%			40,00%	46,2%	52,42%	58,09%	63,50%	68,68%	73,68%
50%		35,57%	43,09%	50,00%	56,46%	62,57%	68,40%	73,99%	79,37%
60%		37,80%	45,79%	53,13%	60,00%	66,49%	72,69%	78,62%	84,34%
70%		39,79%	48,20%	55,93%	63,16%	70,00%	76,52%	82,79%	88,79%
80%		41,60%	50,40%	58,48%	66,04%	73,19%	80,00%	86,54%	92,83%
90%		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%

Amount and duration of the benefit

-Calculation of the amount of the monthly Disability allowance

- Insured allowance

The amount of the insured allowance is mentioned in the Membership certificate. In no event, the amount of the insured allowance shall be higher than the monthly allowance of the Temporary Incapacity cover.

- Degree of Permanent Disability of less than 33.33%

No benefits will be due for Disabilities of less than thirty-three point thirty-three (33.33)% (=1/3).

- Degree of Permanent Disability between 33.33% (= 1/3) and 66.67% (=2/3)

If the degree of Disability, as determined in accordance with the stipulations of Art. II-7.c) and II-7.e) above, is situated between thirty-three point thirty-three (33.33)% and 6 sixty-six point sixty-seven (66.67)%, then the amount of the Disability allowance will be calculated as follows: ((3 x n) – 1) x insured allowance, 'n' being the degree of Disability (%).

- Degree of Permanent Disability exceeding 66.67% (=2/3)

If the degree of Disability, as determined in accordance with the stipulations of Art. II-7.c) and II-7.e) above, exceeds sixty-six point sixty-seven (66.67)%, then the amount of the Disability allowance will be equal to the amount of the insured allowance (hundred (100)%).

- Additional lump sum benefit in case of need of assistance of a third person

If from the start of the Disability (i.e. as from the start of the payment of the Disability allowance) the degree of Permanent Disability exceeds sixty-six point sixty-seven (66.67)%, and if the Insured, as from the start of the Disability, needs the assistance of a third person to be able to perform the following activities of daily living:

- feeding oneself (taking and eating prepared food);
- dressing oneself;
- washing oneself;
- using the toilet or bedside commode;
- moving around (transferring from a bed to a chair or vice versa, and ability to move on level surfaces);

then the Insurer will pay a once-only additional benefit of 25,000 EUR/ /31,250 USD (single lump sum) to the Insured.

Yearly adjustment of Disability allowance (indexation)

The monthly Disability allowance, paid under temporary incapacity cover or permanent disability cover, shall be subject to an annual increase of two (2)%. This adjustment will be applied for the first time at the end of the first month of the first (1st) calendar year following the first (1st) benefit entitlement.

Duration of benefit

Benefits will be paid at the latest till the end of the month in which the Insured:

- reaches the age of sixty-five (65);
- deceases;
- resumes work;
- has a permanent disability less than thirty-three point thirty-three (33.33)% (=1/3);

whichever event occurs first.

Benefit payment

The Disability allowance shall be payable on a monthly basis, at the end of each month. Before any payment can be made.

MEDICAL EXAMINATION AND ARBITRATION

The physicians and experts designated by the Insurer shall have full access to the Covered Person in order to assess their state of health.

The Insurer may refuse, interrupt or reduce the entitlement to benefits as a result of the conclusions of its physicians and experts, independent of any decisions and payments made by the Social Security or any other organisation.

At risk of the suspension of the benefits, the Covered Person must provide all supporting documents and accept any assessment or examination requested by the Insurer of the Covered Person.

The Insurer shall notify the Covered Person, by registered letter or email, of all decisions made in accordance with the conclusions of the medical expert; the Covered Person may dispute the validity of these conclusions, within 30 (thirty) days following the notification to the Insurer by registered letter or email.

In the event of a disagreement concerning the state of health of the Covered Person, the later must organize at his own cost a counter expertise performed by an expert physician. The conclusions must be send to the Insurer.

If both physicians fail to reach a common conclusion or if it is decided to proceed directly to arbitration, the Covered Person and the Insurer shall appoint a medical arbitrator to decide between them.
If the parties fail to appoint the medical arbitrator, the appointment shall be made by legal process.

Each party shall pay all costs and fees of its physician and all arbitration costs and fees due shall be divided equally among the parties.

EXCLUSIONS

FORFEITURE OF THE RIGHT TO A BENEFIT

The Covered Person is deprived of all rights to the benefits of a claim in the event the Covered Person voluntarily makes a false declaration about that claim including the date, nature, causes, circumstances and/or consequences and/or amount of the loss.

The forfeiture of this right also applies in the event the Covered Person knowingly uses inaccurate documents as supporting documents for that claim.

GENERAL EXCLUSIONS

The following events are excluded from coverage:

- The suicide of the Covered Person, before one year of continuous coverage; however suicide is covered if, prior to another group insurance policy with compulsory membership, the Covered Person has a combined one year of continuous insurance on the date of suicide on account of his/her enrolment in this Policy;
- The consequences of an illness or accident intentionally provoked by the covered person intentional, conscious or unconscious, self-injuries or suicide attempt;
- The consequences directly or indirectly resulting from the decay of an atomic nucleus/core,
- the consequences of an insurrection, a riot, an attack, protest or acts of terrorism, wherever the location of these events and whomever the protagonists, except if the Covered Person does not actively participate in such event or if he/she is called upon to perform a maintenance or monitoring mission in order to ensure the security of people and assets for the benefit for his employer It is understood that in cases of self-defence and assistance to person in danger are covered.
- When the Insured (or covered Dependent) is travelling to or from or is residing in a country or a part of a country publicly known to be in state of War or civil War at the time damages (bodily Injury, or death) to the Insured or his/her covered Dependents happen. 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. In the event the Insured, whilst abroad or is residing in a country, is faced with the sudden, unanticipated occurrence of a new (outbreak of) War or warlike situations and acts, these insurance cover remains valid for fourteen (14) days starting from the beginning of the hostilities.

Nevertheless, the Insurer reserves the possibility of modifying the coverage for one or several specific territories, subject to a 15 days prior notice to the Policyholder. The Policyholder may refuse this modification and terminate the policy by sending the Insurer a registered letter with acknowledgement of receipt within 30 days from the date of receipt of the endorsement submitted by the Insurer. The termination shall take effect on the first day of the calendar quarter following the refusal notification.

The Policyholder shall inform the Member of the termination.

The consequences from:

- a surgical operation necessitated by an accident excluded from the insurance,
- alcoholism, obvious drunkenness or if it is revealed that at the time of the accident, the Covered person at the origin of the accident had a blood alcohol level at least equal to legally permitted blood alcohol level in application of French law, or to the legally permitted level in application of the country where the accident took place,
- the use of narcotics or medicinal substances in the absence or outside the limits of medical prescription. It is understood that the claims resulting from an utilization in contra-indication of the drug leaflet are not covered.
- participation in a crime, an intentional offense or a fight, except in the case of self-defense and assistance to a person in danger,
- participation in all sports and competitions in a professional capacity,
- participation in military or police actions,
- detention, possession or manipulation by the Covered Person at the place of the accident of mechanisms of war or a weapon,
- an act of belligerence or terrorism claimed or not,
- the participation of the Covered Person in all competitions (and their trials) involving the use of vehicles or motor boats,
- an accident resulting from the practice of bungee jumping and kitesurf, and the Covered Person's use (including as a passenger) of hang gliders, paragliders, ultra-light motorized aircraft and any other non-approved aircraft to carry out public transport,
- loss resulting directly or indirectly from the disintegration of the atomic nucleus,
- the practice of any sports activity carried out in clear violation of the safety rules defined by the public authorities in such a way that the Covered Person could not ignore the risk,
- accidents occurring during the active participation (does not apply to spectators) of the Covered Person in competitions, aerial demonstrations, aerobatics, acrobatics, raids, record attempts, flights on prototypes, test flights, jumps made with unauthorized parachutes and military seafaring activities, bets, racings and aerobatic.
- Mental or nervous disorders of the Covered Person except when they result from a serious accident (i.e causing at least a 21 days Temporary Incapacity).

Nonetheless risks resulting from an aerial navigation accident are only covered in the following cases:

- the aircraft was authorized as airworthy in accordance with to the governing regulatory technical specifications and issued a valid navigability certificate,
- the members of the crew flying certificate and pilots license and qualifications required for the position they hold on board, the day of the accident, taking into account the aircraft used for the flight and the type of flight, including the special authorisations when necessary,
- the aircraft used for the flight has been officially accepted by the governing regulatory aviation authority issuing a valid certificate as such, to provide transportation of passengers.

FORMALITIES IN THE EVENT OF A CLAIM

Any event that may give entitlement to benefits must occur during the effective period of the coverage concerned and be declared within the periods stipulated therein or, if no period is stipulated, within six months following the event.

Except in the event of force majeure, illnesses or accidents not declared within six months following the beginning of the sick leave shall be excluded from the coverage and therefore be not subject to compensation, provided that the absence or delay in declaring the claim has resulted in prejudice to the Insurer.

The following documents must be provided for the payment of benefits in the event of a claim:

In Case of Death

- notification of death provided by the Insurer;
- official death certificate issued by the attending physician who pronounced the death and indicating the cause of death;
- photocopy of the complete family register/or proof of family status;
- photocopy of the Civil Solidarity Pact (PACS) or foreign equivalent of civil union partnership defined herein;
- photocopy of the official certificate attesting to the status of cohabiting couple, as defined herein;
- Certified copy of the birth certificate of the deceased Covered Person;
- Certified copy of the birth certificate(s) of the beneficiary(ies), for both the beneficiaries of the lump sum and the beneficiaries of annuities as applicable;
- last income tax notice in case of dependents;
- School attendance certificate for each child aged more than 16 and less than 26, as applicable;
- bank account information;

In case of Total and Irreversible Loss of Autonomy

- Certified copy of the birth certificate of the Covered Person;
- last income tax notice;
- bank account information;
- Medical certificate justifying the Total and Irreversible Loss of Autonomy established by the treating physician."

In Temporary total incapacity

- Declaration of incapacity or disability from work duly completed by the Employer or the Insured Member in they are self-employed (signed and stamped) detailing the amount of salary paid over the last 12 months preceding the sick leave ;
- Medical certificate duly completed by the treating physician, and
- Notice of the prolongation(s) by the treating physician.

In Case of Disability

- bank account information for the automatic transfer of payment ;
- medical certificate justifying the disability established by the treating physician addressed to the Medical Director of the Insurer; and
- If the Covered Person pursues a remunerated activity, the photocopies of the salary statements for the relevant quarter, or the certification of unemployment benefits paid by the local unemployment insurance scheme.

In Case of a Claim Arising from an Accident

- In addition to the aforementioned documents, the photocopy of the police report or other official authorities (for example : a report established by the emergencies or the treating physician confirming to a certain extent the circumstances of the incident).

In case of endorsement for the continuation of death benefits after termination of the employment contract (dismissal):

- a photocopy of the employment termination letter or a certificate of the Employer specifying the employment termination date of the Covered Person; an

The Insurer reserves the right to request any other supporting documentation necessary to process the claim.

Assessment of the Claims

Within the context of reviewing the claim, that the Insurer's advising medical expert may request any other supporting documentation necessary to process the claim. Insofar as the documentation listed herein to be submitted is incomplete, gives rise to doubt, or the Insurer is unable to investigate thoroughly its obligation to pay the claim, the Insurer's advising medical expert is entitled to request data from the following organisations and persons subject to Article 5.8 hereinabove and as defined in the Data Privacy Notice

- Doctors,
- Hospitals,
- Other medical institutions,
- Care homes,
- Caregivers,
- Other personal insurance providers,
- Statutory health insurance bodies,
- Occupational insurance organisations and
- Official bodies

In the event the members of the category of covered persons, including dependents, where applicable, as defined herein, explicitly reject concrete data collection in the context of claims processing or revoke consent the benefit may not become due if the Insurer is unable to determine whether and to what extent the Insurer is liable for payment of the claim.

The Insurer shall not otherwise be held liable by the Policyholder for the impossibility of performing the services under the present contract.

Any fraud, misstatement or concealment in relation to any matter affecting the insurance or in connection with any claim shall render the cover of a Covered Person null and void and have the result that all claims there under are forfeited as provided herein.

OTHER PROVISIONS

LIMITATION ON ACTIONS

The provisions relating to the statute of limitations on actions arising from the insurance contract are established by Articles L.114-1 - L.114-3 of the French Insurance Code indicated hereafter:

Article L.114-1 of the French Insurance Code

All actions arising from an insurance contract are limited to two years after the incident giving rise thereto. However, this statute of limitations only applies:

1° In case of concealment, omission, false or inaccurate declaration of the risk involved, from the day on which the insurer had knowledge thereof;
2° In the event of a claim of damages, from the day on which the parties involved became aware thereof, if they prove that they were unaware of it until then.
When the action of the Insured Party against the Insurer is due to the action of a third party, the statute of limitations only starts to run from the day on which the third party initiated legal proceedings against the Insured Party or was compensated by him.
The limitation is extended to ten years in life insurance contracts when the beneficiary is a person distinct from the policyholder and, in accident insurance contracts affecting people, when the beneficiaries are the beneficiaries of the deceased insured party.
For life insurance contracts, notwithstanding the provisions of Item 2, the actions of beneficiaries are limited to thirty years after the death of the Insured Party.

Article L. 114-2 of the Insurance Code The running of the statute of limitations is interrupted by one of the ordinary causes of interruption and by the appointment of experts following an incident. The interruption of the statute of limitations of the action can furthermore result from the sending of a registered letter with return receipt requested sent by the Insurer to the Insured Party regarding the action for the payment of the premium and by the Insured Party to the Insurer for the payment of the compensation.

Article L. 114-3 of the Insurance Code
As an exception to article 2254 of the French Civil Code, the parties to the insurance contract cannot, even by joint agreement, modify the duration of the statute of limitations, nor add to the causes of its suspension or interruption.

Additional Information:
The ordinary causes of interruption of the statute of limitations are mentioned in Article 2240 and in accordance with the Civil Code; among the latter include notably: the questioning of one of the joint debtors by a judicial action or by an act of compulsory execution or the acknowledgement by the debtor of the right of the person against whom he applied the statute of limitations. For the exhaustive list of the ordinary causes of interruption of the statute of limitations refer to the aforementioned articles of the Civil Code hereinabove.

SUBROGATION

Pursuant to the French Insurance Code, the Insurer may be subrogated to the right of the person entitled to benefits in order to exercise any recourse proceedings against any liable third party.
The Insurer waives its right of recourse proceedings against the Policyholder and the Covered Person.

COMPLAINT

In the event of a disagreement with the Insurer, the Policyholder, the Covered Person shall first contact their representative at AWP Health & Life S.A.

If the proposed solution does not meet the expectations of the Policyholder, the Covered Person, a complaint may be submitted by ordinary letter or email to:

AWP Health & Life S.A.
Client relations
Eurosquare 2
7 rue Dora Maar
93400 Saint Ouen

France
Email: client.care@allianzworldwidecare.com

AWP Health & Life SA is a signatory to the mediation charter of the French Federation of Insurance Companies. Therefore, in the event of a persistent and definitive disagreement, the Policyholder and/or Covered Person have the option, after exhausting all other possible amicable remedies, to opt for the **Mediator of the French Federation of Insurance Companies**, without prejudice to other possible legal action, who can be contacted at the following address:

La Médiation de l'Assurance
TSA 50 110
75 441 Paris Cedex 09
https://www.mediation-assurance.org/

DATA PROTECTION

Personal data concerning the Parties to the present contract , the category of **Covered Person** to be covered, their Dependents and/or beneficiaries as applicable, and/or any identified or identifiable natural living person to whom personal data relates hereto, herein referred to as **"Data Subject(s)"**including the signatories to the contractual agreements and the various schedules, exhibits, attachments and other documents referenced or incorporated herein and/or endorsements, amendments or addendums hereto, are used for the sole purpose of the management thereof, whether or not by automated means, such as collection, processing, recording, organization, purpose limitation and data minimization, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transfer, dissemination or otherwise making available, alignment or combination, security, relating to the collection and processing of personal data, including but not limited to the privacy and security thereof, in accordance with the Amended French Data Protection Act no. 78-17 of 06.01.1978 on Information Technology, Data Files and Civil Liberties and all applicable laws and regulations relating to the protection and processing of Personal Data, including the General Data Protection Regulation (Regulation (EU) 2016/679) of the European Parliament and of the Council of 27 April 2016, hereinafter referred to as the **"Regulation",** sector-specific laws and applicable guidance and codes of practice issued by supervisory authorities and as stipulated in the Data Privacy Notice at www.allianzcare.com/fr/pages/privacy/france.html

The Data Subjects have the rights to request access to, rectification, deletion of their personal data, restriction of processing concerning their data, objection to processing, and data portability as defined in the Data Privacy Notice.

In addition, in accordance with the performance of the contract, personal data may be subject to an extra-European transfer due to specific needs linked to the policy. This transfer occurs in full compliance with the Regulation, sector-specific laws and applicable guidance and codes of practice issued by supervisory authorities relating to the personal data transfers.

The terms used herein shall have the meaning given in the Regulation, as stipulated in the **Definitions** section of the Data Privacy Notice on the protection of natural persons with regard to the processing of personal data and on the free movement of such data as a result of, or in connection with the present contract. "Personal Data" shall be any personal and/or sensitive data in relation to Data Subjects.

Any and all necessary endorsements, where applicable, to existing contractual agreements, all relevant Data Protection Agreements with third-parties, and Data Transfer Agreements relating to the collection, processing, use, storage, and/or transfer of any personably identifiable data are concluded in application

of all aspects of data protection and information security regulations as stipulated in the Data Privacy Notice and in application of the Regulation.

In the event the Data Subject wishes to exercise his/her rights in relation to the present contract, a request may be sent to:

AWP Health & Life S.A.
Information Technology and Civil Liberties
Eurosquare 2
7 rue Dora Maar
93400 Saint Ouen
France
Email : informatique.libertes@allianzworldwidecare.com

The Insurer will assess the corresponding requests under the scope of the Regulation, and will respond by justifying meeting the request or denial thereof.

The Data Subjects have as well the right to lodge a complaint with the Data Protection Supervisory Authority as provided hereunder if they consider the processing of their data is not lawful or do not agree with the conclusions resulting from their requests for exercising their rights.

In the event the Data Subject has any queries about how the personal and/or sensitive data is used in relation to the present contract, the Data Subject may contact the Insurer as follows:

AWP Health & Life S.A.
Data Protection Officer
Eurosquare 2
7 rue Dora Maar
93400 Saint Ouen
France
Email: AWC.DataPrivacyOfficer@allianz.com

Data Protection Supervisory Authority
Pursuant to Article 51 of the Regulation, the independent public authority established by a Member State is concerned by the processing of personal data:

- the controller or processor is established on the territory of the Member State of that supervisory authority;
- data subjects residing in the Member State of that supervisory authority are substantially affected or likely to be substantially affected by the processing; or
- a complaint has been lodged with that supervisory authority.

Obligations of the Parties
The present contract implements the regulations and requirements on the protection of Personal Data and on the collection, processing and use of Personal Data in the performance and management of the present contract.
In relation to all Personal Data, each Party warrants and undertakes the following as relevant:

- To process Personal Data only as necessary to perform its obligations herein;

- To process Personal Data in compliance with its obligations under applicable data protection law, including the Regulation;

- To implement and maintain appropriate technical and organizational security measures giving due regard to the risks inherent in the processing and nature of the personal data concerned to protect against accidental or unlawful destruction, loss, alteration, unauthorized disclosure of, or

access to the Personal Data and which provide a level of security appropriate to the risk represented by the processing and the nature of the data to be protected as stipulated hereunder;

- The Policyholder shall provide appropriate notice to the category of **Persons** to be covered, their dependents and/or beneficiaries where applicable whose personal data is processed in a timely manner and in accordance with applicable data protection law, including the Regulation and as stipulated herein;

- To have in place procedures so that any third party or service provider authorized have access to Personal Data, will respect and maintain the confidentiality and security of the Personal Data. Any person authorized to have access to Personal Data shall be obligated to process the Personal Data in accordance with applicable data protection law, including the Regulation and, where the recipient is a data controller in their own right, subject to terms no less onerous than those set out in this section;

- Personal data may be processed both inside and outside of the European Economic Area (EEA) subject to contractual restrictions regarding confidentiality and security in line with applicable data protection laws and regulations. No personal and/or sensitive data may be disclosed to parties who are not authorized to process them.

  In the event of a transfer personal and/or sensitive data outside of the EEA, such transfers shall be done in application of the terms and conditions stipulated in Data Transfer Agreements in conjunction with the rules of the Regulation, sector-specific laws and applicable guidance and codes of practice issued by supervisory authorities. Full and accurate records of any transfer of Personal Data outside the European Economic Area shall be kept and such records shall be made available to upon request;

- To delete (and procure that third-party data processors delete or return to the relevant Party for deletion) Personal Data of a Data Subject where such Data Subject ceases to be a Data Subject for purposes of the present contract, unless and until the Parties no longer need to retain such Personal Data under applicable data protection law, including the Regulation;
- In the event a Data Subject has exercised his/her rights by sending a request directly to one of the parties, the other Party is responsible for immediately informing the other party of said request and to immediately inform the party responsible for assessing the request and responding to the request.
- To promptly notify the other Party if a Party becomes aware of any unauthorized or unlawful processing or breaches of security relating to the Personal Data:
  - In case of suspected data protection infringements, data breaches, data losses or any other material discrepancies, the Party shall without undue delay and within the **immediate 24 following hours**, inform the Data Protection Officer of the other Party.

- Except where prohibited to do so by law, notify the other Party of any request by a law enforcement authority for Personal Data in advance of providing such data; and

- Upon reasonable request of one of the Parties, as applicable, the requested Party agrees to submit its data processing facilities, data files and documentation needed for processing Personal Data to reviewing, auditing and/or certifying by the requesting Party (or any independent or impartial inspection agents or auditors, selected by the requesting Party and not reasonably objected to by the Insurer) to ascertain compliance with applicable data protection law including the Regulation and this section, with reasonable notice and during regular business hours.

Upon written request and no more than once a year the Parties may, as applicable:

- meet with the each other's security team to discuss security questions that they may have; or

- complete a questionnaire regarding compliance with applicable data protection law, including the Regulation.

Confidentiality

Each Party undertakes that it shall not at any time disclose to any person and shall treat as confidential all information of a confidential nature received or obtained directly or indirectly as a result of entering into or performing the present contract except as expressly permitted in writing by the other party.

Each party may disclose Confidential Information:

- to its employees, officers, external auditors, professional advisers, consultants who need to know such information for the purposes of enabling the party to perform its obligations under the contract. The party shall use all reasonable endeavors to ensure that its employees, officers, external auditors, professional advisers, consultants to whom it discloses Confidential Information comply with this section.
- where required by law, court order or any governmental or regulatory authority provided that, subject to any legal or regulatory obligations that apply to the receiving party, the receiving party shall give notice to the other party that it proposes to disclose the Confidential Information;
- where the Confidential Information is now in or comes into the public domain otherwise than as a result of a breach of the present section.
- where the Confidential Information is already known by the party in circumstances when it was not bound by any form of confidentiality obligation.

Furthermore, the Parties undertake to treat as strictly confidential all matters not generally known in the public domain and in particular the business and company secrets of the other Party, only to use such information within the scope of the Parties' relationship and – to the extent not required in order to achieve the purpose of the present contract– not to record, disclose or make use of such information.

In the event of a breach or a suspected breach of its obligations under this Section the party must notify the other party promptly as stipulated hereinabove and use all reasonable endeavors, at their own cost, to remedy or mitigate the effects of such a breach.

Each Party shall ensure that its personnel engaged in the processing of personal data are informed of the confidential nature of such Personal Data, have received appropriate training of their responsibilities and have executed confidentiality agreements. The parties shall ensure that such confidentiality obligations survive the termination of the employment term with said personnel.

The Parties shall therefore only deploy employees for conducting any collections of processing activity of Personal Data, who have received adequate training and who are subject to an individual obligation to maintain data secrecy. Compliance with such obligation must be verified by the Parties on request by means of a signed declaration form.

The Parties shall ensure that authorized third-party contractors and their relevant authorized sub-contractors commit their personnel to the same scope of secrecy and confidentiality and shall verify such commitment to the relevant Party upon request.

Information Security

Each Party hereto agrees to guarantee compliance with adequate technical and organizational security measures necessary to properly protect and secure the Personal Data collected, processed and used by the Party and/or by third-party data processors. Any authorized third parties shall audit compliance with these measures regularly and provide the Party with sufficient documentation thereof as applicable.

Each Party must implement and/or ensure any authorized third-party processing or controlling data on behalf of a Party implements the following minimum security measures:

- prevent unauthorized persons from gaining access to data processing systems for processing or using personal data (access control);
- prevent data processing systems from being used without authorization (access control);
- ensure that persons authorized to use a data processing system have access only to those data they are authorized to access, and that personal data cannot be read, copied, altered or removed without authorization during processing, use and after recording (access control);
- ensure that personal data cannot be read, copied, altered or removed without authorization during electronic transfer or transport or while being recorded onto data storage media, and that it is possible to ascertain and check which bodies are to be transferred personal data using data transmission facilities (disclosure control);
- ensure that it is possible after the fact to check and ascertain whether personal data have been entered into, altered or removed from data processing systems and if so, by whom (input control);
- ensure that personal data processed on behalf of others are processed strictly in compliance with the Data Controller's instructions (job control);
- ensure that personal data are protected against accidental destruction or loss (availability control),
- ensure that data collected for different purposes can be processed separately.

Each Party guarantees that compliance with these technical and organizational security measures will be assured notwithstanding the location in which the processing activity of Personal Data actually takes place.

All appropriate security measures necessary to properly protect and secure the Personal Data and Sensitive data collected, processed and used shall be in application the Amended French Data Protection Act no. 78-17 of 06.01.1978 on Information Technology, Data Files and Civil Liberties and the laws and regulations relating to the protection and processing of Personal Data, and, in particular pertaining to Sensitive data, as applicable, the implementation of confidentiality relating to medical data processing in accordance with the Regulation, the French AERAS Agreement (Insurance and Loans with an Increased Health Risk), effective 2006, revised on 1 February 2011 and 2 February 2015 and the Code of Conduct appended to it as well as the French Code of Medical Ethics.

LIMITATION OF LIABILITY – PRIOR DECLARATION

In the event that several claims are caused by the same single event and subject to the provisions of the following paragraph, the accumulation of benefits provided by the Insurer in this regard for all Group Life & Disability Insurance policies subscribed to by the Policyholder cannot exceed EUR 60 (sixty) million. If this sum is reached, it shall be apportioned among all affected Covered Persons in proportion to the respective amounts of insured benefits before the limitation.

Prior Declaration in the Event of Group Transportation or other Aggravating Circumstances

When, due to the action of the Policyholder, more than 50 (fifty) Covered Persons are required to travel together in the same transport vehicle, whether for professional reasons or otherwise, the Policyholder must notify the Insurer of such circumstances by written declaration at least 15 (fifteen) working days in advance of such trip.

When, on the basis of this declaration, the limitation on the benefits specified above is likely to be applied, the Insurer shall inform the Policyholder of the conditions for exemption within 10 (ten) working days from the date of receipt of the declaration.

In addition to this obligation, the Policyholder must request the Insurer, under the same notice requirement, to examine any other likely situation in which this limitation may apply, including, if the coverage involved, for a trip of no more than 30 (thirty) Covered Persons is particularly high. Guarantees will only be acquired subject to the conditions provided by the Insurer, after the required declaration is addressed to the Insurer at least 10 (ten) days before said travel.

SANCTION LIMITATION AND EXCLUSION CLAUSE

Cover is not provided if any element of the cover, benefit, activity, business or underlying business violates any applicable sanction law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction law or regulations.

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