SwissLife

Assurance Santé Monde *Healthcare and Providence Information Note*

This information note contains the terms and conditions of the contract underwritten by Association Santé Monde

Assurance Santé Monde

Your healthcare and providence information note

The information note is a document that defines the insurance covers and how they come into force as well as the formalities to be completed in the event of a claim. It must necessarily be established by the insurer and then be provided to members by the underwriting association (Article L.141-4 of the French Code of Insurance).

Warning: the cover level, the effective date of coverage and the persons benefiting from the contract are specified on the membership certificate.

The Assurance Santé Monde contract has been concluded by:

Association Santé Monde
19, rue La Boétie
75008 Paris
France
the underwriting association.

It has been taken out with:

SwissLife Prévoyance et Santé
Registered office:
7, rue Belgrand
92300 Levallois-Perret
France
French Plc with a share capital of €150,000,000
Company governed by the French Code of Insurance
322 215 021 RCS Nanterre

and

SwissLife Assurance et Patrimoine
Registered office:
7, rue Belgrand
92300 Levallois-Perret
France
French Plc with a share capital of €169,036,086.38
Company governed by the French Code of Insurance
341 785 632 RCS Nanterre
the insurer.

The insurance supervision authority

Autorité de Contrôle Prudentiel et de Résolution (ACPR)
4 Place de Budapest
75436 Paris
France

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Definitions

Accident
Any unintentional bodily injury caused to the insured person, arising from abrupt, sudden and unexpected action from an external cause. **Infarctions and sudden pathologies are not considered as Accidents.**

You / Subscriber
Member of the underwriting association who opts to subscribe to the Contract, pays the premiums thereto and benefits from the coverage.

Insured
Natural person mentioned on the membership certificate on which the risk is based. It refers to you and your beneficiaries, as the case may be.

Beneficiary
In the context of the providence covers, the beneficiary of the lump-sum payment is the one that you have named under the beneficiary clause, or otherwise, in the model clause indicated in the application form.

Contract
Collective Insurance Contract with participation on a voluntary basis, which covers the options you have chosen.

Waiting Period
Period during which a benefit is not paid out.

Delegate
M.A.I – 39, rue Anatole France – 92300 Leallois-Perret – France. Third party mandated by the insurer and/or by the underwriting association to manage the different management tasks that it has been entrusted with.

CFE - Caisse des Français de l'étranger
CFE is the French social security scheme for expatriates.

Eligible Healthcare Facility
Public or Private healthcare facility qualified to perform medical acts and to provide medical treatment to sick or injured patients and that holds all sanitary and administrative authorisations for this purpose.

Expatriate
Member of the underwriting association living outside of his home country, alone or with his beneficiaries, during at least 6 consecutive months (excluding holidays and business trips of less than 30 consecutive days in another country that the one of expatriation).

Reimbursable Costs
These are the costs incurred by you or by your beneficiaries as the case may be (in accordance with the chosen coverage and the T&C of the Contract) that the insurer undertakes to reimburse through its delegate.

Deductible
Period of medical leave from work after which the insurer pays out to the contract holder a per diem allowance.

Inpatient care
inpatient care prescribed by a doctor in an eligible healthcare facility, insofar as the purpose of this inpatient care is the medical or surgical treatment of an illness or the consequences of an accident.

TTIW
Total Temporary Incapacity for Work.

Unexpected illness
Sudden and unpredictable alteration of the insured person's health diagnosed by an accredited medical authority.

PACS (pacte civil de solidarité)
Civil union within the meaning of Articles 515-1 et seq. of the French Civil Code.

Country of Expatriation
Country included in one of the covered geographical areas in which the subscriber and his beneficiaries, as the case may be, live in, pursuant to the definition of "Expatriate".

Coverage Period
Period during which the insurer, via its delegate, is committed to indemnify the risks that occur during the performance of the contract. This period starts at the earliest on the date stipulated on the membership certificate and stops at the latest at the end of the subscription.

CILA
Complete and irreversible loss of autonomy

CILAA
Complete and irreversible loss of autonomy caused by an accident

Medical History Form
Document retracing the medical history to enable the consulting physician to assess the risk in terms of health for a potential subscriber. Such a document must be dated less than one month from the subscription date.

Rehabilitation
The insured having undergone surgery, can benefit from rehabilitation sessions in a rehabilitation centre but only after inpatient care.

Base Salary
This is your global gross annual remuneration.

Geographical Area of Coverage
The area is defined according to your country of expatriation. The cover applies to the reimbursement of reimbursable costs which occurred in the geographical area of coverage.

Part I
The Contract

Article 1 – Purpose of the Contract

The purpose of your subscription to the Assurance Santé Monde contract is:

- the reimbursement of health expenses incurred during the coverage period by you and your beneficiaries as the case may be. The benefits provided for by the contract are paid out in addition to CFE reimbursements or in addition to the reimbursements of the French Social Security for seconded staff; from the first euro of costs incurred.
- the pay-out of a lump-sum, per diem allowances and an annuity in the context of the optional Providence cover.

Article 2 – Coverage Level Choices

You can choose the coverage levels that are applicable to you and your beneficiaries as the case may be, as follows:

Health Covers

Compulsory Basic Cover: inpatient care and/or medical expenses

You must choose at least one of these two covers: it is possible to choose both of them together.

You can add the **Optical and Dental** cover. The latter cannot be chosen on its own, it must necessarily complete the Basic cover (inpatient care and/or medical expenses).

Optional Covers: Comfort Option and Deluxe Option

These two options are meant to improve the reimbursement of your benefits. Each option can be chosen for each selected cover in the compulsory basic cover. For example, you have chosen the inpatient care, medical expenses and optical/dental covers: you could add the Comfort option to inpatient care and the Deluxe option to the medical expenses and the optical/dental care, or the other way around.

The reimbursements under the optional covers are added to the basic cover reimbursements.

NB: the covers are valid within the geographical area that is applicable to you.

Optional providence covers

Death - Accidental Death / CILA - CILAA

This cover guarantees the payment of a lump-sum amount to the beneficiary(ies) that you have named in case of death. The lump-sum is paid out to you in advance in case of complete and irreversible loss of autonomy (CILA).

In case of accidental death or complete and irreversible loss of autonomy caused by an accident (CILAA), the amount of the lump-sum is doubled.

TTIW - Permanent disability

This cover guarantees the payment of per diem allowances or an annuity in case of total temporary incapacity for work (TTIW) or total or partial permanent disability.

The TTIW - Permanent Disability cover can only be taken out as in addition to the Death / CILA cover above.

NB: the Providence covers are optional. They cannot be chosen alone without the Basic Health Cover.

Article 3 Insurance Application - Persons Covered

You, the subscriber

To be able to apply to this contract, you must meet the following criteria:

- Be between 18 and 70 years of age on the day of the application;
- Be of different nationality than the one of the country of expatriation;
- Live during at least 6 consecutive months in the country of expatriation;
- You have paid your subscription rights to the underwriting association to be a member.

And, furthermore if you have opted for the TTIW - Disability cover - Permanent Disability:

- Be at least 63 years of age on the day of the application;
- Be employed and not be a majority shareholder in the company that employs you.

Your beneficiaries

Are considered as beneficiaries and able to benefit from the covers you have chosen:

- Your **partner**: the spouse not legally separated (subject to providing a sworn statement of non-separation from the partner), the partner linked by a PACS subject to providing a copy of the agreement registered at the Registry of the Court of first instance of the joint residence, or the de facto spouse (subject to providing proof of joint residence and a sworn statement) who is 70 years of age at most (included).

  NB: if you choose to get reimbursed in addition to the French Social Security or the CFE and that your partner is not recognised as one of your beneficiaries by one of these institutions, he/she will be able to benefit from the covers, provided that he/she is individually affiliated with this institution. ***Only one person will be covered as a "partner" of the subscriber under the Contract.***

- **Dependent children**: your children and/or those of your partner, dependent for tax purposes, until their 16th birthday in all cases and until their 20th birthday if they are pursuing secondary studies (subject to providing a current certificate of school attendance or a photocopy of their student card).

  NB: when you subscribe to a contract in addition to the CFE or French Social Security, the covers of the dependent children can be maintained after their 20th birthday only if they individually subscribe to one of these institutions.

Your partner and your dependent children must live in the geographical area applicable to your country of origin to be covered.

Article 4 - Admission to Insurance

4.1 To set-up the membership, you must provide the delegate with:

- The **application form** completed and signed by yourself;
- The **medical history form** completed and signed by you and your beneficiaries. Each medical history form must be sent, to the delegate's consulting physician and marked as confidential;
- The **certificate of affiliation to the CFE or Social Security** when the cover is chosen in addition to benefits of one of those institutions;

- The **certificate of school attendance** for the current year or the photocopy of the current year **student card** when dependent children benefit from the insurance.

NB: The delegate can later on ask for any additional information to study the file and assess the risk and for any document from your beneficiaries to justify their capacity.
All provided documents form the application file.

4.2 Any changes in personal circumstances (address, country of expatriation and/or status, family situation), you must let the delegate know in writing.

4.3 After assessing your application form, the delegate will notify your acceptance by issuing a **membership certificate** mentioning the coverage period, your full name and those of your beneficiaries, if any, the chosen covers, the country of expatriation and the amount of corresponding premium.

Depending on the outcome of the medical assessment, the delegate reserves the right to:

- to apply, as the case may be, an additional premium to the total premium;
- to refuse the insurance application. In this case, the delegate will notify his refusal by registered letter with acknowledgement of receipt in the month after receiving the application.

Article 5 - Effective Date, Duration and Contract Renewal - Effective Date of the Covers

You, the subscriber

The effective date of your subscription is the date stipulated on your membership certificate. It starts at the earliest on the 1st day of the month following the reception of your application form by the delegate, subject to your membership acceptance and the payment of your first premium; or the 1st day of the month starting from the date of entitlement to CFE or French Social Security benefits as the case may be.

Your beneficiaries

The effective date of their registration in the same conditions as your subscription. In the event of a change in your family situation (wedding, PACS, new de facto spouse or birth of a child), their registration will be effective in the month following the delegate's express acceptance.

NB: Any children born after your subscription are deemed registered subject to your declaration of their birth to the delegate in the month after their date of birth.

5.1 Your subscription is automatically renewed on the 1st of January each year for further successive periods of one year. **However, you have the option to terminate the subscription to the contract after a one-year period by registered letter, at least two months before the term.**

5.2 The effective date of coverage starts on the membership date indicated on your membership certificate and the one of your beneficiaries, subject to any waiting periods. The delegate with will only cover reimbursable costs incurred starting from the effective coverage date and for the duration of the coverage period.

Article 6 – Change in the geographical area and cover level

6.1 In case of country of expatriation change, you must inform the delegate, in writing, 15 days before the effective change of country.
When this change triggers a geographical area change, the pricing for the new area will be applicable on the first day after the effective date of the change.

6.2 Coverage Changes

6.2.1 Modification of the coverage following a change in the geographical area of coverage.

In parallel to the geographical area change, you can also change the level of coverage previously chosen; **however, changing the Optical/Dental cover is excluded during the course of the membership year.** The delegate must be notified of such change by registered letter with acknowledgement of receipt.

6.2.2 Coverage change after the contract has started

During the membership, it is possible to change the level of cover initially chosen It is necessary that:

- You must have subscribed to the contract for at least one year;
- You must provide a new filled-out and signed medical history form dated less than one month from said change.

The modification can only take place at the next annual renewal of your subscription. Therefore, to change cover levels during a subscription, you must advise the delegate by registered letter with acknowledgement of receipt, at least two months before the renewal date.

6.3 The pricing for the new coverage will be applicable to you from the first calendar month following the date of reception of the letter mentioning the express agreement of the delegate to endorse the new level of coverage.

Article 7 - Premium Payments

7.1 You are responsible for paying the premiums to the underwriting association. Premiums are payable in advance only in euros (€) by cheque, bank transfer or by direct debit from your bank or post office account, according to the schedule and the terms indicated on your application form.
Failing to pay all or part of a premium 10 days after it is due will suspend coverage 30 days after a formal notice to pay remained unheeded that the delegate must send to the member by registered letter with acknowledgement of receipt (indicating the date of the termination as the case may be).
Past this 30-day deadline, the subscription termination is automatic 10 days afterwards, without any other formality.

7.2 **Bank charges are exclusively borne by you. And any tax and charge, present or future, applicable to the premiums or to sums due or to be due, are also borne by you.**

7.3 Contributions relating to CFE affiliation must be directly paid to the Caisse des Français de l'étranger.

Article 8 - Coverage Termination

You, the subscriber:

- **On the termination date of the Contract;**
- **in case of non-payment of your premium (article 7 part I);**
- **On the day the delegate receives a letter indicating that you wish to terminate your subscription in the context of your cancellation right (Article 9, Part I);**
- **in case of termination of the subscription (Article 5.1, part I);**
- **at the time of your death;**
- **as soon as you do not fulfil any one of the subscription conditions (Article 3 part I);**
- **At the end of the month on which you turn 71 years of age.** Members with the same Assurance Santé Monde contract for at least 2 years, will have the option to be covered by the Health cover. For this purpose, a new membership certificate will be issued.

Your beneficiaries

- **At the same time as your membership termination under the conditions defined above;**
- **As soon as they no longer qualify as partner or dependent children (Article 3, Part I).**

Article 9 - Subscription Cancellation Right

9.1 The subscription to the contract can be terminated by the subscriber by exercising his cancellation right in the context and under the conditions laid down in Articles L.112-9 and L.112-2-1 of the French Code of Insurance and by Articles L.121-20-8 et seq. of the French Consumer Code. The first paragraph of Article L. 112-9 of the French Code of Insurance states that:

"Any natural person that has been subject to door to door selling at their home address or workplace, even at their request, and who signed within this framework an insurance proposal or contract for purposes not falling within the context of their commercial or professional activity, has the right to cancel the latter by registered mail with request for notification of receipt during a deadline of 14 consecutive calendar days, as of the date of the conclusion of the Contract, without having to give reasons or bear penalties. (….) Once he/she becomes aware of an incident calling the contract coverage into play, the subscriber may no longer exercise this right of cancellation. "

For a subscriber wanting to use his/her cancellation right, it is advised to write a letter as follows:

Cancellation letter template

By this letter, I the undersigned *(full name of the subscriber)* living at (*address*) hereby cancel my membership of the Assurance Santé Monde Contract number A 4892 (*membership number*) which I signed on (*dd/mm/yyyy*)

(*If premiums have been paid*) and ask for reimbursement of the premium payments I made, under the conditions laid down in Article L. 112-9 of the French Code of Insurance, after deducting the premium due on a prorata basis of the coverage period.

(*For distance selling*) I undertake to reimburse any benefits paid out to me.

In …….....…, on……

Signature of the subscriber

Effects of the cancellation right within the context of Article L. 112-9 of the French Commercial Code

Exercising the cancellation right triggers the contract subscription termination from the date on which the registered letter was received. However, once the subscriber becomes aware of a loss calling the contract coverage into play, he/she may no longer exercise this right of cancellation.

In case of cancellation, the insurer will proceed to reimbursing the premiums paid within 30 days of such termination, after deducting the amount corresponding to the length of time during which the subscription was effective.

The entire premium shall remain due to the insurer if the subscriber exercises his cancellation right whereas a loss triggering the insurance which he was not aware of, took place during the cancellation period.

9.2 In the event of exercising the cancellation right in the context of Articles L.112-2-1 of the French Code of Insurance and L.121-20-8 of the French Consumer Code (distance selling)

In return for the immediate and full execution of the subscription before the end of the cancellation period, the premium for which the subscriber is liable is equal to the annual premium on a prorata basis for the period between the effective date of the subscription and any later date on which the cancellation right is exercised.

If benefits have been paid, the subscriber commits to reimbursing them to the insurer within a 30-day period.

If premium payments have been received, the insurer will reimburse them within 30 days, after deducting the premium due for the coverage period on a prorata basis.

Article 10 Declarations and Communications

10.1 **Pursuant to Article L. 113-8 of the French Code of Insurance, the insurance contract shall be null and void in the event of reluctance or intentional false statement of the insured, when such omission or fraudulent misrepresentation changes the subject of the risk or decreases the insurer's assessment thereof, even if the risk that the insured concealed or distorted has had no impact on the loss.**

In the event of reluctance or intentional false statement of the insured, the insurer shall then be entitled to all due premiums by way of damages as provided for in paragraph 2 of Article L. 113-8 of the French Code of Insurance.

10.2 **In accordance with Art. L. 113-9 of the French Commercial Code:**

- **Any non-intentional omission or misrepresentation by the insured that is recorded prior to any loss shall entitle the insurer either to continue the contract in consideration of an increase in premium accepted by the insured or to terminate the contract 10 days after notice sent to the insured by registered letter;**
- **Any non-intentional omission or misrepresentation by the insured that is recorded after a loss has occurred, the compensation shall be reduced in proportion to the rate of the premiums paid in relation to the rate of premiums that would be owed if the risks had been truthfully and exhaustively declared.**

Article 11- Complaint Reviews - Mediation

First contact: the members' usual contact

In case of a complaint with regards to the contract, members are invited to first get in touch with their usual interlocutor (sales representative or customer service)

Second contact: the complaints department

If a disagreement persists, the members can contact the complaints department: SwissLife Prévoyance et Santé, Service Réclamations, TSA 36003 – 59781 LILLE CEDEX.

As a last resort: the Mediation Department

The Mediation Department gets involved when all other internal departments have been unable to resolve a complaint.
The contact details of the Mediation Department are systematically given to members by the complaints department in the event where the complaint isn't, partially or totally upheld.

After all internal procedures have been exhausted: la Médiation de l'Assurance

The association La Médiation de l'Assurance can be contacted after all internal procedures have been exhausted in the event that a complaint isn't partially or entirely upheld. The insurance ombudsman is competent for all disputes between the issuer and third party beneficiaries of a guarantee or insurance benefit. The ombudsman cannot accept complaints for which litigation has been or is being filed. Complaints to the Ombudsman must be sent to : La Médiation de l'Assurance – TSA 50110 – 75441 Paris Cedex 09 - France

Article 12 - Protection of Personal Data

In accordance with the regulations in force related to the protection of personal data, the entity in charge of processing the collected information is the subsidiary of the Holding Swiss Life France (named Groupe Swiss Life France) mentioned in this document.
The collected data is used by the insurance companies of the Swiss Life France Group, namely Swiss Life Assurance et Patrimoine (SLAP), Swiss Life Prévoyance & Santé (SLPS) and Swiss Life Assurances de Biens (SLAB):
- for the approval, management and execution of your policy;
- for processing in the context of anti-money laundering and combating the financing of terrorism, for the application of the regulatory obligations and management of operational risks, especially concerning insurance fraud;
- for possibly being cross-referenced in order to improve our products, to evaluate or predict your situation and to personalise the offers that might be offered to you.

Your data is also transmitted between the 3 insurance companies of the Group, as mentioned above, which are the recipients of the information, as well as to their representatives, partners and re-insurers or authorised bodies within Groupe Swiss Life France for the needs of its operations.
You have the right to access, correct, erase or port data oncerning yourself. You also have the possibility of defining directives related to the release of your data after your death, or you may choose to limit its use. If you have expressly consented to certain uses of your data, you can withdraw this consent at any time provided that the application of your policy is not dependent on this processing.
You may oppose the processing of your data on legitimate grounds.
You may also refuse to receive, by SMS and email, commercial offers from the 3 insurance companies of Groupe Swiss Life France (Swiss Life Assurance et Patrimoine, Swiss Life Prévoyance & Santé and Swiss Life Assurances de Biens) for similar services and products.
For all requests related to your rights, please contact the data quality and governance department: 7, rue Belgrand – 92300 Levallois-Perret. Medical applications must be sent to the same address and for the attention of the medical officer. You may also write to our Data Protection Officer (DPO): 7 rue Belgrand 92300 Levallois-Perret *(DPOswisslife@swisslife.fr)*
Concerning data collected and processed in the context of anti-money laundering and combating the financing of terrorism, you may directly contact the French National Committee for Information Technology and Liberties *(https://www.cnil.fr/)*.
Our personal data protection policy embodies the essential values of Swiss Life: attention, serenity and reliability. In day-to-day life, this is materialised in the implementation of measures, standards and strict rules for ensuring physical and logical safety, in accordance with any regulatory developments. You can familiarise yourself with them at our website: http://www.swisslife.fr/Protection-des-donnees or request for a document to be sent to your registered email address.

Article 13 - Subrogation

For benefits having a compensatory nature and being paid in compensation for the expenses incurred by the Insured, the provisions of article L.131-2 of the Insurance Code may be applied, if necessary. "*However, in policies that cover the compensation of damage resulting from trespass to the person, the insurer may be subrogated in the rights of the policy holder or the beneficiaries against the responsible third party, for the reimbursement of benefits of a compensatory nature defined in the policy*".

Article 14 - Legal Limitation

The limitation is the loss of a right after a certain period of time provided by law. All actions resulting from the contract are limited by the timeframes and terms of the following articles of the French Code of Insurance:

Limitation Period

Article L. 114-1

All legal actions arising from an insurance contract shall be limited to two years as from the event that gave rise thereto.
However, said time limit shall run:
1) in the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only as from the date on which the insurer is aware thereof,
2) in the event of loss, only as from the date the concerned parties are aware thereof, if they prove that they were unaware of such facts up until then.
When the insured's action against the insurer arises from a third party's recourse, the limitation period shall run only from the date on which said third party brings a legal action against the insured or the latter has paid it compensation.
The limitation period shall be increased to ten years for life insurance contracts when the beneficiary is not the subscriber and in insurance contracts covering personal injury when the beneficiaries are the deceased insured's assigns.
For life insurance contracts, notwithstanding the provisions of the 2nd paragraph hereabove, the actions of the beneficiary are limited to thirty years at most from the death of the insured.

Causes for the Interruption of the limitation period

Article L. 114-2

The limitation period shall be interrupted by one of the ordinary causes that interrupt the limitation period and by the appointment of experts following a loss. The limitation period of the legal action may also be interrupted by the insurer sending the insured a registered letter with acknowledgement of receipt in respect of the action for payment of the premium and by the insured to the insurer in respect of the settlement of the claim.

Limitation as a matter of public policy

Article L. 114-3

Ordinary causes of interruption of the limitation period

The ordinary causes of interruption of the limitation period provided for in the aforementioned Article L.114-2, are those laid down in accordance with the terms and conditions of the following articles of the French Civil Code:

Recognition by the debtor of the right of the person against whom he was prescribing

Article 2240 of the French Civil Code

The acknowledgement by the debtor of the right of the person against whom he was prescribing interrupts the period of limitation.

Legal Claim

Article 2241 of the French Civil Code

A legal claim, even by way of summary proceedings, interrupts the delay of prescription and the delay of foreclosure.

The same occurs when the claim is brought before a court without jurisdiction when the act of referral to the court is annulled on account of a procedural defect.

Article 2242 of the French Civil Code

The interruption resulting from the judicial demand has continuous effect until the proceedings terminate.

Article 2243 of the French Civil Code

Interruption fails to occur if the plaintiff abandons his legal claim or allows the proceedings to lapse, or if the demand is definitively rejected.

Precautionary measure and forced act of performance

Article 2244 of the French Civil Code

The period of limitation or the period of foreclosure is also interrupted by a conservatory measure taken in application of the Code of the Civil Procedures of Enforcement or of an act of forced execution.

By derogation to Article 2254 of the French Civil Code, the parties of the insurance contract, even by mutual agreement, cannot modify the limitation period nor add any causes for its interruption.

The limitation period extended to persons

Article 2245 of the French Civil Code

The calling in of one solidary debtor by judicial demand, or by an act of forced execution, or by the acknowledgement by the debtor of the right of the person against whom he was prescribing, interrupts the period of limitation against all the others, even against their heirs.

But the calling in of one of the heirs of a solidary debtor, or the acknowledgement by that heir does not interrupt the limitation period against co-heirs, even in case of a hypothecary claim, if the obligation is divisible. This calling in or this acknowledgement only interrupts the period of limitation against the other co-debtors for the share for which this heir is bound.

To interrupt the period of limitation for the whole, for all the other co-debtors, the calling in must be addressed to all the heirs of the deceased debtor or the acknowledgement must be addressed to all these heirs.

Article 2246 of the French Civil Code

A calling in addressed to the principal debtor or his acknowledgement interrupts the period of limitation against the surety.

Article 15 - Right to communicate and amend data

In accordance with the French Data Protection Act of the 6 January 1978, the data processing officer is the entity of the Swiss Life Group mentioned in this document. The data are used for the management and the follow-up of your file by this entity and for the purpose of sending documents regarding products of the companies of the Swiss Life Group, recipients, with its agents, partners and reinsurers, of the information. They are also processed in the context of the fight against money laundering and the financing of terrorism, failing to give mandatory information can result in your file not being processed. Optional data are flagged as such. You have a right to access and rectify your personal data, and you may also object to this information being processed, subject to a legitimate reason. You can send your requests to the Marketing Division of Swiss Life – 1, rue du Maréchal de Lattre de Tassigny – 59671 Roubaix Cedex 01 – France. For requests related to medical information, please address such requests to the consulting physician – 7, rue Belgrand – 92300 Levallois-Perret – France.

Article 16 - Applicable Law

We draw your attention to the fact that the contract and therefore your subscription, are governed by French Law.

Part II
Health Covers

Article 1 - Benefits covered

1.1 The health covers have for purpose to reimburse all or part of your medical, surgical, optical and dental expenses and those of your beneficiaries. Expenses taken into consideration are exclusively those stipulated in the tables of benefits.

1.2 Regarding you and your beneficiaries, the covers entitle to Reimbursable costs benefits for which the date of care is included between the effective date and the termination date of the subscription, subject to the medical acts being prescribed and performed by authorised and accredited doctors to practice such acts, or by eligible healthcare facilities.
When the reimbursement comes in addition to the reimbursements of the CFE or French Social Security (for seconded staff):

- The delegates reimbursement is contingent to the reimbursement of these institutions;
- Only the expenses for which the beginning of the care, as indicated in the CFE slip, (or the French Social Security for seconded staff) is included between the effective date and the termination of the subscription.

The benefits covered by the contract are in addition to the benefits of same nature that could be paid out by the CFE or by another complementary cover that you or your beneficiaries may benefit from, without any of you being able to receive in total an amount greater than the costs actually incurred.

Article 2 – Direct Care Payment

Emergency hospitalisation

You must contact and inform your delegate of your emergency hospitalisation and/or the hospitalisation of your beneficiaries within 48 hours of such hospitalisation in order to set-up the direct payment of all reimbursable costs.

Inpatient care

For inpatient care, a prior authorisation request must be addressed to the delegate at least 2 weeks before the planned hospitalisation date. After authorisation is granted, the delegate will issue an agreement to cover the treatment which will be paid directly to the eligible healthcare facility.

NB: External consultations directly linked to a hospitalisation (pre and post hospitalisation) and pre and post childbirth sessions are excluded from direct care payment.

Article 2 - Healthcare Contributions

3.1 If you and/or your beneficiaries only subscribe temporarily or in the event of a departure during the course of the year, the premiums will be adjusted and the premium for the last quarter of subscription is due for the entire quarter.

3.2 The pricing conditions are established according to the coverage chosen, the type of cover (from the first euro, in addition to the benefits paid by the CFE or by the French Social Security), the applicable geographical area, the age group and the family situation of the member.

The delegate reserves the right to adjust the premiums on the 1st January each year according to the change in medical cost of healthcare expenses in each country, the modification of local legislation and the technical results of the contract issued by the insurer.

Article 4 - Healthcare Payment Process

4.1 For benefits to be paid out, you must send the following original documents to the delegate:

- The **Claim form** duly filled out and indicating your contact details and/or those of your beneficiaries;
- **The medical prescription;**
- The detailed paid **invoice**, as well as all the practitioner fee statements and fees from any eligible healthcare facility;
- if the covers complement the French Social Security or the CFE benefits: the **benefit statements** and a **copy of the invoices**;
- The **receipts** issued by pharmacies with the relevant prescription;
- The **delegate's authorisation** for any treatment subject to prior authorisation.

The payment is made in your name or in the name of a representative that you will have expressly designated.

NB: On pain of lapse, reimbursement requests must be presented to the delegate within 2 years from the date on which treatment started on.

Reimbursements are made in euros (€). However, if the country of expatriation is outside of the euro zone, you can opt for the benefits to be paid by bank transfer on a foreign account in the currency of your choice (at the applicable exchange rate on the date of treatment).

Article 5 - Waiting Periods

5.1 You and your beneficiaries can take advantage of the health covers after a waiting period of:

- 3 months for reimbursable costs related to treatment and inpatient care, except in case of an accident or an unexpected illness;
- 3 months for dental care;
- 6 months for any devices, implants, dentures (dental prosthesis) and orthodontics;
- 6 months for psychiatric inpatient care;
- 10 months from the date of membership for maternity costs (including IVF).

5.2 These waiting periods are applicable:

- at the subscription of the contract;
- In case of coverage increase: in this case during the waiting period, you and your beneficiaries are covered by the previous level of coverage.

Waiting periods can be lifted except for the Maternity cover, if you can justify an equivalent cover in the month preceding your subscription to the Assurance Santé Monde contract.

Article 6 - Territorial Scope - Expatriation Area

Area 1	*Area 2*	*Area 3*
Worldwide except the countries in in areas 2 and 3 (exclusive of the United States and Switzerland).	Brazil, China, United Kingdom, Spain, Portugal, Russia, Singapore, Italy, Greece, Germany, Australia, United Arab Emirates, Saudi Arabia, Israel, Lebanon, Monaco, New-Zealand, Bahrain, New Caledonia, Qatar, Bahamas,	Canada ınd Japan.

6.1 Your area is determined by your country of expatriation

The cover applies to the reimbursement of reimbursable costs which occurred in the geographical area of coverage. However, coverage can also be applied as follows:

- in areas 1 and 2 for a membership in area 3;
- in area 1 for a membership in area 2.

Any exemption must be submitted to the prior authorisation of the delegate, failing which the reimbursement can be refused.

6.2 **Healthcare costs must be incurred as a priority in your country of expatriation or in your home country. By derogation, the costs can be incurred in a neighbouring country to the country of expatriation if the quality of care is better, subject to the prior authorisation of the delegate. Transportation costs are exclusively borne by you.**

6.3 For emergencies (accident or unexpected illness), the reimbursable costs incurred in countries located outside the subscribed geographical area of coverage will be covered if they occur during your private or business trips and/or those of your beneficiaries, lasting 30 days at most. **Travel expenses are exclusively borne by you.**

Article 7 - Health Benefit Tables

7.1 Inpatient costs

	Basic Cover	*Comfort Option*	*Deluxe Option*
Hospitalisation *(1) (2)* – Surgical and medical hospitalisation – Day hospitalisation – Inpatient care linked to critical illnesses (cancer, AIDS, organ transplants, strokes) – Inpatient fees, medical and surgical fees – Any treatment during hospitalisation	100% of AC	100% of AC	100 % of AC
Psychiatric Hospitalisation	No	100% limit 30 days	100% limit 60 days
Postoperative treatment and aftercare(1)	100% of AC		
- Rehabilitation after inpatient care(1)	Maximum 30 days	+ 15 days (+ basic = 45 days)	+ 30 days (+ basic = 60 days)
– Individual room (including the provision of a telephone and television)	€60 per day	+ €70 (+ basic = €130)	+ €160 (+ basic = € 220)
– Bed for accompanying adult to a child of less than 16 years of age	€40 per day	€25 (+ basic = €65)	€80 per day (+ basic = €120)
– Day hospitalisation – Home hospitalisation	100% of AC	100 % of AC	100 % of AC
External consultations linked to inpatient care (before and after)	90% of AC	100% of AC	100% of AC
- Transportation by land ambulance related to covered inpatient care	90% of AC	100% of AC	100% of AC
Maternity *(1) (2)* - Childbirth With a 10-month waiting period	No	100 % of AC Maximum (including individual room) €3,000 A 1 €5,000 A 2 €10,000 A 3	100 % of AC Maximum (including individual room) €5,000 A 1 €8,000 A 2 €15,000 A 3
- Childbirth with surgery	No	See inpatient care section 100% of actual costs	See inpatient care section 100% of actual costs
- In vitro fertilisation- IVF 10-month waiting period Maximum 45 years old	No	4 IVF treatments per membership - Maximum €1,000 par IVF treatment	4 IVF treatments per membership - Maximum €1,600 par IVF treatment
- Pre and post childbirth sessions	No	14 sessions Maximum €40 per session	16 sessions Maximum €60 per session

(1) Request for prior authorisation is compulsory.
(2) Direct care payment.
(3) AC: Actual costs.
A : Area.

7.2 Medical expenses

	Basic Cover	Comfort Option	Deluxe Option
Consultant Fees(1) - Consultations and visits: • General Practitioners • Specialists • Psychiatrists	100 % of AC Maximum €40 per act Maximum €60 per act No	100 % of AC Maximum €60 /act (+basic = €100) Maximum €80/ act (+basic = €140) Maximum 6 sessions per year €150/act	100 % of AC Maximum €140 /act (+basic = €180) Maximum €160 /act (+basic = €220) Maximum 12 sessions per year €240 per act
Medical Staff(1) Podiatrists, speech therapy, orthoptics, nursing care, physiotherapy.	100 % of AC Maximum €80 per session Maximum €1,000 per year	100 % of AC Maximum €70 per session (+ basic = €150) Maximum €1,500 per year (+ basic = €2,500 per year)	100 % of AC Maximum € 140/ act (+ basic = € 220) Maximum €2,500 per year (+ basic = €3,500 per year)
Complementary Therapy or Alternative Medicine(1) - Acupuncture, chiropractic therapy, homoeopathy, osteopathy, phytotherapy, Chinese medicine	No	100 % of AC Maximum €120 per session Maximum €1,000 per year	100 % of AC Maximum €200 per session Maximum €2,000 per year
Blood tests / Radiology(1) Including medical imaging (MRI, scanner) - Other medical treatment out of hospital facilities	100 %	100 %	100 %
Pharmacy Including vaccines	100 %	100 %	100 %
Health Assessment(1) Every 2 years + prevention and screening	No	100 % of AC Maximum €800 per year and per person	100 % of AC Maximum €1,500 per year and per person
Non-dental devices and prostheses	100 % of AC Maximum €200 per prosthesis After an accident with inpatient care: €300 per prosthesis	100 % of AC Maximum €200 per prosthesis (+ basic = €400) After an accident with inpatient care + €700 per prosthesis (+basic = €1,000)	100 % of AC Maximum €800 per prosthesis (+ basic = € 1,000) After an accident with inpatient care: + €1,200 per prosthesis (+ basic = €1,500)

(1) Prior authorisation necessary for treatments in series in excess of 10 sessions.
AC: Actual costs.

7.3 Optical and Dental Care

	Basic Cover	Comfort Option	Deluxe Option
Eyesight - Lenses and frames	100 % of AC Maximum €300 per year and per person	+ €200 (+ basic = €500) per year and per person	+ €250 (+ basic = €350) per year and per person
- Contact lenses Including disposable lenses	€100 per year and per person	+ € 100 (+ basis = € 200) per year and per person	+ €250 (+ basic = €350) per year and per person
- Refractive surgery(1)	No	100 % of AC Maximum €500 per year and per person	100 % of AC Maximum €800 per year and per person
Dental Care - Dental care, implants, devices and dentures (1) (2)	100% of AC €250 limit per tooth Maximum €900 the 1st year and €1,500 from the 2nd year onwards Per year and per person	100% of AC Limit: €300 per tooth (+ basic = €550) Maximum €1,000 the first year (+ basic = €1,900) €1,500 from the 2nd year onwards (+basic = €3,000) Per year and per person	100% of AC Limit: € 550 per tooth (+ basic = € 800) Maximum €1,500 the first year (+ basic = €2,400) €2,500 from the 2nd year onwards (+basic = €4,000) Per year and per person
- Orthodontics(1) For treatment started before the age of 16	No	100 % Maximum €1,000 per year and per person Maximum 3 years	100 % Maximum €1,800 per year and per person Maximum 3 years

(1) Request for prior authorisation is compulsory.
(2) Limits per tooth and per visit for any dental care, device, denture not accounted for per tooth. AC: Actual costs.

Article 8 - Request for Prior Authorisation

8.1 **Non-compliance with the prior authorisation process will result in the reimbursement of costs being refused. Where treatment payment has been denied by the delegate, any costs are borne by you.**

8.3 Prior authorisation must be requested to the delegate for the following treatments:

Inpatient care and Maternity

A prior authorisation request must be addressed to the delegate at least two weeks before the planned inpatient care, except for emergencies.

For emergencies: a prior authorisation request must be sent to the delegate within 48 hours after entering the eligible healthcare facility (hospital or clinic) with mention of the urgency of the hospitalisation.
Exceptionally, this 48-hour timeframe can be extended if the delegate attests that the clearly urgent situation in which you or your dependent was, made it impossible to make a prior authorisation request within the given timeframe.

NB: for any extension of the hospitalisation, beyond 10 consecutive days, the prior authorisation request must be renewed every 10 days. It must be sent to the delegate within 48 hours following the end of the said period.

For any medical or surgical service transfer, a new prior authorisation request must be filled out imperatively within 48 hours of such transfer.
In case of service change during your hospitalisation, you must renew your prior authorisation request.
For stays in rehabilitation centres, a prior authorisation request must be sent to the delegate at least two weeks before the rehabilitation starts following inpatient care.

Medical expenses

The acts performed in series: if their number is greater than 10 per prescription and per person insured (prior authorisation must also be requested in the case of a renewal of a prescription for less than 10 acts bring the total number to more than 10).
The prior authorisation request must include the prescribing doctor's prescription and must indicate the pathology and the anticipated treatment period.
You and/or your beneficiaries must send to the delegate's consulting physician at least 10 days before the beginning of the medical treatment, the prior authorisation request filled out and signed by the practitioner and marked as confidential.

Dental Care

- Dental devices, implants and dentures (including temporary crowns).
- Orthodontics

At least 10 days before the treatment, a prior authorisation request must be filled out and signed by the practitioner and returned to the delegate. Depending on the acts, objects of the prior authorisation request, a panoramic x-ray might be required.

Optical Care

- Refractive surgery.

Article 9 - Reimbursable Costs Limits

9.1 **"Unusual or unreasonable costs", can be the object of a payment refusal or a limitation of the amount covered by the delegate. Assessing the "unusual or unreasonable" character of costs as well as deciding whether to refuse or limit the covered amount, the delegate will take into account the costs ordinarily applicable for a similar service or benefit, in the best possible conditions, locally to where the service or benefit was performed.**

9.2 The delegate reserves the right to perform administrative or medical checks in the case of unusual or unreasonable costs. He can set-up a meeting with you and/or your beneficiaries, for an inspection except if this is incompatible with your/their state of health. Transportation costs are exclusively borne by you.

9.3 Where treatment payment has been denied, any costs are borne by you.

Article 10 - Maximum Commitment

The maximum commitment is set according to the level of Inpatient care coverage chosen. If only medical expenses coverage has been subscribed to, then the maximum commitment shall be set according to the level of that cover.
Health covers are valid for up to the following amounts, per insured and per calendar year of insurance, including the benefits paid by the CFE or French Social Security (for seconded staff):

- EUR 500,000 for the mandatory "Basic" cover
- EUR 800,000 for the "Comfort Option" cover
- EUR 1,500,000 for the "Deluxe Option" cover

Article 11 - Excluded Risks

Are cumulatively excluded from the Health cover the following risks:

- **Pathologies and addictions: treatment of pathologies and addictions or of their consequences, or of the consumption or the abuse of any substances, drugs or alcohol. Treatments including in particular addiction treatments, psychoanalyses, psychotherapies;**
- **Conflict and disaster: the treatment of any affection, illness, injury resulting from a nuclear or chemical contamination, war, riot, revolution, act of terrorism, fight or similar events, in which the insured took an active part. The events of legitimate defence, accomplishing professional duty and assisting a person in danger are risks that are covered;**
- **Care relating to an aesthetic treatment or to cosmetic surgery: the treatment undertaken for aesthetic or psychological reasons to enhance the appearance, except of the treatment is reconstructive surgery due to an accident of the insured that occurred during the coverage period or reconstructive surgery after breast cancer;**
- **Treatments for teeth whitening even on medical prescription and performed by a qualified practitioner;**
- **Organ donation: the costs borne for the acquisition of an organ and in particular the removal of the donor's organ, the harvesting of the insured's organ for a transplant to another person, the compatibility tests, the donor organ transportation and the cost of administrative procedures;**
- **Experimental treatments: the treatment, including the medication, according to the insurer's or his delegate's reasonable opinion, is experimental or the effectiveness of which has not been proven on the basis of established medical practices, and that has not been accredited by official authorities in the country where the insured received treatment;**
- **Thalassotherapy: accommodation costs, treatment or services received in thalassotherapy centres, spa or similar establishment, even on medical prescription;**
- **Treatments targeting the relief of symptoms of ageing, or another natural physiological cause;**
- **Intentional injuries: the treatment resulting from intentional assault and battery by the insured himself, during an attempt to commit suicide;**
- **Sports and leisure: the expenses resulting from pathologies linked to the professional practice of a sport or hobby and the consequences of participating in dangerous sports, dangerous competitions or certain hobbies like sports that are airborne, combat sports, mountain climbing, off-piste mountain sports, scuba diving (except for recreational scuba diving at depths of less than 50 metres), sports requiring the use of air vehicles;**
- **Non-essential expenses linked to inpatient care which are not covered by the insurance, such as newspapers, visitor meals and cosmetic products;**
- **All personal expenses namely alcohol, toothpaste, shampoo and clothing;**
- **Non-recognised healthcare facility or practitioner: the administered treatment by a practitioner that is not accredited by the official authorities in the country where the care is given;**
- **Treatment in a healthcare facility or done by a practitioner or any other service provider who was informed by the insurer or by his delegate, by written notice, that it is not recognised for insurance purposes;**
- **Treatments relating to any type of contraception that is not reimbursed by the CFE or the French Social Security, sterilisation, abortion or family planning except in the case of a proven health hazard for the pregnant woman;**
- **Obesity diagnosis and treatments such as tests and weight-loss programmes;**
- **Treatments for growth issues such as growth hormones;**
- **The treatment of personality disorders, particularly emotional disorders, histrionic personality disorders, behaviour disorders, schizoid personality disorder, autism spectrum disorders, obsessive-compulsive disorders, hyperactivity, adjustment disorder, eating disorders and the treatments designed to encourage socio-emotional relationships such as communication therapies except in case of psychiatric treatment by a psychiatrist as opposed to a psychoanalyst, psychotherapist or a coach;**
- **Genetic testing to determine the risks of developing an illness when the person is not affected by such illness except when it is reimbursed by the French Social Security or by the CFE;**
- **Diagnosis and treatment of hair loss except when it is due to cancer treatment;**
- **The treatment of problems of a sexual nature such as impotence, sex change and sexual reconstruction;**
- **Transportation costs incurred during treatment except when they are covered by inpatient care;**
- **Costs relating to the treatment of complications due to an excluded illness or injury;**
- **Treatments relating to surrogacy, that the insured be the surrogate or the receiving parent;**
- **Life-sustaining treatment which will not heal the insured such as respirators;**
- **Medical equipment not classified as prosthesis or device except as otherwise provided in the tables of benefit;**
- **Foot care treatment such as corns, calluses and nails, not performed by a podiatrist;**
- **Accommodation in an eligible healthcare facility (hospital or clinic) for other purposes than to receive treatment like the convalescence, general nursing care or the surveillance, or when the given treatment does not require inpatient care in an eligible Healthcare Facility such as help for everyday tasks or the services of a therapist or medical personnel. Providing a bed for the person accompanying a hospitalised child that is less than 16 years old is not excluded from coverage;**
- **the products classified as vitamins or minerals as well as food supplements except during pregnancy if they are the object of a medical prescription;**
- **Expenses incurred before the effective date or after the termination date of the subscription;**
- **The expenses that are not or that would not be reimbursed by the CFE or French Social Security, except for contact lenses, individual rooms, per diem allowances, alternative medicine, refractive surgery and health assessments;**
- **The expenses not covered by the CFE caused by the non-payment of CFE contributions;**
- **The costs relating to preventive medicine not reimbursed by this contract;**
- **Medical expenses incurred during a pregnancy, when the inpatient care cover with the Comfort or Deluxe options have not been chosen.**

Part III
Optional Providence Covers

Section I Death - Accidental Death

Article 1 - Benefits covered

1.1 In case of **death**: the insurer will pay out a lump-sum to the beneficiary(ies) stipulated on the membership certificate. With the exception of the exclusions mentioned in Article 6 Section I, the insurer covers the risks of death for any cause.

You can choose the lump-sum amount between a **minimum of 20,000 euros** and a **maximum of 300,000 euros**, **by increments of 20,000 euros**. However, the amount of the lump-sum paid out is limited to 300% of your base salary if you are employed and 100,000 euros if you are not employed.

1.2 **Accidental death** benefit: the insurer pays out to the beneficiary(ies) of the benefit, the double of the lump-sum for all-cause death stipulated on your membership certificate.
Accidental death means the death of the subscriber resulting from an accident and happens immediately or within 12 months from the day of the accident.

Article 2 - Lump-sum Beneficiaries

You name the beneficiary(ies) in the beneficiary clause of your application form. This designation can be modified at any time as long as the beneficiary(ies) has(have) not accepted the benefit of the lump-sum under the conditions of Article L. 132-9 II of the French Code of Insurance. In any case, you must send a date and signed registered letter to the delegate informing him of the new designation. **Any designation or change of designation is unenforceable if it wasn't notified.**

If you haven't named a beneficiary in your application form or if this designation is obsolete, the beneficiary of the lump-sum is allocated in order of preference to:

- the spouse not legally separated;
- otherwise, the partner linked by a PACS or the de facto spouse;
- otherwise, shared equally between them, the children, born or to be born, living or represented;
- otherwise, the father and mother, shared equally between them, or the surviving one of them;
- otherwise, the heirs.

This designation can be the object of a private or authentic deed in accordance with aforementioned Article L. 132-9 II.

Article 3 How to Claim – Guaranteed Lump-Sum Payment

3.1 How to Claim

A subscriber's death must be declared to the insurer by the beneficiary(ies), the legal representative if applicable or the underwriter as soon as he/she is aware of it.

3.2Supporting documents

In all cases, the supporting documents, translated and validated by consular services, to be given to the insurer for the payment of the benefit are:

- the extract from the Death Register;
- a medical certificate indicating the cause of death and in the absence of an exact cause, an indication of such cause as it was given to the beneficiaries;
- the updated family record book stipulating the subscriber's death and the usual annotations;
- the beneficiary's birth certificate;
- a two-sided photocopy of the beneficiary's currently valid ID card or passport;
- a salary certificate from the employer with the salary over the past twelve months subject to social contributions separating: gross wages and gratifications;
- the notarial certificate if applicable;
- a sworn statement of non-separation from the spouse or a PACS agreement registered at the Registry of the Court of first instance of the joint residence of the partner if he is a beneficiary;
- Supporting documents for the subscriber's dependent children when the benefit paid out depends on the family situation of the subscriber on the day of his/her death.

Additionally, only in the case of an accidental death:

- a medical certificate from the doctor having confirmed the subscriber's death including a stipulation that the accidental death does not result from an excluded risk;
- If applicable, any documents describing the cause and circumstances of the accident having caused the subscriber's accidental death (newspaper clippings, police report, etc.).

3.3Additional Information

The insurer reserves the right to ask for any additional supporting document that he might deem necessary and to verify that the member's death does not result from an excluded risk.

3.4Lump-sum payment

3.4.1 Appreciation of the capital

The capital planned in application of the specific conditions is capitalised under the provisions of Article R.132-3-1 of the French Code of Insurance until the day following the reception of the supporting documents mentioned above, required for the performance of the Contract, or, as the case may be, until this sum is deposited with the Caisse des Dépôts et Consignations pursuant to Article L. 132-27-2 of the French Code of Insurance.

3.4.2 Timeframe for the payment

The payment of the benefit is made in euros (€) to the beneficiary(ies) within thirty days from the date on which all the supporting documents were received.

Article 4 - Coverage termination

The death and accidental death covers end:

- **When the insurer has paid out the lump-sum as provided for in case of death or accidental death, in advance in the case of CILA or CILAA;**
- **When the subscriber no longer benefits form the Health cover.**
- **At the end of the calendar quarter during which the subscriber has reached the age determined by Article L. 351-8 of the French Social Security Code (legal retirement age to receive a full pension in France).**

Article 5 - Countries excluded from the cover

5.1 The risks of death and of accidental death are covered worldwide **with the exception of the following countries**: **Afghanistan, Angola, Burundi, North Korea, India (only the following provinces : Jammu, Kashmir, Punjab, Rajasthan, Gujarat), Iraq, Kosovo, Palestine, Gaza Strip, West Bank, Liberia, Libya, Mali, Mauritania, Nigeria, Pakistan, Democratic Republic of the Congo (ex-Zaire), Rwanda, Sierra Leone, Somalia, Sudan, South Sudan, Syria, Chad, East Timor, Yemen.**

5.2 The insurer reserves the possibility to update the list of countries above.

Article 6 - Excluded Risks

6.1 The Death cover does not apply on any of the following grounds:

- **The member's suicide: no insurance benefit can be claimed if the member voluntarily kills himself/herself, knowingly or unknowingly, during the first year of insurance under this contract and potentially in the previous death insurance plan comprising similar coverage taken out by the policyholder. In the case of increased coverage during the course of the contract, the suicide risk, for additional cover is only available from the second year after the increase;**
- **The subscriber's death caused by the beneficiary(ies): the coverage stops having a binding effect on the beneficiary(ies) when they have voluntarily killed or cause the death of the subscriber. The guaranteed capital is then passed on to the next beneficiary in the order of the designation or model clause in the application form;**
- **Aviation risk and risk of any aerial sport: the risks resulting from an accident of aerial navigation is only covered if the insured person is on board an aircraft with a valid certificate of airworthiness and flown by a pilot with an unexpired permit or licence. The pilot can be the insured person him/herself.**
  Matches, bets, races, aerial acrobatics, records, record attempts or preparatory tries as well as type-approval tests are excluded from coverage.
  Is included in air navigation, the use:
  – of ultralights (ULM);
  – flying wings (hang gliding) and of parachutes as long as these devices are in compliance with existing standards;
- **Risk of war: the coverage of war risks can only be granted in the conditions laid down by French legislation imposed on insurance companies on life in times of war. War means any armed conflict occurring on French territory or on territory where France is one of the belligerent parties;**
- **Serious health risk: coverage stops when the insured persons do not observe, more than 10 days after the dissemination of advice by French consular authorities to its nationals or by the World Health Organization following a serious health risk (classified as a public health emergency of international concern - PHEIC), potential repatriation recommendations decided by the World Health Organization.**
  This exclusion does not apply if relevant local authorities restrict or prohibit travelling.

6.2 the exclusions of the Accidental Death cover are the ones indicated in the Death cover (Article 6.1 above), completed as follows:

- **The risks and consequences of cosmetic surgery non-consecutive to an accident or the treatment of congenital malformations;**
- **The insured's drunkenness or the use of drugs or tranquillisers in non-medically prescribed quantities;**
- **Practising a sport professionally or a dangerous sport such as: The use of an ultralight (ULM), hang gliding, paragliding, auto racing, motorcycle racing or kart racing, parachuting, mountain climbing, rock climbing (excluding artificial support), climbing, scuba diving except for recreational diving at depths of less than 50 metres, spelunking, skeleton racing, ski jumping, mountain sports, bobsleighing, bungee jumping, rafting, canyoning, kitesurfing, hot air ballooning, jet-skiing, as well as any sport requiring the use of any kind of land, sea or air engine; hunting;**
- **foreign war, civil war, riot, insurrection, fight, act of terrorism, if the person actively and voluntarily took part in the event.**
  The events of legitimate defence, assisting a person in danger and accomplishing professional duty are risks that are covered;
- **The consequences of the disintegration of the atomic nucleus or ionising radiation released suddenly and fortuitously by nuclear fuels or by radioactive products or waste coming from reactors and having contaminated the surroundings of the source of emission (whether stationary or moving) to the extent that within a one kilometre radius, the measured absorbed dose on the ground, 24 hours after the emission, exceeds 0.01 Gray (or 1 rad) per hour.**

Section II - Complete and irreversible loss of autonomy - Complete and irreversible loss of autonomy caused by an accident

Article 1 - Benefits covered

1.1 In case of complete and irreversible loss of autonomy (CILA), the insurer pays out to you in advance, the death benefit (Article 1.1 Section 1 " All-Cause Death").

1.2 In case of complete and irreversible loss of autonomy caused by accident (CILAA), the insurer pays out to you, in advance, the accidental death benefit (Article1.2 Section I "Accidental Death").

1.3 The CILA or CILAA benefits cannot be cumulated and the payment of the lump-sum in advance puts an end to the all-cause death and accidental death benefit (Article 1 section I "Death - Accidental Death")

1.4 In all cases, you are considered in a state of CILA or CILAA when:

- You are declared indefinitely incapable of holding an occupation, nor any work generating an income or profit;
- You are obliged to get assistance from a third party to help you with ordinary day-to-day tasks.
- And if it is established that your state, as a permanent disability, cannot eventually improve.

And additionally, in case of CILAA:

- When the CILAA is recognised immediately or within 12 months of the accident.

Article 2 - How to Claim - Insured Lump-sum Payment

You must declare your state of CILA or CILAA to the insurer. The statement must be done in writing, on pain of lapse, within 3 months, except in unforeseeable circumstances or in the case of force majeure, from the date on which you were qualified as in CILA or CILAA (Article 1 above).
Proving your CILA or CILAA is your responsibility.

Supporting documents, translated by consular services, to be given to the insurer are, **in all cases**:

- The **membership certificate;**
- The **detailed medical certificate** stipulating the nature of the disability and the date of medical diagnosis of the occurrence of the event causing the disability. This certificate must also attest that the disability satisfies the conditions laid down in Article 1 above and that it is not expected to improve.

And if this insurance is taken out in addition to a basic social security scheme (like the French Social Security):

- The decision notice from this institution granting an allowance for the assistance of a third party.

Additionally, for the proof of CILAA:

- A medical certificate from the doctor having assessed that the CILAA does not result from an excluded risk (Article 5 Section II);
- If applicable, any documents describing the cause and circumstances of the accident having caused the CILAA (newspaper clippings, police report, etc.).

2.1 The insurer can ask for any additional supporting document as he deems appropriate.
The insurer's consulting physician reserves the right to verify in the meantime that the CILA or CILAA does not result from an excluded risk (Article 5 Section II) and to submit you to a medical expertise, at his expense.

2.2 As soon as the consulting physician recognises that your state of CILA or CILAA does not result form an excluded risk, and at the earliest, 6 months after such recognition, the insurer will pay out the lump-sum to you in advance, in euros (€), whether there is an accident or not (Article 1.1 and 1.2).

Article 3 - Coverage termination

The CILA and CILAA coverage ends:

- **when the insurer had paid out the lump-sum in advance, in the case of the subscriber's CILA or CILAA;**
- **when the subscriber no longer benefits from the Health cover.**
- **at the end of the calendar quarter during which the subscriber has reached the age determined by Article L. 351-8 of the French Social**

Article 4 - Countries excluded from the cover

CILA and CILAA risks are covered globally except for the countries stated in Article 5 of the Death and Accidental Death benefits.

Article 5 - Excluded risks

5.1 Exclusions from the CILA benefit:

- **The excluded risks are those stipulated in case of death (Article 6.1 section I);**
- **Are also excluded the disabilities provoked deliberately or intentionally, knowingly or unknowingly, by the person insured (attempted suicide, injuries and mutilations) as well as disabilities caused by a work-related accident or by an occupational disease.**

5.1 Exclusions from the CILAA benefit:

- **The excluded risks are those stipulated in case of death (Article 6.2 section I);**
- **Are also excluded the disabilities provoked deliberately or intentionally, knowingly or unknowingly, by the person insured (attempted suicide, injuries and mutilations) as well as disabilities caused by a work-related accident or by an occupational disease.**

Section III - Total Temporary Incapacity for Work– Permanent disability

Article 1 - Benefits covered

1.1 Total Temporary Incapacity for Work (TTIW)

1.1.1 If you are in TTIW, the insurer will pay you a per diem allowance, after the expiry of the deductible, from the 1st euro, in addition to the benefits of the CFE or the French Social Security.

1.1.2 The per diem allowance is paid out to you from the 31st, 61st or 91st day of medical leave depending on the deductible that you have chosen and that is stipulated on your membership certificate. The periods of return to work on a therapeutic part-time basis compensated by the CFE or French Social Security are taken into consideration for the calculation of the deductible.

1.1.3 Likewise, you choose your per diem allowance between a minimum of 20 euros and a maximum of 140 euros, in increments of 20 euros within the limit of 0.1% of the chosen lump-sum (Article 1.1 Section I "Death")

1.1.4 You are considered in TTIW when, because of an accident or an illness, your health prevents you from working. When the cover is chosen in addition to the reimbursements of the French Social Security or CFE you will also receive a per diem allowance from one of these institutions in respect of this medical leave.

1.2 Partial or Total Permanent Disability

1.2.1 If you are totally or partially disabled, the insurer will pay you a per diem allowance, after the expiry of the deductible, from the 1st euro, in addition to the benefits of the CFE or the French Social Security.

1.2.2 The global amount of the disability annuity corresponds to the per diem allowance chosen (Article 1.1.3 section III) multiplied by 360.

1.2.3 You are considered totally or partially permanently disabled when after an illness or an accident having triggered the payment of per diem allowances by the insurer, you are unable to resume a professional occupation and simultaneously, after your health has had time to stabilise, you present a functional incapacity and a professional incapacity:

- **Functional incapacity** is determined with regards to the nature of your impairment, your general state, your age, your physical and intellectual capacities. It is established on the indicative common law functional incapacity table;
- **Occupational incapacity** is assessed with regards to the rate and the nature of the functional incapacity in comparison to the professional occupation, the normal conditions of work, what part of the occupation can still be done now, the options to change occupation for a socially equivalent one and the possibilities for rehabilitation.

The nature and the rate of the disability are set by the delegate's consulting physician.
The occupational and functional incapacity rates are therefore defined and the disability rate "R" is determined in the table hereafter:

Occupational incapacity rat	*Functional 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	36.34	42.17	47.02	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	89.79
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

When the cover is chosen in addition to the reimbursements of the French Social Security or CFE, your permanent disability must also be recognised by this institution.

1.3 The amount of the full disability annuity corresponds to 70%, 80% or 90% of the 365th part of your base salary, depending on what is shown on your membership certificate. The amount of the disability annuity is determined by the full disability annuity and by your disability rate "R" as defined hereabove:

- If the disability rate "R" is greater or equal to 66%, the disability annuity paid out is the full disability annuity.
- If the disability rate "R" is between 33% and 66%, the disability annuity paid out is equal to the product of the full disability annuity and the ratio between "R" and 66%.
- If the disability rate "R" is lower than or equal to 33%, no benefit is due by the insurer.

1.4 **The per diem allowance and the disability annuity actually paid out are limited so that the cumulative benefits that you receive, including those from the French social security, the CFE, another basic scheme, another complementary insurance and a potential salary does not exceed the percentage of your base salary defined above for the per diem allowance and the disability annuity.**

Article 2 - How to Claim - Insured Lump-sum Payment

2.1 Proving your TTIW or total or partial permanent disability is your responsibility.
You must provide the delegate with the following original supporting documents, translated and approved by consular services:

2.1.1 At the time of determining the right to benefits:

- The insurance claim entirely filled out by you and with which the CFE or French Social Security compensation slips will be attached, if any;
- The medical certificate filled out by your doctor indicating the nature of the pathology, the date of the first symptoms, the probable duration of the disability or incapacity. This medical certificate must be sent, to the delegate's consulting physician and marked as confidential.

Furthermore, for TTIW or permanent disability caused by an accident:

- The accident declaration form that you will have filled out.
- The hospital or clinic situation report showing your dates entry and discharge.

2.1.2 During the payment of the benefits: The payment receipts of the benefits in cash by the CFE or the French Social Security of their incoming payments as and when received, if applicable.

The delegate reserves the right to ask for additional supporting document that he might deem necessary and in particular, documents showing the loss of income.

2.2 The insurer's consulting physician reserve the right to verify in the meantime that your disability or your incapacity does not result from a risk excluded by Article 7 hereafter, and to submit you to a medical expertise, at his expense.

2.3 As soon as your incapacity or your disability is recognised as not being related to an excluded risk, the insurer will pay out to you:

- In the case of TTIW: the chosen amount of per diem allowance (Article 1.1.3 Section III) after the expiration of the deductible (Article 1.1.2 Section III);
- In the case of permanent disability: a disability pension (Article 1.3 Section III).

Article 3 – Checks

3.1 **At any time, the insurer reserves the right to send one or several doctors that he has appointed to assess your state of heath. In that respect, the insurer reserves the right to call you in, at his expense, on the French territory**.

3.2 **Unless justified by an event of force majeure, any refusal to comply with this check shall result in the automatic termination of the insurance and the end of the ongoing benefit payments**.

3.3 When the doctors appointed by the insurer assess that your state of health does not justify a medical leave, the insurer will stop paying your allowance or annuity from the date of the visit.

In the event of any dispute: an expertise will take place. Each party (insurer and subscriber) will appoint a doctor at their own expense. In case of a disagreement between the appointed doctors, a third doctor will have to be appointed and his fees will be paid for half by the subscriber and for half by the insurer. If one of the parties fails to appoint his expert or in the event of a disagreement between the doctors on the choice of the third doctor, the appointment shall be made by the president of the tribunal de grande instance de Paris.

Article 4 - Benefit Payments

4.1 TTIW

The benefits due for TTIW are paid monthly in arrears, up until the 1095th day of TTIW and at the latest until you have access to your pension from a pension scheme and at the latest when you reach the age determined by Article L. 351-8 of the French Social Security Code (legal retirement age to receive a full pension in France).
Per diem allowance payments are subject to producing a medical certificate indicating the persistence of the TTIW and a sworn statement that the member has not resumed a professional activity. When the cover is chosen in addition to the reimbursements of the French Social Security or CFE, you must also provide the slips showing the payment of these per diem allowances by this institution.
In all cases, per diem allowance payments stop on the date on which work resumes.

4.2 Permanent Disability

Disability annuities are paid out quarterly in arrears, and, at the latest until you have reached the age set in accordance with Article L.161-17-2 of the French Social Security Code (legal retirement age in France) or until the age set pursuant to Article.
L. 351-8 of the same Code (legal retirement age to receive a full pension in France) if you work (in case of partial disability).
At least once a year, you must produce a medical certificate justifying your state of permanent disability. When the cover is chosen in addition to the reimbursements of the French Social Security or CFE, you must also provide the slips showing the payment a disability annuity by this institution.

Article 5 - Resuming work– Relapse

5.1 **When you have started receiving benefits in respect of the TTIW or the permanent disability, any return to work in the same job as before the incapacity or disability for a two-month period or less, shall only trigger a suspension of payment of the benefits**.

5.2 In this case, and on the condition that the new medical leave is given for the same cause, illness or accident, the payment of per diem allowances will resume under the same conditions, if there is a relapse. The contractual expiration of the per diem allowances will be extended by the period of time during which work resumed, without however leading to exceeding the age limit for the payment of benefits (see Article 4 above).

Article 6 - Coverage termination

The TTIW and permanent disability covers stop:

- **When the membership stops as per the provisions of Article 8 Part I;**
- **At the end of the calendar quarter during which the member has reached the age set by Article L. 351-8 of the French Social Security Code (legal retirement age to receive a full pension in France);**
- **When the member no longer qualifies for the TTIW and permanent disability covers: when he/she is no longer employed or becomes majority shareholder of the company that employs him/her (Article 3 Part I).**

Article 7 - Excluded Risks

7.1 Are excluded from the TTIW and permanent disability covers, medical leaves resulting:

- from illnesses and accidents that are the deliberate act of the subscriber or that result from attempted suicide or from deliberate mutilations;
- from acts of foreign or civil war, riot or insurrection, fight and act of terrorism, if the person actively and voluntarily took part in the event. The cases of legitimate defence, assisting a person in danger and accomplishing professional duty are risks that are covered;
- from injuries, lesions caused by races, matches or bets except for normal sports competitions to which the subscriber could take part as an amateur;
- from modifications of the structure of the atomic nucleus;
- from ionising radiations, regardless of their origin and intensity, to which the member was exposed, even intermittently, caused by and during his/her professional activity;
- from the member's intoxication. With regards to road accidents: when the member is the driver of the land motor vehicle (LMV), is excluded regardless of the circumstances, the TTIW or permanent disability caused by an accident occurring:
- Drunk driving defined as blood alcohol levels equal or exceeding the applicable legal limit in France at the time of the road accident or the legal limit in force in the country where the accident happened if the limit is lower;
- under the influence of drugs;
- from the use of an ultralight (ULM), a flying wing or a parachute;
- from races, matches, bets except for normal sports competitions to which the subscriber could take part as an amateur;
- from the practice of the following activities:
  - motor sports: car racing, kart racing, motorcycling
  - mountain sports: climbing, mountain climbing, ski jumping, bobsleighing,
  - other sports: spelunking, horse polo, bungee jumping, scuba diving;
- from sciatic pain, lumbagos, dorsalgia, cervical pain (except those caused by an accident);
- from neuroses, psychasthenias, psychoneuroses and psychoses for the permanent Disability cover;
- from any condition of which the first symptoms were observed before the effective date of coverage and before the subscriber took out the insurance.

7.2 **Air navigation risks are covered under the same conditions as for the all-cause death benefit (Article 6.1 Section I).**

7.3 **No benefits are due in the periods relating to the legal statutory or conventional maternity or paternity leave (1) or of unpaid leave, whether the beginning of the medical leave starts before or during such leave. However, if at the end of the unpaid leave, the member's medical condition does not permit him/her to return to work, the benefits are due, the deductible period being in this case counted from the end of the unpaid leave.**

(1) it is agreed that statutory maternity or paternity leave is assessed in reference to the one of employees according to the Basic Scheme of the French Social Security.

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