MYHEALTH INTERNATIONAL

GENERAL CONDITIONS 2022

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STAATENLOS
WEIL DEIN LEBEN DIR GEHÖRT

Staatenlos Rahmenvertrag

april International
INSURANCE MADE EASY

If you have any questions at all about your plan, we would be pleased to advise you and help make everything as straightforward as possible:

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1. DEFINITIONS

The language used in insurance can be technical so, to help you better understand how your plan operates, we have provided you with definitions of the key terms used.
Whenever the following terms are written in italics and with a capital letter, they have the following meanings:

1.1. DEFINITIONS WHICH APPLY TO ALL COVER

A

ACCIDENT: any physical injury not intended by the *Insured*, arising from an abrupt, sudden action of an unexpected and unpredictable nature with an external cause. In accordance with article L.1353 of the French Civil Code, *You* are responsible for providing proof of the *Accident* and of the direct cause-and-effect relationship between it and the costs incurred.

C

CFE : Caisse des Français de l'Étranger.

COUNTRY OF COVER: the country or countries shown on your *Membership certificate* as the destination country and country of cover, different from your *Country of nationality*.

COUNTRY OF NATIONALITY: the country shown on your passport or on any other official identity document under the heading "nationality".

COUNTRY OF ORIGIN: the country of residence of the *Insured* before their expatriation or the *Country of nationality*.

D

DEPENDENT CHILD: your child, or that of your *Spouse*, who is unmarried and dependent for tax purposes up to the age of 21. Children under the age of 28 who are in education are also covered, even if they are not living in the family home, but are living in the same cover zone as you.

E

EFFECTIVE DATE: date on which the plan starts. It is specified on the *Membership certificate*.

EXCLUDED COUNTRY: as a result of events taking place in certain countries or or for regulatory reasons, the cover in these countries or zone of countries are excluded from the plan. The complete list of excluded countries is available at www.april-international.com or by calling us on +33 (0)1 73 02 93 93 or by sending an email to info.expat@april-international.com. The list of excluded countries is liable to change.

EXCLUSIONS: what is not covered by the insurance plan. All insurance plans have exclusions from cover.

F

F.O.D.R. (French Overseas Departments and Regions): French Guyana, Guadeloupe, Martinique and Reunion Island.

I

INSURANCE YEAR: period of twelve consecutive months starting on the *Effective date* of the plan.

L

LOSS/CLAIM: event, illness or *Accident* giving rise to payment of benefits during the life of the plan.

M

MEDICAL AFFLICTION: deterioration of the health state or illness.

MEDICAL AUTHORITY: any person holding a valid medical or surgical diploma who is authorised to practise in their specialist field in the country where *You* are staying.

MEDICAL MANAGEMENT: a medical consultation and/or a medical testing prescription and/or a medical treatment.

MEMBER: an individual or legal entity who/which enrols in the open group insurance plan purchased by the contracting association and agrees to comply with the corresponding obligations, including the payment of the *Premiums*. Their contact details are shown on the Insurance certificate. The *Member* enrols in the plan either on their own behalf or as the legal representative of an insured person or as the legal representative of the subscribing company.

MEMBERSHIP CERTIFICATE: document which *We* issue to the Member confirming their cover under the MyHealth International plan and specifying the *Insured*, the *Effective date* and the benefits and packages selected. The *Membership certificate* corresponds to the plan schedule.

P

PATHOLOGY: all the manifestations of a disease, the symptoms and morbid effects that it causes.

PRE-EXISTING CONDITION: *Medical affliction* or *pathology* which was diagnosed, under medical management, explored through medical testing and/or treated before the signature date of your *Application form* (including the medical questionnaire). Any illness or affliction whether diagnosed or symptomatic which may have been under medical management of which You were aware, or of which *You* may have been reasonably aware when enrolling in the present plan is considered a pre-existing condition.

PREMIUM: sum paid by the Member in exchange for cover granted by the insurer.

PRINCIPAL INSURED, "YOU": individual accepted by the insurer and to whom cover under the plan applies.

S

SPOUSE: husband or wife of the *Primary insured*, from whom they are neither divorced nor legally separated, or the Pri*mary insured*'s civil partner (Article 515-1 of the French Civil Code), where the civil partnership is in force on the date of the *Loss*. The *Primary insured*'s long-term partner will be classed as a *Spouse* if documentary evidence is provided and must be listed on the *Membership Certificate*.

SUDDEN ILLNESS: any deterioration in health certified by a competent Medical authority, of a sudden and unpredictable nature.

SYMPTOMS: functional signs, felt or observable, which represents a manifestation of a condition or illness allowing to detect it.

W

WE/US: APRIL International Care France.

1.2. DEFINITIONS WHICH APPLY SPECIFICALLY TO MEDICAL EXPENSESCOVER ACTUAL

C

CNS: Caisse National de Santé, Luxembourg National Health Fund.

COSTS: total amount of medical expenses charged to you.

COMPLICATIONS OF PREGNANCY AND CHILDBIRTH: these are complications that arise during the prenatal period of pregnancy and, in this context, will be covered in the following cases: ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, risk of miscarriage and stillbirth or hydatidiform mole. The following pathologies are also covered if they appear during childbirth and require an obstetric procedure: postpartum hemorrhage and retained placenta.

CONFIDENTIAL MEDICAL CERTIFICATE: medical questionnaire which must be completed by your doctor and returned to us before *You* are admitted to hospital (or as soon as possible following an *Accident* or in case of *Medical emergency*) in order to obtain our *Prior agreement*. A *Deductible* of 20% will be applied to your reimbursement if *You* do not follow this procedure.

CRITICAL ILLNESSES: AIDS, Alzheimer's disease, Cancer, Cardiomyopathy, Chronic degenerative arthritis, Creutzfeldt-Jacob disease, Heart attack, Hepatitis C, HIV, Legionnaire's disease, Motor neuron disease, Multiple sclerosis, Myopathy, Stroke, Terminal kidney failure and Type 1 diabetes.

D

DAY HOSPITALISATION: *Hospitalisation* of less than 24 hours where *You* are allocated a bed but do not stay overnight.

DEDUCTIBLE: amount which you will pay towards the settlement of a Claim.

DIRECT PAYMENT OF HOSPITAL CHARGES: *You* may be eligible for direct payment of hospital charges (*Hospitalisation* of more than 24 hours or *Day hospitalisation*) with no upfront payment if *You* have cover from the 1st €/$ or as a top-up to the CFE, subject to the review of your *Confidential medical certificate*. *You* can benefit from this service by using the emergency numbers accessible from your Easy Claim app or by showing your insurance card at the hospital.

H

HOME CARE: nursing care received immediately after or as a replacement for *Hospitalisation* or day care in hospital. This type of care is covered if the treating doctor decides that, for medical reasons, a nurse must come to your home at least once a day. This type of care is subject to the *Prior Agreement* of our Medical Examiner.

HOME HOSPITALISATION (HH): this is full-time *Hospitalisation* following a stay in hospital, organised at the patient's home by a coordinating doctor and in conjunction with the hospital to which the patient was admitted. The coordinating doctor acts alone or with other colleagues to carry out complex, technical medical treatments and procedures. This doctor arranges for services to be provided by other health professionals, for example nurses and physiotherapists, and, if necessary, sets up medical monitoring or assistance devices such as respiratory aids or vital signs monitors. The delivery of medication, including chemotherapy, at the patient's bedside forms part of the Home *Hospitalisation* services. This type of care is subject to the *Prior Agreement* of our Medical Examiner.

HOSPITALISATION: stay of more than 24 hours (with or without surgery) in a public or private hospital due to an *Accident* or illness.

I

INSURED, « YOU »: all the individuals with medical expenses cover under this plan. This means *You* and the members of your family who meet the conditions of insurance. They are listed on the *Membership certificate*. Family members are your *Spouse* and your *Dependent children*.

M

MEDICAL EMERGENCY: any sudden and unforeseen deterioration in health that needs to be certified by a competent medical authority and requires an immediate intervention of a doctor (within 48 hours), postponing of which could lead to serious health problems.

MEDICALLY NECESSARY: medical procedure, which is necessary for the diagnosis or treatment of an illness or accidental bodily injury, based on generally accepted current medical practice. A service or supply will not be considered medically necessary if it is provided only as a convenience to the provider or insured member and/or is not appropriate for insured member's diagnosed symptoms, and/or exceeds in scope, duration or intensity that level of care which is needed to provide appropriate diagnosis or treatment of an illness or injury.

P

PRIOR AGREEMENT: *Hospitalisation* and medical treatments or procedures costing more than €/$ 2,000 are subject to the *Prior agreement* of our Medical Examiner. Before starting the treatment, *You* will therefore have to send us an itemised estimate of costs and a form called "*Request for prior agreement*". In the event of *Hospitalisation*, please ask your doctor to complete the form called "*Confidential medical certificate*".

R

REASONABLE AND CUSTOMARY COSTS: medical expenses are considered to be reasonable and customary if they do not exceed the rates normally charged for an identical service or treatment in the location in which they are incurred.

Medical costs vary greatly depending on the country, and even between practitioners and facilities in the same area: some charge higher prices than others, but with the same quality of service. To avoid this type of abuse, and using our in-depth knowledge of the local health systems, we have been compiling pricing databases for over 30 years. These databases are continually added to and are updated every year. If we consider a claim to be inappropriate, we reserve the right to reduce the amount we will pay or refuse the claim.

REQUEST FOR PRIOR AGREEMENT: form to be completed by your doctor in order to obtain our *Prior agreement* before beginning any treatment or procedures.

V

VACCINES REQUIRED FOR TRAVEL: Cholera, Hepatitis A, Hepatitis B, Hepatitis C, Japanese encephalitis, Leptospirosis, Meningitis, Rabies, Rotavirus (gastro-enteritis), Tick-borne encephalitis, Tuberculosis, Typhoid fever and Yellow fever.

W

WAITING PERIOD: period during which no *Claims* will be paid. *The Waiting period* begins on the *Effective date* of the plan, as shown on the *Membership certificate*

1.3. DEFINITIONS WHICH APPLY SPECIFICALLY TO REPATRIATION ASSISTANCE COVER

A **ACT OF TERRORISM OR SABOTAGE AND ATTACKS:** any clandestine action with an ideological and/or political motive carried out by individuals or groups directed against persons or public or private entities in order to:

- carry out a criminal action intended to harm the lives of others,
- alarm the population and create an atmosphere of general insecurity,
- disrupt public transport and the operation of businesses or institutions manufacturing or processing goods or providing services.

ASSAULT: any unintentional bodily injury to the *Insured*, resulting from the deliberate, sudden and brutal action of another person or group of persons.

B **BAGGAGE:** the *Insured*'s travel bags and suitcases and the personal effects and items contained in them as well as any items which have been checked in with a carrier.

BODILY INJURY: injury causing a person physical harm.

F **FAMILY MEMBER:** your *Spouse*, child, brother, sister, father, mother, parents-in-law, grandchildren, grandparents or your legal guardian residing in your *Country of nationality*.

FRIEND: any individual named by *You* or one of your dependants, residing in your *Country of nationality*.

FORCE MAJEURE: any unpredictable, overwhelming, external event.

I **INSURED « YOU »:** see definition in paragraph 1.2

M **MEDICAL TEAM:** structure adapted to each individual case and defined by the liaison doctor at Europ Assistance.

S **STABILISATION:** stabilisation of the state of health of a victim of an *Accident* or person suffering from an illness.

1.4. DEFINITIONS WHICH APPLY SPECIFICALLY TO *PERSONAL LIABILITY* (PRIVATE CAPACITY) COVER BODILY

C **CONSEQUENTIAL DAMAGE:** damage other than physical harm and material damage that is the direct and immediate consequence of *Bodily injury* or *Material damage* covered under the plan.

D **DEDUCTIBLE:** see definition in paragraph 1.2.

I **INJURY:** damage causing a person physical harm.

INSURED: see definition in paragraph 1.2

M **MATERIAL DAMAGE:** damage causing harm to the structure or substance of the thing and resulting from an insured event.

P **PERSONAL LIABILITY:** legal obligation of all people to remedy damage they cause to others.

1.5. DEFINITIONS WHICH APPLY SPECIFICALLY TO DEATH AND TOTAL AND IREEVERSIBLE LOSS OF AUTONOMY COVER

B **BENEFICIARY:** any individual(s) chosen by the *Insured* to receive the insurance benefits.

Unless other arrangements have been made which are valid on the day of the *Insured*'s death, the lump sum is paid first to their surviving *Spouse* on condition that they were neither divorced nor legally separated from the *Insured*, or to their surviving civil partner, failing which to their children, living, unborn or represented as such for the purposes of inheritance, failing which to their other heirs. If the *Insured* does not want the insured lump sum to be allocated in the manner described above or if, during the life of the plan, they wish to designate one or more other *Beneficiaries*, they must designate their chosen beneficiary or beneficiaries and provide this information to the insurer. This designation can be carried out by means of a privately witnessed document or an authenticated deed. To avoid any risk of duplication of names and to make it easier to locate the designated *Beneficiaries*, the *Insured* should provide, for each *Beneficiary*, details which will allow them to be accurately identified, including their full name and date and place of birth. *We* can provide the *Insured* with a form entitled "Designation of *Beneficiary*" containing helpful advice on how to allocate the death benefit when enrolling in the plan or if any subsequent changes are made to the designation. **Any designation or change in designation that we are not told about will be non-binding. We would draw the *Insured*'s attention to the need for regular updates of their special *Beneficiary* designation(s).** With the agreement of the *Insured*, any designation of Beneficiary may be accepted, at the end of a period of at least 30 days following the effective date of membership of the plan if the designation has been carried out free of charge. As long as the *Insured* is alive, this acceptance must be formalised either by an endorsement signed by the insurer, the *Insured* and the *Beneficiary* or by a privately witnessed document or an authenticated deed signed by the *Insured* and the *Beneficiary*. The acceptance will only be binding on APRIL International if they have been notified of it in writing.

The requirement to provide proof of such notification lies with the person claiming the benefit. **It should be noted that the designation in favour of a specific *Beneficiary* becomes irrevocable if it is accepted by them under the above conditions.** A privately witnessed document is a document which is freely drafted, drawn up by one of the parties and signed by all participants. There must be as many originals as there are participants. This type of privately witnessed document may or may not be registered with the tax department. An authenticated deed is a document drawn up by a public official and signed before them by all parties. The entitlement of *Beneficiaries* to the insured lump sum is subject to them being alive on the day following the day of the *Insured*'s death. In respect of the total and irreversible loss of autonomy cover, the *Beneficiary* is the *Insured*.

I **INSURED, « YOU »:** *Principal insured* and/or their *Spouse* if the *Spouse* is expatriated also.

1.6. DEFINITIONS WHICH APPLY SPECIFICALLY TO INCOME PROTECTION COVER

I **INSURED, « YOU »:** *Principal insured* and/or their *Spouse* if the *Spouse* is expatriated also.

S **STABILISATION:** long-term *stabilisation* of the *Insured*'s state of health, which neither improves nor worsens. The state of health will also be considered to have stabilised as soon as it is possible to assess the degree of total or partial permanent disability.

W **WAITING PERIOD:** the period of sick leave, starting on the first day of cessation, during which no compensation will be paid by the insurer.

2. BENEFITS AND GEOGRAPHICAL SCOPE OF YOUR PLAN

2.1. WHAT IS COVERED UNDER YOUR PLAN?

Membership of this plan, depending on the packages and benefits you selected, provides you with medical expenses cover:

- from the 1st €/$ ***or***
- as a top-up to the *CFE* ***or***
- as a top-up to French Social Security (or any other statutory French scheme) ***or***
- as a top-up to the *CNS*.

Basic repatriation is included in your medical expenses cover. You can also purchase the following optional cover:

- Comprehensive Repatriation assistance and Personal Liability (private capacity);
- Death and total and irreversible loss of autonomy lump sum;
- Income protection during periods of sick leave from work. (This benefit must be combined with the death and total and irreversible loss of autonomy lump sum benefit.

It is possible to subscribe the Repatriation assistance (basic and comprehensive) and Personal Liability (private capacity) benefits independently of medical expenses cover.

2.1 WHERE ARE YOU COVERED?

For medical expenses and basic repatriation assistance:
Cover is provided for a year at a time in the *Countries of cover* listed on your *Membership certificate*. Cover also applies in countries located within the same zone of cover as your *Countries of cover*.

6 zones of cover are available:
Zone 0: Worldwide
Zone 1: Worldwide, excluding Bahamas (Island), Puerto-Rico, United States
Zone 2: Worldwide, excluding Bahamas (Island), Puerto-Rico, United States, Japan, Singapore
Zone 3: Worldwide, excluding Bahamas (Island), Puerto-Rico, United States, Japan, Singapore, Brazil, Chile, China, Hong Kong, United Kingdom, Russia, Switzerland, Saint Barthelemy, Saint Martin
Zone 4: France and D.R.O.M (Guadeloupe, La Reunion, Martinique, Mayotte and French Guiana), Belgium, Luxembourg, Monaco
Zone 5: Worldwide, excluding Bahamas (Island), Puerto-Rico, United States, Japan, Singapore, Brazil, Chile, China, Hong Kong, United Kingdom, Russia, Switzerland, Saint Barthelemy, Saint Martin, Andorra, Armenia, Australia, Austria, Azerbaijan, Belarus, Cambodia, Canada, Cyprus, Costa Rica, Denmark, United Arab Emirates, Equator, Spain, Estonia, Faeroe (Iles), Finland, Georgia, Germany, Gibraltar, Greece, Hungary, British Virgin Island, Ireland, Iceland, Israel, Italy, Latvia, Liechtenstein, Lithuania, Malaysia, Malta, Mexico, Moldavia, Norway, New-Zealand, Netherlands, Poland, Czech Republic, Saint Marin, Slovakia, Slovenia, Sweden, Svalbard et Jan Mayan, Taiwan, Thailand, Vatican, Venezuela, France and D.R.O.M (Guadeloupe, La Reunion, Martinique, Mayotte and French Guiana) Belgium, Luxembourg, Monaco

In addition, regardless of the coverage zone selected, benefits are valid worldwide (including in your *Country of nationality* if it is not in your coverage area) in the event of an *Accident* or *Medical Emergency* during temporary stays, for non-medical reasons, not exceeding 90 consecutive days.

Special case: if *You* choose **Belgium, Luxembourg or Monaco as your destination country**, *You* are also covered for scheduled and emergency medical care in Italy and France.

Special case for zone 5: cover is valid in countries in zone 5 on a year-round basis (including your *Country of nationality* if it is situated in zone 5. It is extended to France (including the French Overseas Departments and Regions) during temporary stays not exceeding 90 consecutive days. Please note: medical care received in private clinics and hospitals in France will be covered up the *Reasonable and customary costs*. Cover also applies in the event of *Accident* or *Medical emergency* during stays of less than 90 consecutive days in zones 0, 1, 2, 3 and 4 (including your *Country of nationality* if it is situated in these zones).

For a stay of more than 90 consecutive days outside the zones of cover, the *Member* must inform *Us* so that their *Countries of Cover* and *Premium* can be adjusted.

For comprehensive repatriation assistance, personal liability (private capacity), death lump sum, total and irreversible loss of autonomy and income protection:
Cover is provided for a year at a time worldwide (including in your *Country of nationality*) except in *Excluded countries*.

As a result of heightened tension or regulatory reasons in certain countries, prior confirmation must be obtained from *Us* that the cover is valid there. The complete list of excluded countries is available at www.april-international.com and by calling +33 (0)1 73 02 93 93 or by email at info.expat@april-international.com. This list is subject to change.

3. WHO IS COVERED UNDER THE PLAN?

To be covered by the insurance, *You* must:

- On the *Effective date* of the plan, be:
  - between the age of 16 and 64 for medical expenses, repatriation assistance and personal liability (private capacity) cover, if covered in zone 0, Thailand and Mexico,
  - between the age of 10 and 70 medical expenses, repatriation assistance and personal liability (private capacity) cover, if covered in zones 1 and 2,
  - between the age of 10 and 75 medical expenses, repatriation assistance and personal liability (private capacity) cover, if covered in zones 3, 4 and 5 (excluding Mexico and Thailand),
  - 18 years old or more and under the age of 66 for death and total and irreversible loss of autonomy and income protection cover,

  The minimum age for medical expenses, repatriation assistance and personal liability (private capacity) cover applies only to children insured alone on a policy. *You* can insure your children under these minimum ages if you are insured yourself.
- for *CFE* or French Social Security top-up cover, be a member of the *CFE* and be covered under this scheme for illness/maternity and by the *CFE*'s occupational accidents scheme or be covered by French Social Security (or an equivalent French scheme) for the duration of the plan,
- for the *CNS* top-up cover, be a member of the *CNS* and be covered under this scheme for illness/Maternity,
- for death and total and irreversible loss of autonomy and income protection, enclose a copy of your ID (national identity card or passport) with your application form,
- for income protection cover, you must be in employment without the need for any special arrangements in terms of working time or working environment for health reasons,
- have complied with the medical formalities specified in the plan and have completed and signed the Health questionnaire a maximum of three months before the *Effective date* of the plan.

Special provisions if you are staying in France (including the French Overseas Departments and Regions) - Universal Health Protection ("Protection Universelle Maladie" or PUMA)
If *You* are living in France on a long-term basis and without interruption for more than 3 months and/or if *You* are in paid employment or are self-employed, *You* may be entitled to universal health protection from French Social Security to cover your medical expenses.
If you enroll in a plan from APRIL with cover from the first euro, and *You* subsequently meet the conditions for Universal Health Protection, *We* can provide you with cover as a top-up to your Universal Health Protection benefits and make the necessary changes to your plan.
It is *Your* responsibility to check if this applies to you and if you are entitled to Universal Health Protection benefits. More information on the conditions for enrolment is available at: https://www.ameli.fr/assure/droits-demarches/principes/protection-universelle- maladie (in French).

Your family members may also benefit from cover under this plan (if they are listed on your *Membership certificate*), provided they comply with the following conditions, namely:
For medical expenses, repatriation assistance and personal liability (private capacity) cover:

- your *Spouse*,
- your *Dependent children*.

Adding your *Dependent children* to the plan:

- **If *You* have had Maternity cover for at least 12 consecutive months**:
  > To cover *Your* child at birth with no medical formalities, please send us your application for enrolment, together with **a birth certificate within 30 days** of the birth.
  > **After this period**, newborns are enrolled **subject to the approval of our medical department**:
  - *You* will be asked to complete a **health questionnaire** and provide a **hospital birth report**,

- The newborn's membership of the plan will only take effect at the earliest on the day after our *Medical Approval*.

Please note: if an in-depth review is required, the membership will take effect at the earliest on the day of acceptance of the special conditions sent to you.

- **If *You* do not have Maternity cover *(or if you have been covered for less than 12 months)***: please send us your application for enrolment, together with a **health questionnaire** and a **hospital birth report**. The newborn's membership of the plan will only take effect at the earliest on the day after our *Medical Approval*.

Please note: if an in-depth review is required, the membership will take effect at the earliest on the day of acceptance of the special conditions sent to you.

For **newborns born as a result of surrogate motherhood, and for children who are adopted or placed in a foster family or care home**, please note that membership will be subject to a full medical review and a Health questionnaire or medical certificate of good health may be requested; cover will commence on the date of approval subject to the agreement and conditions of approval issued.

Membership is subject to our medical approval and *We* reserve the right to request additional medical formalities based on the responses given in the Health questionnaire. If *You* (or one of your family members) present an aggravated risk (professional or medical), *We* can either accept your application for insurance under special conditions or reject it.

4. EFFECTIVE DATE, DURATION AND CANCELLATION OF THE PLAN

4.1. WHEN DOES YOUR PLAN START?

Your date of enrolment corresponds to the benefits effective date which *You* specified in your application form. It can be no earlier than on the day of receipt of the completed membership application (including the completed and signed Application form and Health questionnaire for all Insured), subject to payment of the first *Premium*. If your application requires a medical review, your plan will begin at the earliest on the day of your medical approval. If you have opted for cover as a top-up to the *CFE*, the *CNS* or French Social Security, your cover is subject to you being eligible for benefits from your basic scheme.
This date is shown on the *Membership certificate* which can be accessed securely in your Customer Zone and on your Easy Claim app.

4.2. WAITING PERIODS WHICH APPLY TO YOUR PLAN

The cover takes effect for each of the Insured on the Effective date of the plan subject to the application of the following Waiting periods for medical expenses cover:

- 3 months for dental treatment, periodontology and endodontics,
- 6 months for dentures, dental implants, orthodontics and vision care (contact lenses, frames, lenses and laser eye surgery),
- 12 months for maternity and medically assisted procreation.

Any treatments or procedures prescribed before the *Effective date* of the plan or during the *Waiting period*s are excluded from cover and will not be reimbursed.
***Waiting period*s may be waived subject to a review of our *Medical Examiner* (excluding Maternity). if *You* can prove that *You* had medical expenses cover equivalent to or greater than the MyHealth International benefits in the month preceding the effective date of this plan.**
This waiver of the *Waiting period*s is subject to our agreement following a review of the Certificate of cancellation from your previous insurance plan which *You* must send us along with details of the cover *You* had previously.

4.3. DURATION OF COVER AND RENEWAL OF YOUR PLAN

Membership of this plan is effective for a period of 12 months. It is renewed automatically on the anniversary date of your plan, for a period of one year, for as long as the agreements entered into with the insurers of the plan remain in force.
You can renew your cover each year, regardless of your age, state of health or medical expenditure. Medical expenses, repatriation and personal liability (private capacity) cover is valid for as long as You wish. This means that the insurers will not be able to cancel your insurance other than in the cases specified in paragraph 4.4.
We undertake to notify the *Member* of any changes to the benefits, levels of reimbursement, exclusions and the terms and conditions of the plan administration (three months before each anniversary date), as well as any changes in pricing (two months before each anniversary date). The *Premium* may be adjusted on the anniversary date of your plan based on your age, your *Country of cover* and the level of your cover, *Deductible* or coinsurance.
Any changes made to the proposed cover or to the terms of the plan administration will take effect on the anniversary date of the plan. If you do not reply within 30 days, the plan will be renewed automatically for a period of one year, subject to receipt of the corresponding payment.

4.4. YOUR COVER COMES TO AN END

a) if the *Member* cancels at the annual renewal date (anniversary date of the plan) in accordance with Article L.113-12 of the French Insurance Code, with 60 days' notice;
b) if the *Member* cancels mid-year at any time after twelve months of membership. Your termination will take effect 30 days following receipt of the request;
c) if the *Member* cancels at the annual renewal date (anniversary date of the plan) 30 days following receipt of the new conditions of cover;

To exercise their right to terminate their insurance plan, the *Member* should send their request to APRIL International Care France:
- by ordinary or registered mail at the following address: Service Courrier - 1 rue du Mont - CS 80010 - 81700 Blan – FRANCE;
- by using the contact form available from your Customer Zone and selecting "Ask for a termination";
- or by email to care@april-international.com.

or by any other means provided for in Article L.113-14 of the French Insurance Code.

d) if the Premium is not paid (see paragraph 5.4);
e) in the event of termination of the policy by the insurer or by "l'Association des Assurés APRIL" on the annual due date (in this case the Association will inform each *Member*);
f) when *You* no longer meet the conditions of insurance (see paragraph 3). Cancellation will take effect at the end of the current period and at the latest within 30 days of receipt of notification, subject to receipt of a supporting document;
g) if You have *CFE, CNS* or French Social Security top-up cover, when *You* cease to be enrolled in the *CFE, CNS* or French Social Security (or an equivalent French scheme). In this case, cancellation will take effect one month following receipt of written notification by our Customer Service department;
h) when *You* reach the age of 65 for death, total and irreversible loss of autonomy and income protection cover;
i) if *You* are no longer an expatriate. Supporting documentation must be produced (for example, proof that *You* are covered under the Social security scheme of your *Country of nationality* or a copy of your new contract of employment).

In the event of termination by the insurer or the Association as per paragraph d) above, the insurer agrees to maintain, at the *Member*'s request, medical expenses cover equivalent to that in force on the date of termination. On expiry of a period of two years following the *Effective date* of the plan, the same provisions apply to death, total and irreversible loss of autonomy and income protection benefits.

Penalties for false declaration:

Whether in respect of declarations made on enrolment in the plan or those made during the life of the plan, any intentional concealment or false declarations and any omission from or misrepresentation of the risk will, depending on the circumstances, invoke the application of articles L.113-8 and L.113-9 of the French Insurance Code.
In addition, any omission, concealment, false declaration, whether intentional or not, in making a *Claim*, failure to declare any other concurrent insurance cover, the submission of inaccurate supporting documentation or the use of any fraudulent means puts the *Insured* and the *Member* at risk of withdrawal of cover and cancellation of the plan.
***We* reserve the right to take legal action in order to seek compensation for any damage caused to us. *You* will be required to pay back any benefits that were unduly paid to you under this plan**

4.5. HOW TO CANCEL YOUR PLAN?

Signing the Application form does not constitute a binding agreement for the *Member*.

If the Member purchased the insurance as a result of door-to-door canvassing:
The following provisions under article L.112-9-I of the French Insurance Code apply: "*Any person who is canvassed at their home or residence or place of work, even if this visit was at their own request, and who signs an insurance proposal or contract for a purpose which is not related to their commercial or professional activity, may cancel this agreement by sending a letter by recorded delivery with proof of receipt during a period of 14 calendar days from the date of entering into the agreement without requiring to specify the reasons for the cancellation or being subject to penalties. (...). As soon as they become aware of any circumstances giving rise to a claim under the insurance contract, the policyholder loses this right to cancel*".

If the *Member* has entered into a distance contract (by telephone or internet):
The *Member* may cancel their membership within 14 days of entering into the insurance contract.

For death, total and irreversible loss of autonomy and income protection cover:
Signing the *Application form* does not constitute a binding agreement for the *Member* who can cancel their membership within 30 days of receipt of the *Membership certificate*. The cancellation is backdated so that the plan is considered never to have existed. The *Member* will then receive a refund of any sums they may have paid within 30 to 90 days of receipt of the request to cancel. If the *Insured* has made a Claim under the plan during the 30-day period, the right to cancel no longer applies.

In all cases, in order to exercise this right to cancel:
The *Member* must notify us of their decision to cancel their plan by means of a clearly-worded statement within the timescales specified above. To do this, simply complete the cancellation form available on page 31 or send a letter to APRIL International Care France using the following template:
"I, the undersigned, M..... (first name, last name, address),
wish to cancel my membership of the "MyHealth International" plan number .....
Signed in (town)..... on.....
Signature....."

If the *Member* decides to cancel the plan, they will only be required to pay the *Premium* corresponding to the period during which the risk was covered, with this period being calculated up to the date of cancellation. *We* will refund the balance to the *Member* no later than thirty days following the date of cancellation.
However, if the *Member* exercises their right to cancel when a Claim has been made under the plan during the cancellation period, the entire *Premium* remains due.

5. COTISATIONS

Membership of this plan does not exempt you from paying contributions to any state scheme to which *You* may belong.

5.1. HOW IS YOUR PREMIUM CALCULATED?

The *Premium* is adjusted each year on the anniversary date of the plan based on the Insured's age.
The *Insured*'s age used to calculate the first year's *Premium* is the *Insured*'s age on the *Effective date* of the plan. For each subsequent year, the *Insured*'s age used to calculate the *Premium* is the *Insured*'s age on the anniversary date of the plan.
Taxes currently payable by the *Member* are included in the *Premium*. Any change in the level of these taxes will be reflected in the amount of the *Premium*. The currency selected when enrolling in the plan determines the currency in which your plan will be managed. This currency will be used for paying your premiums and processing your reimbursements. If you have chosen CFE/French Social Security top-up cover, the "US dollar" currency option is not available.
The *Premium* may be adjusted on the anniversary date of the plan depending on the claims history of the insured group. The composition of the group takes into account age, profession, country of residence and the benefits and packages selected.
The *Insured*'s state of health and their level of medical expenditure are not taken into account in the calculation of the *Premium*.
If the *Member* requests an amendment to the level of cover selected on enrolment in the plan, the age used for the calculation of the *Premium* will be the *Insured*'s age on the date on which the amendment takes effect.

5.2. PAYMENTS METHODS

Premiums are payable in advance in euros or US dollars annually, twice-yearly, quarterly or monthly according to the payment method selected by the *Member*:

- bank card;
- PayPal;
- bank transfer (costs of bank transfer are the responsibility of the *Member*);
- SEPA direct debit (from a bank account in one of the SEPA zone countries) not available for the US dollar;

Monthly payments are only available with SEPA direct debit.

5.3. WHAT HAPPENS IF THE PREMIUM IS NOT PAID?

If the *Premium* remains unpaid 60 days after its due date, *We* will serve the *Member* with formal notice of suspension of cover. The plan will then be suspended. Following a further period of 10 days, *We* will terminate the plan as of right. *We* may also take legal action to secure payment of any unpaid *Premiums*. Once formal notice has been served for non-payment, the *Premium* due for the entire year is immediately payable under the French Insurance Code.

Please note that failure to pay the *Premium* and the termination of the plan do not cancel the debt. *We* will take appropriate action to obtain payment of the outstanding *Premium* and will have recourse to a debt recovery firm specialising in international debts. The *Member* is liable for any administration charges incurred as a result of any action taken by us or by our service providers.
If the amount stated in the letter of formal notice is paid after suspension of the plan but before termination, the plan will be revived at noon on the day following payment of the *Premium*.

No expenses incurred during the period of suspension of cover will be reimbursed under the plan, even once the *Premium* has been paid.

6. MAKING CHANGES TO YOUR PLAN

6.1. HOW TO MAKE CHANGES TO YOUR PLAN?

The Member can at any time amend the benefits, zones and packages initially selected. The effective date will be no earlier than 30 days following receipt of the requested amendment, unless the requested amendment is in respect of the amount of the annual *Deductible*, coinsurance or the currency of the plan. In these three cases, the amendment will take effect on the next anniversary date of the plan. If *You* upgrade your cover or change to a higher cover zone, You may be subject to new medical formalities as specified in the plan. These requested amendments apply for a minimum period of 12 consecutive months.
However, it should be noted that changing to a package offering a lower level of reimbursement is only possible after 1 year of membership of the previous package (unless there is a change of marital status or Country of destination).
If the medical expenses package is changed during the period of membership, the fixed amounts (dental, vision care etc.) are not cumulative.

6.2. WHAT DO YOU NEED TO TELL US ABOUT?

The *Insured* and the *Member* must inform us in writing of any change in status, situation or contact details **(otherwise all correspondence sent to the last known address will be deemed to have been served)**. *We* must also be informed of any change of occupation or termination of employment.

7. WHAT IS COVERED UNDER YOUR PLAN AND HOW TO MAKE A CLAIM?

Double insurance:
Reimbursements from the insurer and from any other public or private body cannot be higher than the amount of expenses actually incurred. Double insurance operates within the limits of each type of cover regardless of the date of purchase. Within these limits *You* can claim reimbursement from the provider of your choice.
YOU RISK TERMINATION OF THE PLAN IF YOU DO NOT DECLARE ANY DOUBLE INSURANCE ARRANGEMENTS. THIS OBLIGATION REMAINS IN FORCE DURING THE ENTIRE DURATION OF THE PLAN.
The limiting of reimbursements to the amount of costs actually incurred is determined by the insurer for each service or treatment covered under the plan.
Your cover includes the following when specified on your *Membership certificate*.

7.1. MEDICAL EXPENSES

Medical expenses are covered within the limits of *Actual costs* and *Reasonable and customary costs* considering the country in which they were incurred.

7.1.1. TYPE AND AMOUNT OF REIMBURSMENT

The reimbursement of medical expenses is covered for all medically required treatments and procedures listed in the benefits schedule (see Appendix 1) which are prescribed by a qualified *Medical authority*.
If you have cover as a top-up to the *CFE*, *CNS* or a basic French insurance scheme:
Only medical expenses covered by the *CFE*, *CNS* or *French Social Security* are covered (unless stated in the benefits schedule). The amounts shown include the reimbursements from your basic French insurance scheme (*French Social Security* or an equivalent French scheme) the *CFE*, or the *CNS*. Our reimbursement tops up the one provided by your basic insurance scheme.

Expenses are reimbursed item by item based on the package, the benefits and the level of reimbursement selected in accordance with the benefits schedule (see Appendix 1). For medical expenses invoiced in a currency other than the euro or the US dollar, the exchange rate applied will be the one in force on the date on which the Claim occurred. Only expenses related to treatment received during the period of cover will be reimbursed.
There are five medical expenses packages available depending on your needs: Emergency, Basic, Essential, Comfort and Premium. The Basic package is not available in the cover zone 0. Within each package the *Member* can choose from the following benefits:

Emergency:
Hospitalisation and basic repatriation assistance

Basic:
Hospitalisation and basic repatriation assistance
Hospitalisation and basic repatriation assistance + Outpatient care
Hospitalisation and basic repatriation assistance + Outpatient care + Vision and dental care

Essential, Comfort and Premium :
Hospitalisation and basic repatriation assistance
Hospitalisation and basic repatriation assistance + Outpatient care
Hospitalisation and basic repatriation assistance + Outpatient care + Vision and dental care
Hospitalisation and basic repatriation assistance + Outpatient care + Maternity
Hospitalisation and basic repatriation assistance + Outpatient care + Maternity + Vision and dental care

Maternity benefits under the Essential package are only available if you choose cover in zones 3, 4 and 5.
The package, the benefits, the amount of the *Deductible* and the level of reimbursement selected by the *Member* are shown on the *Membership certificate* and are acquired by all family members enrolled in plan.

Upper limits:
The cumulative amount of the reimbursements from the insurer is limited per *Insured* and per *Insurance year* to the amount shown in the benefits schedule for each package (see Appendix 1).
If cover is provided as a top-up to the CFE or a basic French insurance scheme:
Any compensation or benefits of the same type paid by the CFE or French Social Security (or an equivalent French scheme) or any public or private body in France or abroad, will be deducted from the reimbursement paid by the insurer.

How Deductibles work:
Deductibles are not available under the Emergency package or if cover is provided as a top-up to the CFE or French Social Security.
If *You* opted for an annual *Deductible*, *You* will pay any costs incurred up to the amount of the *Deductible You* selected. The *Deductible* applies per *Insurance year* and per *Insured*, for all selected medical expenses benefits.
To allow us to calculate how much of the *Deductible* has already accumulated, *We* ask you to send us the invoices for all medical expenses as they are incurred. When calculating how much of the *Deductible* has accumulated, *We* take into account the upper limit shown in the benefits schedule for the type of treatment or procedure you have had, according to the benefits package *You* have purchased. If that type of treatment or procedure is excluded from cover under your plan, the corresponding expenses will not be taken into account.
If you choose a *Deductible*, *You* will not be able to use the Caremark card (pharmacy direct billing).

How coinsurance works:
By default we propose a cover at 100% of actual costs. *You* can however reduce your premium by choosing reimbursement at 90% or 80% of actual costs for Routine healthcare-Maternity and Optical-Dental cover. Hospitalisation cover will nevertheless remain at 100% of actual costs.

7.1.2. WHAT TO DO IF YOU ARE HOSPITALISED?

***Hospitalisation* (including maternity) is always subject to *Prior agreement*.**
To obtain this *Prior agreement*, *You* will need to ask your doctor to complete a form called "*Confidential medical certificate*" at least 5 days before your admission to hospital.
In the event of emergency *Hospitalisation*, please contact us as soon as possible so that we can send you this form.
This form, giving the reason for your admission to hospital, the dates and nature of the condition and the date of the appearance of the first symptoms or the circumstances of the *Accident* (with, in this case, a supporting *Accident* report) should be sent to our Medical Examiner along with any other medical documents which may assist with the assessment of your claim:
If this *Prior agreement* procedure is not followed, a 20% *Deductible* will be applied to the reimbursement of your medical bill (other than in cases of *Accident* or *Medical emergency*).

7.1.3. HOW TO REQUEST PRIOR AGREEMENT BEFORE CERTAIN PROCEDURES OR TREATMENTS?

All medical expenses of €/$ 2,000 or more are subject to the *Prior agreement* of our Medical Examiner (valid for 6 months). Before incurring these expenses, *You* will have to ask the practitioner prescribing the treatment to complete a *Request for prior agreement* form together with an itemised quote.
If you are pregnant, please send us a document confirming your condition.

If this *Request for prior agreement* procedure is not followed, a 20% *Deductible* will be applied to the reimbursement of your

medical bill (other than in cases of *Accident* or *Medical emergency*).

7.1.4. HOW TO MAKE A CLAIM FOR REIMBURSEMENT UNDER THE PLAN

You must **keep your original medical bills (and other supporting documents) for a period of 2 years** from the date on which *You* made the claim. *You* may be asked to produce them when your claim is being processed. In all cases, please enclose the following documents with your claim:

- the originals of your paid medical bills and fees and dated medical prescriptions. These must show the patient's full name and date of birth, the type of illness, the nature and date of the consultations and the treatment received, together with proof of payment. Prescriptions must clearly show the name and price of the drugs, and indicate the local currency
- if the treatment requires a *Request for prior agreement*, the *Request for prior agreement* form approved by our medical department;
- for *Hospitalisation*, *You* must also enclose the hospital report and the *Confidential Medical Certificate* completed by your doctor. Please also ensure that your medical bill shows the cost of the private or semi-private room.

If double rooms are not available in the country where you are staying:
Under the Emergency and Basic packages: in the event of a medical emergency or an accident making it impossible to transfer to a facility offering shared rooms, *We* will cover the cost of a standard private room (based on reasonable and customary costs charged locally).
We will not cover the cost of a private room for scheduled hospitalisation.

We may request any other supporting documentation we deem necessary to ensure your treatment is covered under this plan.
If there is a disagreement over the amount of the payment, please let us know within 6 months of the date on which the reimbursement statement was generated.
All reimbursements are subject to compliance with the rules listed in paragraph 7.1.

7.2. REPATRIATION ASSISTANCE

2 levels of cover are available:

- Basic repatriation assistance: included in your Medical expenses cover.
- Comprehensive repatriation assistance: available as an option.

How to benefit from repatriation assistance?
It is essential to obtain ***Prior agreement* from Europ Assistance** to benefit from the following cover.

CONDITIONS OF APPLICATION

Europ Assistance only intervenes in a medical capacity after emergency aid has been organised on the orders of a qualified *Medical authority*.
From the first phone call, the *Medical team* contacts the local treating doctor in order to best meet the needs of the sick or injured person.
If *You* or the persons accompanying you organise any of the assistance services listed below, these costs will only be reimbursed if Europ Assistance has been notified of this procedure, given their express agreement and provided you with a case reference number. In this case, costs are reimbursed based on supporting documentation and up to the amount that Europ Assistance would have incurred if they had organised the service themselves.
Europ Assistance will not be held responsible for any delays or failures in the provision of their services in the event of industrial action, riots, popular movements, reprisals, restrictions on the free movement of goods and people, acts of terrorism or sabotage, state of belligerency, civil or foreign war whether war is declared or not, nuclear decay, exposure to ionizing radiation and other fortuitous events or in cases of force majeure.

7.2.1. BASIC REPATRIATION ASSISTANCE

The conditions and levels of cover apply per insured person, within the limits specified for each type of cover.

REPATRIATION FOR HEALTH REASONS
In the event of an *Accident* or *Sudden illness*, the Europ Assistance doctors will contact the local treating doctors and take the decisions best suited to your condition, based on the information gathered and based solely on medical necessity.
If the Europ Assistance *Medical team* recommends you are repatriated, Europ Assistance will organise and cover the cost of repatriation, solely on the basis of the medical priorities determined by its *Medical team*.

The repatriation destination may be:

- the most suitable hospital, or

- the hospital nearest your home in your *Country of nationality* (or in your country of origin, if different) or your primary residence in your *Country of cover*, or
- your home in your *Country of nationality* (or in your country of origin, if different) or your primary residence in your *Country of cover*.

If *You* are hospitalised in a healthcare facility outside the hospital district of your usual place of residence in your *Country of nationality* or your primary place of residence in your *Country of cover*, Europ Assistance will organise your return trip after the medically confirmed *Stabilisation* of your condition and will cover the cost of your transfer to your primary place of residence in your *Country of cover* or your home in your *Country of nationality*.
Repatriation may be carried out by light sanitary vehicle, ambulance, train, scheduled airline or air ambulance. The *Medical team* is solely responsible for the final choice of the place and date of *Hospitalisation*, your need to be accompanied, and any means to be used. Any refusal of the solution proposed by the *Medical team* will result in the cancellation of personal assistance cover.
Europ Assistance may ask you to use your own travel ticket, if it can be used or changed.

REPATRIATION OF OTHER BENEFICIARIES IF THE INSURED IS REPATRIATED FOR HEALTH REASONS
If the *Insured* is repatriated for health reasons, Europ Assistance will organise the return trip home for the insured family members who were travelling with him or her.
Europ Assistance will cover the cost of a one-way ticket by air in economy class or by train in 1st class provided the original means for their return journey cannot be used or changed.

ACCOMPANYING CHILDREN
If *You* are repatriated and are unable to take care of your *Dependent children* under the age of 18 who are also covered under the plan, Europ Assistance will provide a person of your choice with a round-trip ticket by air in economy class or by train in 1st class to bring your *Dependent children* back to your *Country of nationality*.

COMPRENHENSIVE REPATRIATION ASSISTANCE PRESENCE OF A FAMILY MEMBER IF YOU ARE HOSPITALISED
If your condition does not allow or does not require your repatriation and if you are hospitalised locally for more than 6 consecutive days, Europ Assistance will provide a Family member with a round-trip ticket by air in economy class or by train in 1st class to be with you. This benefit is only provided if there is no legally-adult Family member with you. Europ Assistance will also arrange and cover the cost of their hotel accommodation (bed and breakfast only) for a maximum of 10 days at €/US$ 80 per night.
No other temporary accommodation solution will be reimbursed.

CARE OF CHILDREN UNDER THE AGE OF EIGHTEEN
If the *Insured* is hospitalised and the *Dependent children* cannot take care of themselves or be looked after by a *Family member*, the *Insurer* will cover the cost of:
- care of the *Dependent children* at the *Insured*'s home for up to a **maximum of 20 hours**;
- this entire benefit is **capped at €/US$ 500**.

RETURN OR CARE OF PETS IF THE INSURED IS REPATRIATED
Europ Assistance will arrange and cover the cost of returning a pet, if the *Insured* and all of the *Family members* are repatriated, to the *Country of nationality* (or the country of origin if different) or the country of residence. The repatriation, as well as the most suitable means, are decided and chosen by Europ Assistance. **This repatriation is covered up to a maximum of €/US$ 500**, regardless of the number of pets to be repatriated. Europ Assistance will not be held responsible if this repatriation cannot be arranged due to the legislation in force in the country of secondment or expatriation or due to it being prohibited by the local authorities for any reason whatsoever. Under no circumstances can this benefit be provided for wild animals
Care of pets:
If the *Insured* is hospitalised and if the pets cannot be taken care of, the insurer will cover the cost of accommodation in an appropriate care facility for the duration of your stay in hospital **up to a maximum of €/US$ 500** regardless of the number of pets.

HOME HELP
The *Insurer* will cover the cost of providing a home help to carry out housework at your home, either when you return home from hospital, or from the date of your admission to hospital, or while you are confined to the home.
The insurer will reimburse the cost of the home help for a maximum of **10 hours** allocated at your convenience during the month following the date of your admission to hospital or your return home or while you are confined to the home, **up to a maximum of €/$ 250.**

SEARCH AND RESCUE COSTS

The purpose of this cover is to provide you with the reimbursement of search and rescue costs incurred by the intervention, in a public or private location, of fully equipped, specialised teams, including the use of a helicopter.

This cover tops up or takes over from any other similar cover *You* may have.

In all cases, cover is capped at **a maximum of €/US$ 5,000 per person and €/US$ 15,000 per event.**

REPATRIATION IN THE EVENT OF AN ACT OF TERRORISM OR SABOTAGE OR AN ATTACK OR ASSAULT

If the *Insured* is the victim of an *Act of Terrorism or sabotage* or an *Attack or Assault* resulting in *Bodily Injury* or a state of shock, Europ Assistance will arrange the *Insured*'s repatriation to their *Country of nationality* (or the country of origin if different).

The repatriation, and the most suitable means, are decided and chosen by Europ Assistance.

POLITICAL EVACUATION AND NATURAL DISASTERS

If the *Insured*, on the advice of the local authorities or those of their *Country of nationality*, due to events rendering the political regime unstable or due to a natural disaster (such as an earthquake or a flood), is obliged to leave their expatriation location, they should, on returning to their *Country of nationality*, provide Europ Assistance with all documents enabling them to obtain the reimbursement of the return trip by air (economy class) or train (1st class), **up to a maximum of €/$ 1,500.**

The *Insured* must be able to prove that, following events rendering the political regime unstable or following a natural disaster, the French Ministry of Europe and Foreign Affairs has classified the zone where they are living as one to which travel is "strongly discouraged" (red zone). This benefit is not available in *Excluded countries*.

REPATRIATION OF THE BODY IN THE EVENT OF DEATH AND COST OF THE COFFIN

If you were to die, Europ Assistance will arrange and cover the cost of the repatriation of the body or ashes from the place of death to the place of burial in your Country of nationality, residence, expatriation or origin (if different).

Europ Assistance will cover the cost of post-mortem care, casketing and transportation requirements. Coffin expenses in connection with transportation organised by the assistance services are covered **up to a maximum of €/US$ 1,500**. The funeral, ceremony, local transportation and burial or cremation expenses remain payable by your family. The choice of companies involved in the repatriation process is exclusively that of Europ Assistance.

RETURN OF INSURED FAMILY MEMBERS

If the *Insured*'s body is repatriated, Europ Assistance will arrange the return trip home for the insured *Family members* who were travelling with them. Europ Assistance will cover the cost of a one-way ticket by air in economy class or by train in 1st class provided the original means of returning home cannot be used or changed.

RETURN AFTER STABILISATION IN YOUR COUNTRY OF COVER

If following medical repatriation, *You* are able to return to work, Europ Assistance, with the agreement of their *Medical team*, will organise your return to your *Country of cover*. Europ Assistance will cover the cost of a one-way ticket by air in economy class or by train in 1st class.

PRESENCE OF A FRIEND OR RELATIVE TO ACCOMPANY THE DECEASED

If the presence of a *Family member* or *Friend* is essential to identify the body of the deceased *Insured* and to complete the repatriation or cremation formalities, Europ Assistance will provide a round-trip ticket by air in economy class or by train in 1st class.

This benefit is only available if the *Insured* was alone abroad at the time of their death. Europ Assistance will arrange local accommodation and cover hotel accommodation costs (bed and breakfast only) for a *Family member* or a *Friend* **for a maximum of 4 consecutive nights and up to €/US$ 50 a night. No other temporary accommodation solution will be reimbursed.**

SOURCING AND DELIVERY OF MEDICATION NOT AVAILABLE LOCALLY

In the event that indispensable drugs or their equivalents cannot be obtained locally and were prescribed before departure by your treating doctor in your *Country of nationality* (or in your country of origin, if different), Europ Assistance will source them in France.

If they are available, they will be sent as soon as possible subject to the constraints of local legislation and available means of transport.

This service is available for one-off requests. It does not apply, under any circumstances, to long-term treatments that require regular deliveries or requests for vaccines. *You* are responsible for the cost of the medication unless it is covered under your medical expenses cover. *You* agree to reimburse the amount plus any custom clearance charges within a maximum period of 30 days from the shipment date.

LEGAL ASSISTANCE ABROAD (EXCEPT IN YOUR COUNTRY OF NATIONALITY)

Following an unintentional infraction of the laws and regulations of your *Country of cover*, and for all non-criminal acts, Europ Assistance will intervene, on written request, if legal action is taken against *You*. This benefit does not apply to matters related to your professional activity. Europ Assistance will cover the local legal fees **up to a maximum of €/US$ 1,500 per event.**

ADVANCE OF BAIL ABROAD (EXCEPT IN YOUR COUNTRY OF NATIONALITY)

Europ Assistance will advance the cost of bail stipulated by the authorities to free you or to allow you to avoid incarceration. This advance is made through the intermediary of a local lawyer up to **a maximum of €/$ 15,000 per event.**

You must reimburse this advance to Europ Assistance:

- following restitution of bail in the case of nonsuit or acquittal,
- within 15 days of judicial sentencing being carried into effect in the case of conviction,
- in all cases, within three months of the date of payment.

TRAVEL ASSISTANCE

When travelling *Abroad*, in the event of the loss or theft of your personal effects (identity documents, means of payment, luggage) or travel documents, and having reported the loss or theft to the competent authorities, Europ Assistance will make every effort to assist you.

Europ Assistance is not authorised to stop payments on behalf of third parties. If replacement documents are produced in your *Country of nationality*, Europ Assistance will deliver them by the most rapid means.

Europ Assistance may send you an advance **up to a maximum of €/US$ 1,500 per event** to allow you to purchase essential items.

In the event of the loss or theft of a travel document, Europ Assistance may advance the cost and send you a new, non-negotiable travel document. **These advances may be made in return for a guarantee provided either by *You* or by a third party. Any advances made must be reimbursed within a period of 30 days from the date on which the funds were made available**

SENDING URGENT MESSAGES

If it is not practically possible for *You* to send an urgent message and if *You* request it, Europ Assistance will send your messages or news to your family members, friends or employer free of charge and by the most rapid means.

The messages remain the responsibility of their authors who must be identifiable and their sole concern. Europ Assistance acts solely as an intermediary in the transmission of the messages. Europ Assistance may also act as an intermediary in the opposite direction.

LOSS, DAMAGE OR DESTRUCTION OF PERSONAL BAGGAGE

During journeys made by the *Insured*, the insurer will cover the loss, damage or total or partial destruction of *Baggage*. The insurer will only cover *Baggage* in the following cases:

- if the loss, damage or destruction occurs while the *Baggage* is in the care of a carrier and has been checked in,
- if the loss, damage or destruction is the result of a catastrophic event such as a fire, a flood, a collapse or an *Act of terrorism.*

Upper limit of cover

How to make a claim

You must declare the *Claim* to the insurer, using the following website **https://www.chubbclaims.com/ace/fr-fr**, within 5 working days of the loss or damage. After this period, the insurer reserves the right to deny cover.

You will be provided with a list of the supporting documents required.

The insurer will cover *Baggage* up to **€/$ 1,000**.

FRAUDULENT USE OF A SIM CARD BY A THIRD PARTY

The insurer will cover the cost of the fraudulent use of a mobile phone by a Third party if the phone is stolen in an Assault during your stay outside your Country of nationality, providing the phone was used in this way before the Insured made the request to block the SIM card and within forty-eight (48) hours of the date and time of the theft.

SPECIAL PROVISIONS APPLICABLE TO PERSONAL MOBILE PHONES, SMARTPHONES AND TABLETS

The insurer will reimburse the Insured up to five hundred euros (€/$500) per Event for mobile phones, smartphones or tablets which are stolen during an Assault or mugging outside your Country of nationality, on presentation of supporting documentation.

Depreciation:

- Twenty percent (20%) in the first year (from the first day of purchase)
- Forty percent (40%) in the second year
- No reimbursement after the second year.

In all cases, the Insured must provide (initial or replacement) invoices for the purchase of the equipment.

FLIGHT DELAYS OR CANCELLATION, OR DENIED BOARDING

If, at any airport whatsoever:

- the *Insured*'s scheduled and confirmed flight is delayed by four (4) hours or more from the initial scheduled departure time,
- the *Insured*'s scheduled and confirmed flight is cancelled,
- the *Insured* is denied boarding due to overbooking and no alternative means of transport is available for at least six (6) hours,
- the Insured will be covered up to Three Hundred euros (€/$300) for all expenses related to food, refreshments, hotel accommodation and/or transfers to and from the airport or the terminal.

Cover will not apply in the following cases:
- Where confirmation is required, the Insured had not previously confirmed the flight unless prevented from doing so by industrial action or a case of force majeure,
- if the delay was caused by industrial action or a Civil War or Foreign War risk of which the Insured was aware before departure,
- in the event of the temporary or permanent withdrawal from service of an aircraft on the orders of the civil aviation authorities or the airport authorities or a similar authority in any country.

MISSED CONNECTION

If the Insured misses the departure of a scheduled flight due to the late arrival of the preceding scheduled flight on which they were travelling and no other means of transport is available for at least six (6) hours following arrival at the connecting airport, their expenses related to hotel accommodation, restaurants or refreshments are covered up to Three Hundred euros/dollars (€/$300).

Flight delays or cancellation or denied boarding' cover and 'Missed connection' cover can be combined.

REIMBURSEMENT OF TRIP EXPENSES

The purpose of this benefit is the reimbursement, on a pro rata basis, of trip abroad outside your *Country of cover*, expenses which have already been paid but not used (excluding travel and accommodation costs) in the event of an early return home following the Insured's medical repatriation to their Country of nationality organised by the assistance provider.

The maximum amount of the daily allowance is €/$250 per day, with an overall cover limit of €/$5,000 per Insurance year.

The benefit is proportional to the number of unused days of the trip. To calculate the benefit, expenses in respect of administration, visa, insurance, tips and reimbursement or compensation paid by the organiser of the trip or any other organisation to which You paid the expenses in question will be deducted.

ENFORCED STAY ABROAD

In case of an event classed as *Force majeure* by the public authorities of the country in which *You* are temporarily staying outside *Your Country of cover* and which prevents you from returning permanently to your *Country of cover*, the assistance provider will cover the additional costs involved in extending your stay up to a maximum of €/$80 per night (food and accommodation only), for a maximum of 14 nights.

Cover only takes effect after the public authorities of the country in which You are temporarily staying have declared a state of Force majeure and with the prior agreement of the assistance provider. All costs incurred without the prior agreement of the assistance provider as well as all costs incurred due to an extended stay which is not due to an event classed as Force majeure will not qualify for any benefits.

EARLY RETURN HOME IN THE EVENT OF THE DEATH OR HOSPITALISATION OF A FAMILY MEMBER

Europ Assistance will provide you with a round-trip ticket by air in economy class or by train in 1st class in the event of the death or *Hospitalisation* for more than 5 days of a *Family member* in your *Country of nationality* (or in your country of origin if different). The outward trip must take place within 8 days of the death or *Hospitalisation*.

This benefit can be claimed when the death or *Hospitalisation* occurs after your departure.

Europ Assistance reserves the right, prior to the provision of its services, to request proof of the covered event (hospital certificate, death certificate etc.). This benefit cannot be used more than once per *Insurance Year* for the same causal event. A causal event is the event or state of affairs causing the use of the benefit. This means that one and the same illness of a family member cannot give rise to several early returns home within the same *Insurance Year*.

In order to claim this benefit, *You* must contact Europ Assistance to obtain their *Prior agreement*. Otherwise, Europ Assistance has the right to refuse to reimburse any tickets which *You* may have bought Yourself.

TRANSLATION OF LEGAL AND ADMINISTRATIVE DOCUMENTS

When *You* are *Abroad* or in case of medical repatriation, if you have serious difficulty understanding legal or administrative documents in the local language, Europ Assistance will arrange and cover the cost of translating these documents into your native language. Europ Assistance will provide cover up to a maximum of **€/$ 500 per Insurance year**. Europ Assistance will not be held responsible for the consequences of poor translations or misunderstandings on your part.

LIMITATIONS ON COVER

If Europ Assistance arranges and covers the cost of repatriation or transportation, you may be asked to use your own

travel ticket. If Europ Assistance has paid for your return trip, *You* must return the unused travel ticket to Europ Assistance.

7.2.2. PSYCHOLOGIC SUPPORT

In the event of the *Insured*'s Accidental Death or Permanent Disability resulting from an insured *Accident*, or in the event of *Bodily Injury* resulting from an *Act of Terrorism* or *Sabotage* or an *Attack* or *Assault*, the assistance provider will provide psychological support to the *Insured* or the *Spouse* and/or *Dependent children* of the insured person who has died in an accident during the Professional Assignment or trip *Abroad*. The clinical psychologist will provide the *Insured* or the *Insured*'s *Spouse* and/or *Dependent children* with wholly confidential medical and psychological support to help them deal with the distress suffered as a result of the Event. The psychologist will help them identify, assess and organise their personal, family, social and medical resources to help them get through this difficult time.

The service is provided by telephone. By simply making a phone call, a suitable appointment is arranged with a psychologist from the assistance provider who will return the call to begin the process. If necessary, the *Insured* may be put through directly to a psychologist if one of the psychologists from the assistance team is available at that time. The consultations are strictly confidential and comply with the codes of ethics in force. **The support provided is limited to a maximum of two thousand Euros (€/$ 2 000) per Event**

.**PERSONAL LIABILITY (PRIVATE CAPACITY)**

PURPOSE OF THE INSURANCE

This benefit covers the financial consequences of any damage for which *You* and the insured members of your family are held liable in a private capacity, including during the commute to and from work and excluding any work-related activity. The benefit is available if the liability for damage **caused to a third party** falls on you or any person for whom *You* are responsible.

UPPER LIMITS ON COVER

Bodily injury, material damage and consequential financial loss: **up to €/$ 7,500,000 per *Claim* and per *Insurance year*** including:

Material damage and consequential financial loss: **up to €/$ 750,000 per *Claim* and per *Insurance year*. *Deductible* of €/$ 150 per *Claim*.**

Damage resulting from fire, explosion and water, caused to third parties in buildings which *You* have rented or borrowed for the organisation of family ceremonies: **up to €/$ 150,000 per *Claim* and per *Insurance year*. *Deductible* of €/$ 150 per Claim**.

How to make a claim:

As soon as *You* become aware of any circumstances that may give rise to a *Claim* under the plan, *You* must inform the insurer, using the following address: **France.DeclarationsRC@Chubb.com,** within a period of no more than 15 days. Details of the circumstances surrounding the *Claim* and their consequences should also be provided.

SPECIAL PROVISIONS

Disputes

In the event of a dispute regarding the measures to be taken to settle a disagreement, the matter may be submitted to a third party designated by mutual agreement or, failing that, to the President of the Tribunal de Grande Instance of Paris acting in summary proceedings. Expenses incurred in the implementation of this option will be covered by the insurer. However, the President of the Tribunal de Grande Instance of Paris may decide otherwise if *You* have implemented this option under improper conditions.

If *You* undertake litigation at your own cost and obtain a solution that is more favourable than that proposed by the insurer or by the third party mentioned above, the insurer will reimburse the costs which You incurred up to the cover limit.

When the procedure described above is put in motion, the time limit on appeals is suspended for all legal proceedings covered by the insurance and which *You* may undertake, until the third party tasked with proposing a solution has disclosed its content.

Choice of legal representation

In the event of legal or administrative action requiring the involvement of a lawyer or any other person qualified by law or current regulations to represent your interests, *You* have free choice and the insurer will pay the fees directly.

If *You* do not know a lawyer, the insurer may make one available to You. This free choice is also applicable if there is a conflict of interest between *You* and the insurer.

Procedure - Transactions

In the event of proceedings involving liability covered by this insurance, the insurer reserves the right, under the limits of the cover, to direct the proceedings and exercise all appeals before civil, commercial or administrative jurisdictions.

Should *You* not allow this option to be exercised, the insurer will have the right to terminate your insurance cover.

In the case of proceedings before a criminal court and if the victim(s) have not been compensated, the insurer will have the

right, with your agreement, to take responsibility for your criminal defence or to take part in the proceedings. In the absence of such an agreement, the insurer may, nevertheless, defend your civil interests. The insurer can also exercise all appeals on your behalf, including an appeal in cassation, when criminal interests are no longer involved. Otherwise, the insurer can only exercise them with your agreement. You are prohibited, within the limits of the insurance, from reaching a settlement with the injured parties.
Any admission of liability or transaction carried out without the involvement of the insurer will not be enforceable; the acknowledgment of a material fact is not considered to be an admission of liability.

7.3. DEATH AND TOTAL AND IRREVERSIBLE LOSS OF AUTONOMY LUMP SUM

The death and total and irreversible loss of autonomy lump sum/ double benefit as well as the income protection benefit can be purchased on a stand-alone basis under certain conditions.

7.3.1. DEATH BENEFIT

a) Choice and amount of the lump sum
The purpose of this benefit is to pay a death lump sum to the designated *Beneficiary* or *Beneficiaries* if *You* die before your 65th birthday.
The insured lump sum can be chosen from amounts between €/$ 20,000 and €/$ 500,000. The *Member* is free to choose the amount of this lump sum. The *Member* has the option of choosing a different amount at a later date. If a higher amount is chosen, medical formalities will be required.

b) Death all causes
If *You* die, regardless of the cause, the insurer will pay the designated *Beneficiary* or *Beneficiaries* a lump sum equal to 100% of the chosen lump sum.

c) Accidental death
If *You* die following an *Accident*, the insurer will pay an additional lump sum equal to 100% of the chosen lump sum paid under paragraph (b) above.
This benefit is payable provided the death occurs no later than six months after the Accident.

d) Procedure for making a Claim and payment of benefits
The death must be declared to the insurer, through our intermediary, by sending the original supporting documents required for payment, including:
- an extract of the death certificate;
- a medical certificate from the doctor who recorded the death, showing the date of death and whether it is was due to natural causes or accidental;
- a report issued by the police or any other competent authority if the death is due to an *Accident*;
- any document proving the identity of the *Beneficiary* or *Beneficiaries*.

When we have received notification of the death and the contact details for the *Beneficiary* or *Beneficiaries*, We have fifteen (15) days to request all the documents required from the *Beneficiary* or *Beneficiaries* in order to process the claim.
When we have received all of the documents required for the claim, and if benefits are due, *We* will pay the lump sum within thirty (30) days. If payment is not made within this timescale, the outstanding lump sum will generate interest in accordance with current legislation.
Without prejudice to the provisions set out in Article L. 132-23-1 of the French Insurance Code, the lump sum due in the event of death, excluding any additional benefits linked to its accidental nature, is automatically revalued by the insurer under the following conditions: The insured lump sum generates interest as of the date of death. This interest, net of charges, is set for each calendar year at the regulatory minimum rate, i.e., on the date of enrolment in this plan, at a rate equal to the lower of the following two rates:
- The average of the Average Borrowing Rate in France over the last twelve months, calculated at 1st November of the previous year.
- The latest Average Borrowing Rate in France available on 1st November of the previous year.

The revaluation ceases on the date of receipt of the supporting documents required for payment or, if applicable, on the date on which the lump sum is deposited at the 'Caisse des dépôts et consignations' in application of Article L. 132-27-2 of the French Insurance Code.

7.3.2. LUMP SUM PAYABLE ON THE SIMULTANEOUS OR SUBSEQUENT DEATH OF YOUR SPOUSE (DOUBLE BENEFIT)

a) Definition of the benefit

If your *Spouse* dies before the age of 65, whether this event occurs at the same time as your death (24 hours before or after) or following your death (within 6 months), a lump sum is paid to the designated Beneficiary or Beneficiaries or, failing that, to the Beneficiaries as of right.

The amount of this lump sum is fixed at 50% of the amount specified in paragraph b) of paragraph 7.4.1 and is paid on the death of your *Spouse*.

b) Procedure for making a Claim and payment of benefits

The supporting documentation required for payment includes:

- an extract of the death certificate;
- a medical certificate from the doctor who recorded the death, showing the date of death and whether it is was due to natural causes or accidental;
- report issued by the police or other competent authority in the event of death following an *Accident*;
- any document proving the identity of the *Beneficiary* or *Beneficiaries*.

The lump sum is paid under the conditions described in paragraph 7.4.1.

Allocation of the lump sum: the insured amount is paid to the designated beneficiary or beneficiaries or, failing that, to the beneficiaries as of right.

7.3.3. TOTAL AND IRREVERSIBLE LOSS OF AUTONOMY

a) Definition of the benefit

Total and irreversible loss of autonomy: where you are totally and permanently medically unfit for gainful employment and require the assistance of a third party to carry out basic daily tasks. Total and irreversible loss of autonomy due to an illness or *Accident* covered under the plan and which is confirmed before your 65th birthday is treated in the same way as death. The death benefit is calculated from the date of medical confirmation of the state of total and irreversible loss of autonomy and an early payment of this benefit is made to you.

To be eligible for benefits, your total and irreversible loss of autonomy must be stabilised before the date of retirement and, at the latest, before your 65th birthday.

Early payment of death benefits in the event of total and irreversible loss of autonomy cancels all other death benefits (with the exception of Double benefit).

b) Procedures for making a *Claim* and payment of benefits

It is your responsibility to declare the state of total and irreversible loss of autonomy and *You* must provide proof to the insurer, through our intermediary, by sending us the required supporting documents. These include:

- a detailed certificate from the treating doctor;
- where applicable, notification of payment from a Social Security scheme of a disability pension requiring the assistance of a third party;
- any document proving identity and/or marital status;
- a report issued by the police or other competent authority in the event of an *Accident*;
- where applicable, any document specifying the cause and circumstances of the *Accident* having caused total and

Recognition and monitoring by the insurer of the state of total and irreversible loss of autonomy

Until the date on which the benefits become payable, the insurer reserves the right to carry out any checks and subject the claimant to any medical examinations deemed useful in order to assess, recognise or monitor the state of total and irreversible loss of autonomy.

In the event of a dispute between your doctor and the insurer's doctor regarding the state of total and irreversible loss of autonomy,

You and the insurer will jointly choose a third doctor to reach a majority decision.

***You* agree to abide by the jurisdiction of the courts of Paris and waive the right to legal action in any other country.**

Payment of the lump sum

The insured lump sum becomes payable six months after the date of recognition by the insurer of the state of total and irreversible loss of autonomy and subject to the continuation of this state.

7.3.4. WAIVER OF PREMIUM – CONTINUATION OF COVER DURING SICK LEAVE FROM WORK

a) Waiver of Premium

If *You* are on total sick leave from work following an illness or *Accident* occurring before your 65th birthday, the *Premiums* for the selected benefits (excluding Repatriation assistance and Personal liability - private capacity) are no longer payable:
if *You* did not select income protection cover: from the 91st day of total and continuous sick leave from work;
if *You* selected income protection cover: from the 31st or 61st day of total and continuous sick leave from work depending on the selected option
To be classed as being on total and continuous sick leave, *You* must be in a state of total temporary incapacity to work or in a state of total permanent disability as defined by paragraph 7.5.2, recognised by the insurer.

b) Continuation of cover
As long as the *Member* is exempt from paying the *Premium* under the terms described in paragraph a) above, the benefits payable in the event of death and total and irreversible loss of autonomy are maintained under the conditions described in the corresponding paragraphs.
Continuation of cover is granted for the duration of periods of sick leave with entitlement to waiver of the Premium.
It ends when you are medically certified to be fit to return to work, regardless of the nature of this work.
If the plan is terminated, the benefits continue to be paid at the level reached on the date of termination.

7.4. INCOME PROTECTION

This benefit can only be selected if *You* are already covered for death and total and irreversible loss of autonomy under the plan (paragraph 7.4.) and are in paid employment.
If *You* opted for CFE or French Social Security top-up cover, we will top up the benefits you receive from your basic French insurance scheme (French Social Security or an equivalent French scheme) or the Caisse des Français de l'Étranger. If You are a member of the CFE, You must therefore have purchased income protection/death lump sum benefits from the CFE.
If your situation does not entitle you to reimbursements from your basic plan, *We* will cover you from the 1st euro/dollar, if You have provided us with proof that you are not covered by your basic French insurance scheme.

7.4.1. PURPOSE OF THE INSURANCE

This benefit provides a daily payment in the event of temporary total incapacity to work or an annual pension in case of permanent disability, following an illness or an *Accident*.

7.4.2. DEFINITIONS

Total incapacity to work means total temporary incapacity following an illness or an *Accident* which renders you temporarily physically unable, as certified medically and recognised by the insurer, to carry out any professional activity.
Permanent total or partial disability means a disability following an illness or *Accident* making it totally or partially physically impossible for you, as certified medically and recognised by the insurer, to continue in your usual profession or in a profession where your earnings would be the same as they were before you took sick leave from work due to an illness or an *Accident*.

7.4.3. LEVEL OF BENEFITS

a) Temporary incapacity
If the insurer accepts that you are in a state of total temporary incapacity to work, they will pay you a daily benefit starting after a period of total and continuous sick leave due to illness or *Accident* of 30 days or 60 days depending on the option selected.
The amount of daily benefit is selected by the *Member* between a minimum and a maximum in line with the obligatory minimum amount of death benefits selected. The amount is shown on the *Membership certificate* for the first year of cover and then on the latest premium notice.

The total amount of daily benefit paid over one month cannot exceed 100% of your net monthly salary (limited to 70% of your net monthly income if you have started or taken over a business within the last year).
If you opted for *CFE* or *French Social Security* top-up cover, the monthly total of the daily benefit from your basic scheme and the MyHealth International plan combined cannot exceed 100% of your net monthly salary (limited to 70% of your net monthly income if you have started or taken over a business within the last year).

b) Permanent disability
You are recognised as being in a state of permanent disability if you meet both of the following two conditions:
- *You* are physically or mentally disabled;

and
- *You* have an occupational disability.

The disability is assessed by a medical specialist. To allow the specialist appointed by the insurer to determine the degree of physical, mental or occupational functional disability, your condition must have stabilised. The degree of functional disability is determined on a scale of 0 to 100%, without reference to any work-related considerations, and based on a reduction in physical

or mental capacity following an *Accident* or illness.
The degree of occupational disability is then determined on a scale of 0 to 100% based on the degree and type of functional disability with reference to your profession, taking into account the nature of your professional activity prior to the illness or *Accident*, the normal conditions of the profession and the ability to continue working in that profession.

Having determined the degree of functional and occupational disability, the degree of disability is determined according to the following disability scale. The level of the benefit selected by the *Member* is shown on the *Membership certificate*, i.e. 360 times the amount of daily benefit selected.

- If the degree of disability "n" determined by the insurer by expert opinion is greater than or equal to 66%, the disability is deemed to be total. The amount of benefit payable is equal to the amount of benefit selected.
- If the degree of disability "n" determined by the insurer by expert opinion is between 34% and 65%, the disability is deemed to be partial. The amount of benefit paid is then equal to n/66th of the total disability benefit selected, where "n" is the degree of disability determined by the insurer.

No benefits are due if the degree of disability "n" determined by the insurer is less than or equal to 33%.

DISABILITY SCALE									
OCCUPATIONAL RATE	FUNCTIONAL RATE								
	20	30	40	50	60	70	80	90	100
10						37	40	43	46
20				37	42	46	50	55	58
30			36	42	48	53	58	62	67
40			40	46	52	58	63	69	74
50		36	43	50	56	63	68	73	79
60		38	46	53	60	66	73	79	84
70		40	48	56	63	70	77	83	89
80		42	50	58	66	73	80	87	93
90		43	52	61	67	76	83	90	97
100	34	45	54	63	71	79	86	93	100

7.4.4. PROVISIONS WHICH APPLY TO ALL INCOME PROTECTION COVER

a) Recognition and monitoring of the state of incapacity or disability by the insurer
The insurer reserves the right to assess, recognise and monitor your state of incapacity or disability and the insurer's doctors, agents or representatives must be able to visit *You* for this purpose. *You* must agree to see them and provide them with an accurate account of your condition. If *You* object to the visits and/or medical examinations, the insurer may by rights **discontinue the payment of benefits.** In the event of a dispute between your doctor and that of the insurer regarding the state of temporary total incapacity to work or on the state of total or partial permanent disability, *You* and the insurer will jointly choose a third doctor to reach a majority decision.
***You* agree to abide by the jurisdiction of the courts of Paris and to waive the right to legal action in any other country.**

b) Payment of benefits
Temporary incapacity: this benefit, although acquired daily, is paid monthly in arrears for as long as *You* are in a state of total temporary incapacity to work and up to the day on which the permanent state of disability is recognised and, at the latest, up to the 1,095th day starting from the start date of sick leave or from the date of the late declaration. This benefit comes to an end on the date on which the *Stabilisation* of your medical condition has been recognised by a medical expert appointed by the insurer. Payment ends, at the latest, on the day on which *You* reach your 65th birthday.
Permanent disability: the level of payments may be reviewed if there is a change in the state of disability. The benefit is paid to you quarterly in arrears, for the duration of the disability, up to the end of the quarter of the calendar year in which *You* reach the age of 65.

c) Return to work for a period of less than two months
If, having started to receive the benefits described above, *You* return to work but require another period of sick leave less than two months later, the aforementioned benefits are restarted without the application of the *Deductible* (30 or 60 days depending on the option selected by the *Member*) provided the plan is still in force on the new date of sick leave and if it can be proved that the new period of absence from work has the same cause as the previous one.

d) Revaluation of benefits
The daily benefits and annual pensions paid during periods of sick leave from work are revalued on the 366th day following

the start date of the period of sick leave every year on the same date.
They are increased by 2% on the anniversary date of the plan. The insurer reserves the right to review this rate depending of the funds available. The benefits remain at the level reached if the plan is terminated.

7.4.5. PROCEDURE FOR MAKING A *CLAIM*

It is your responsibility to declare the period of sick leave from work. *You* must notify the insurer, through our intermediary, by registered letter within 30 days of the start of sick leave. The declaration must include the following:

- a medical certificate specifying the date of sick leave, the probable duration of the incapacity and the nature of the illness or *Accident*;
- proof that you are in paid employment;
- for salaried *Insured*: a declaration of sick leave from your employer and proof of gross earnings over the last 12 months, including bonuses, and your employer's contact details;
- for non-salaried *Insured*: a copy of your income tax notice for the previous year. The insurer reserves the right to request additional supporting documents.

If the sick leave is declared after this 30-day period, no payment will be due in respect of the period preceding the declaration.
At the end of the period of sick leave, *You* must send a return to work certificate to the insurer, through our intermediary.
If the incapacity lasts beyond the date planned for the return to work, a new medical certificate must be provided indicating the probable duration of the new period of sick leave and the nature of the illness or *Accident*.
This requirement applies each time the incapacity is extended beyond the expected date of return to work.

8. WHAT IS NOT COVERED UNDER YOUR PLAN

8.1. EXCLUSIONS WHICH APPLY TO MEDICAL EXPENSES COVER

In addition to the *Exclusions* which apply to all cover listed in paragraph 8.6 below, the following are excluded from the medical expenses cover as well as their consequences:

- **any costs incurred for treatment or procedures prescribed before the *Effective date* of the plan or during the *Waiting periods*;**
- **previously declared conditions which were excluded at the time of enrolment in the plan;**
- **any medical and surgical expenses not prescribed by a qualified *Medical authority*;**
- **for *Insured* members who have CFE, CNS or French Social Security top-up cover, any medical and surgical expenses which are not covered by your basic plan (unless otherwise stated in the benefits schedule);**
- **non-generic drugs, where their generic form is available and can be prescribed to the Insured member;**
- **medical or surgical *Hospitalisation* expenses or stays in a sanatorium or preventorium, if the facility treating the *Insured* is not approved by the relevant public authorities;**
- **ancillary costs (other than those listed in the benefits schedule) in the event of *Hospitalisation* or excessive, unreasonable or unusual costs considering the country in which they were incurred;**
- **transportation costs other than transfer by road ambulance to the nearest suitable care centre;**
- **psychotherapy and outpatient care (consultations, medicines, diagnostic tests and laboratory tests) related to:**
  - **mental and behavioural disorders linked to the abuse of drugs, alcohol and other psychoactive substances;**
  - **sleep disorders (insomnia, hypersomnia and somnambulism) and sleep-wake cycle disorder;**
- **alternative or complementary medicine (other than those listed in the benefits schedule);**
- **the cost of over-the-counter pharmacy items, cosmetics, hygiene products, sunscreens and/or moisturisers, make-up, comfort care, vitamins and minerals, food supplements, dietetic products, baby foods and mineral water;**
- **thermometers and blood pressure monitors;**
- **medicines and treatment related to erectile dysfunction;**
- **the cost of sourcing and transporting organs for transplant;**
- **experimental treatments;**
- **cosmetic treatments, anti-ageing cures, weight-loss and weight gain treatments, thermal spa cures and thalassotherapy;**
- **the treatment of alcoholism, drug addiction or any other addiction or illness linked to such dependency;**
- **stays in a geriatric unit, medical teaching institution and similar facilities;**
- **hospitals and care facilities for the dependent elderly and long-term stays in hospital;**
- **stays in nursing homes and convalescent homes which do not follow *Hospitalisation* for a *Critical illness* or an *Accident*;**
- **growth hormones;**
- **sex change operations and treatments;**
- **non-prescription glasses and contact lenses;**
- **any expenditure which is not *Medically necessary*;**
- **treatments which are not recognised by the *Medical authorities* in the country in which they are provided.**

8.2. EXCLUSIONS WHICH APPLY TO REPATRIATION ASSISTANCE COVER (BASIC AND COMPREHENSIVE OPTIONS)

In addition to the *Exclusions* which apply to all cover as listed in paragraph 8.6 below, costs resulting from the following facts or events are not covered under the repatriation assistance benefits and will not give rise to any compensation whatsoever nor to any intervention on the part of Europ Assistance:

- **any interventions and/or reimbursements related to medical visits, check-ups, or preventive screening;**
- **benign conditions or injuries which can be treated locally and that do not prevent the *Insured* from continuing their journey;**
- **convalescence, conditions in the process of being treated and not yet stabilised and/or requiring further planned treatment;**
- ***Illnesses* which had been identified prior to departure and which were at risk of aggravation or relapse;**
- **conditions requiring *Hospitalisation* in the 6 months prior to departure;**
- **any consequences of a condition which required repatriation (check-ups, further treatment, recurrences);**
- **cosmetic surgery;**
- **the consumption of alcohol and the consequences thereof under local legislation;**
- **travel undertaken for diagnosis and/or treatment;**
- **the consequences of the failure of, unfeasibility of, or reaction to any vaccination or treatment required or mandatory for travel;**
- **congenital *Illnesses* or deformities.**
- **pregnancy other than unforeseeable complications but in all cases:**
  - **pregnancy and any complications and, in all cases, after the 28th week;**
  - **childbirth and post-natal complications relating to newborns;**
  - **elective termination of pregnancy;**

<u>The following are not covered :</u>

- **medical expenses;**
- **cures, stays in rest homes and physiotherapy;**
- **contraception and fertility treatment;**
- **glasses and contact lenses;**
- **cosmetic prostheses, dentures and hearing aids;**
- **regular transportation required as a result of the *Insured*'s health.**
- **events arising from the *Insured*'s participation as a competitor in sporting competitions, bets, games, contests, rallies or their preparatory trials;**
- **the consequences of any neuropsychic, psychological or psychosomatic disorder, any manifestation justifying neuropsychiatric treatment, and in particular nervous depression or anxiety;**
- **expenses resulting from pregnancy, maternity and related complications, childbirth and related complications, fertility treatments and termination of pregnancy.**
- **direct or indirect effects of changing the structure of the atomic nucleus, climatic events such as storms and hurricanes, earthquakes, floods, tidal waves or other disasters unless these are covered under compensation for natural disasters.**

<u>The following are excluded from the search and rescue cover:</u>

- **search and rescue costs resulting from a failure to observe the rules of caution laid down by the site operators and/or regulatory provisions governing the activity being practised by the *Insured*;**
- **search and rescue costs resulting from the practice of a professional sport, participation in an expedition or competition, unless otherwise expressly stipulated.**

***<u>Exclusions</u>* <u>which are specific to the LOSS, DAMAGE OR DESTRUCTION OF PERSONAL BAGGAGE:</u>**

- **dentures and optical or other prostheses, glasses and contact lenses;**
- **cash, personal papers, business documents, administrative documents, traveller's cheques, credit cards, airline tickets, travel tickets and vouchers;**
- ***Damage* caused by normal wear and tear, depreciation or inherent defects of the baggage;**
- ***Damage* caused by mites or vermin or by cleaning, repairs or restoration or misuse of the baggage by the *Insured*;**
- ***Damage* resulting from confiscation, seizure or destruction on the orders of an administrative authority;**
- **valuables, jewellery and furs;**
- **keys or other similar objects (for example, magnetic cards or badges);**
- **any *Baggage* or personal effects left unattended by the *Insured*;**
- **mobile phones;**
- **IT and audio-visual equipment, cameras, video cameras or hi-fi equipment entrusted to a carrier;**
- **costs which may be compensated under another insurance plan or costs for which the *Insured* has been compensated.**

Europ Assistance can only intervene in the following circumstances:

- **can only intervene within the limits of the agreements given by the local authorities;**
- **can under no circumstances replace local emergency rescue services or cover any costs incurred as a result of their intervention;**

- will not be held responsible for any failure or difficulty in carrying out its obligations as a result of cases of force majeure or events such as riots, civil war, foreign war, popular movements, revolution, strikes, seizure of control or restrictions enforced by the forces of law and order, official prohibition, piracy, detonation of an explosive device, nuclear or radioactive fallout or adverse weather conditions;
- is not obliged to intervene in cases where the *Insured* has deliberately violated the laws in force in the countries through which they are travelling or in which they are temporarily staying as a secondee or an expatriate;
- events which occurred as the result of the *Insured*'s participation as a competitor in sporting competitions, bets, games, contests, rallies or their preparatory trials.

8.3. EXCLUSIONS WHICH APPLY TO THE PERSONAL LIABILITY (PRIVATE CAPACITY) COVER

In addition to the *Exclusions* which apply to all cover as listed in paragraph 8.6 below, the following are not covered:

- damage resulting from any professional activity whatsoever or the exercise of the functions of elected offices;
- driving any motorised or animal-drawn vehicle;
- the consequences of any material damage or bodily injury suffered by the *Insured*;
- *Material damage* caused by fire, explosion, or water damage having begun or occurred in the buildings or premises of which the Insured is the owner, tenant or of which he or she has private use in any capacity whatsoever;
- noise and disturbances caused by neighbours;
- *Damage* caused by asbestos (including asbestos fibres or dust), lead (including by lead-containing particles), toxic moulds or fungal contamination and pollution Damage in the USA/Canada;
- *Damage* resulting from the use of automobiles or motor vehicles, sail or motor boats, aircraft or saddle animals of which the *Insured* or the persons for whom they are civilly liable have ownership, control or custody;
- *Damage* to property resulting from fire, explosion or water damage if it occurs on premises of which the *Insured* is the owner or occupier or tenant. However, *Damage* occurring which occurred in a hotel room rented by the *Insured* (or his or her employer) for a period of less than thirty consecutive days remain covered on the express condition that the *Insured* has not taken up residence there;
- non-consequential *Financial loss*;
- all consequences of contractual commitments made by the *Insured* insofar as the resulting obligations exceed those which would be binding under common law;
- legal compensation commonly described as 'Punitive' or 'Exemplary Damages' and generally defined as compensation over and above actual damages which may be awarded to victims by courts in the US or Canada if they consider that the person having caused the *Damage* has demonstrated 'anti-social' or 'more than negligent' behaviour and 'wilful ignorance of its consequences';
- the consequences of any neuropsychic, psychological or psychosomatic disorder, any manifestation requiring neuropsychiatric treatment, and in particular nervous depression or anxiety.

<u>The following are also excluded from cover:</u>

- damage to property, including animals, which the *Insured* is driving or riding or of which they have custody or use even when entrusted to them on a voluntary basis;
- damage resulting from a professional or remunerated activity as well as the holding of public office or a position in a trade union);
- damage resulting from the *Insured*'s involvement in an *Act of Terrorism or Sabotage*, an Attack, a Riot or a Popular movement;
- damage resulting from non-accidental pollution;
- damage to goods, objects, products or animals sold by the *Insured*;
- damage caused by horses or other equines, by dogs in category 1 or 2 as defined in article 211-1 of the French Rural Code, and by wild animals;
- all financial consequences of personal liability incumbent on the *Insured* in his or her capacity as an employer due to an occupational accident or occupational illness affecting one of his or her employees in the performance of their duties;
- *Damage* resulting from the *Insured*'s social management of his or her employees or ex-employees, job applicants, their dependants and the social partners.
- direct or indirect effects of changing the structure of the atomic nucleus, climatic events such as storms and hurricanes, earthquakes, floods, tidal waves or other disasters unless these are covered under compensation for natural disasters;

8.4. EXCLUSIONS FROM THE DEATH AND TOTAL AND IRREVERSIBLE LOSS OF AUTONOMY COVER

See paragraph 8.6.

8.5. EXCLUSIONS WHICH APPLY TO THE DEATH AND TOTAL AND IRREVERSIBLE LOSS OF AUTONOMY COVER

Income protection cover is awarded only when the absence from work is due to illness or an *Accident*. As maternity is not an illness, any absences during pregnancy will be covered under the plan only if they are due to illness (i.e. on medical

grounds). Any leave granted for reasons of maternity or paternity is not due to illness and is therefore excluded under the plan.
The *Exclusions* listed in paragraph 8.6 also apply to income protection cover.

8.6. EXCLUSIONS WHICH APPLY TO ALL COVER

In addition to the *Exclusions* listed for each benefit, all costs and consequences are excluded from cover in relation to:

- intentional acts by the *Member* or the *Insured* and/or infractions of the law of the country where the Insured is staying;
- civil or foreign wars, riots, insurrections, strikes, piracy or sabotage, voluntary participation in fights or popular movements, acts of terrorism regardless of location and protagonists (except in the case of self-defence);
- voluntary participation by the *Member* or the *Insured* in acts of terrorism, regardless of the location of the events;
- suicide or suicide attempts in the first year of cover;
- self-harm or self-inflicted illnesses;
- the use of drugs or narcotics without a medical prescription;
- alcoholism or drunkenness on the part of the *Insured* (alcohol level higher than that defined by the road traffic law applicable on the day of the *Loss* in the country where it took place);
- road traffic accidents involving two-wheeled vehicles if the Insured was not wearing a helmet;
- *Accidents* or *Pre-existing conditions* before the *Effective date* of the plan which were not declared at the time or enrolment and which are subject to relapses or not stabilized and congenital illnesses or deformities unless they were declared and accepted at the time of enrolment in the plan.
- an error of the medical provider or any failure on the part of the provider to use best practices and render evidence-based medicine.
- carrying out all professional activity on an oil rig.

<u>Specific conditions for the cover of consequences of the practice of sports and sporting activities</u>

Professional athletes or students on a sports-study course, including ballet, dance and circus schools, are covered under this plan only in a private capacity. The costs and consequences of the following are also excluded from all cover:

- dangerous sports such as microlighting, hang-gliding, paragliding, driving cars, motorcycles or go-carts, parachuting, mountaineering, climbing (other than on artificial climbing walls), hiking/trekking requiring the use of ropes/ice axes/ crampons, rock climbing, underwater diving except for free-diving to 50 meters, caving, skeleton, ski jumping, bobsleighing, bungee jumping, rafting, canyoning, kitesurfing, air ballooning, jet-skiing, free-running, parkour, ice hockey, speed riding, base jumping, sky surfing, freefall and the following sports when practised off piste: skiing, cross-country skiing, sledging and snowboarding;
- the *Insured*'s involvement in any form of bets (with the exception of sporting competitions), brawls (except in self-defence) or involvement in offenses and crimes within the meaning of the applicable criminal law;
- the piloting of any type of flying device or the practice as a pilot or a passenger of any air sports and in particular hang-gliding, parachuting, paragliding or microlighting;
- participation in all sports competitions and training, practising sports in a club or federation in a professional capacity; sports requiring the use of a land, sea or air vehicle;

hunting;

- air navigation *Accidents* unless the *Insured* is an ordinary passenger and is on board an aircraft operated by a public passenger transport company;
- sailing or cruising on the high seas in a personal or professional capacity (more than 200 nautical miles from land).

Except in application of Articles L.113.8 and L.113.9 of the French Insurance Code, cover applies to the consequences of disabilities or *Pre-existing conditions* dating from before the signing of the *Application form* if they were declared on the *Application form* and were not subject to a particular exclusion of which the Insured had been notified by letter and which has been accepted by the Insured.

9. GENERAL CONDITIONS

9.1. WHO INSURES YOUR PLAN?

This plan is an agreement between "l'Association des Assurés APRIL" (regulated by the Associations Act of 1901 located 114, boulevard Vivier Merle, 69439 Paris, FRANCE Cedex 03, whose purpose is to study, effect and promote, to the benefit of its members, all types of insurance, encourage a spirit of international solidarity between them, make available to them all appropriate means of information and administration and ensure their representation with respect to all insurance companies. The statutes of the Association are available in the General Conditions):

- **for medical expenses, death, total and irreversible loss of autonomy and income protection cover:**

optional group insurance plans with Groupama Gan Vie (medical expenses plan numbers 219/643791/00010,219/643791/00020, 219/643791/55510, 329/643792/00010, 329/643792/00020 and 329/643792/55510 and death & disability plans 9001/643793/00010, 9001/643793/00020 and 9001/643793/55510), a French public limited company with capital of €413,036,043 (fully paid) – RCS Paris 340 427 616 – (APE code 6511 Z) located at 8-10, rue d'Astorg – 75383 Paris Cedex 08 FRANCE;

- **for repatriation assistance and personal liability (private capacity) cover:**

optional group insurance plans with Chubb European Group SE (plan numbers FRBOTA21226, FRBOTA21227, FRBOTA21228 and FRBOTA21229), an insurance company regulated by French Insurance Code with capital of €896 176 662. Head office: La Tour Carpe Diem, 31 Place des Corolles, Esplanade Nord, 92400 Courbevoie, FRANCE. Registered in Nanterre under number 450 327 374 (APE Code: 660E).

9.2. LEGAL

The body responsible for regulating insurance activities is Autorité de Contrôle Prudentiel et de Résolution (Prudential Supervision and Resolution Authority) located at 4 place de Budapest, CS 92459,75436 Paris Cedex 09, FRANCE.

APRIL International Care France is regulated by the Autorité de Contrôle Prudentiel et de Résolution (Prudential Supervision and Resolution Authority), located at 4 place de Budapest, CS 92459, 75436 Paris Cedex 09, FRANCE.

Membership of the MyHealth International plan is evidenced by the Application form, these General conditions and the *Membership certificate*. It is subject to French legislation and in particular to the French Insurance Code.

The benefits and levels of reimbursement provided under the plan will be automatically adjusted in accordance with amendments to legislation and regulations governing insurance plans under French Law.

9.3. LIMITATION PERIOD

Any legal action arising from membership of this plan is inadmissible after a period of two (2) years from the event which gave rise to it (with the limitation period being extended to ten (10) years in respect of the Death lump sum) under the provisions of articles L. 114-1 onwards of the French Insurance Code which state:

Article L. 114-1 "All legal actions arising from an insurance contract are barred two years from the event which gave rise to them. However, this time limit runs:

1. In the event of non-disclosure, omission or false or inaccurate declaration in respect of the risk incurred, only from the date on which the insurer became aware of it;
2. In the event of an insured loss, only from the day on which the relevant parties became aware of it, if they can prove they were unaware of it until then.

If the action taken by the insured against the insurer arises from a claim made by a third party, the limitation period runs only from the day on which this third party brings a legal action against the insured or has received compensation from him or her.

The limitation period is extended to ten years for life insurance policies where the beneficiary is a separate person from the policyholder and in personal accident insurance policies where the beneficiaries are the heirs of the deceased insured. In respect of life insurance policies, notwithstanding the provisions of paragraph 2, the action taken by the beneficiary must be brought within thirty years of the insured's death."

Article L. 114-2 "The limitation period is interrupted by one of the ordinary causes of interruption and by the appointment of experts following an insured loss. The interruption of the limitation period may also be initiated by the dispatch of a registered letter, or an electronic registered letter, with proof of delivery from the insurer to the insured regarding action for payment of the premium and by the insured to the insurer regarding payment of compensation."

Article L114-3 "Notwithstanding article 2254 of the French Civil Code, the parties to the insurance contract cannot, even by mutual agreement, modify the duration of the limitation period, nor add to the motives for its suspension or interruption."

The ordinary causes of interruption of the limitation period under the French Civil Code are:

- the acknowledgement by the debtor of the right of the person against whom they were seeking interruption of the limitation period (article 2240 of the French Civil Code);
- a legal claim (Articles 2241 to 2243 of the French Civil Code);
- provisional measures taken in application of the code of civil enforcement procedures or an act of enforcement (Article 2244 of the French Civil Code);
- a summons served on one of the joint debtors by means of legal action or an act of enforcement or the acknowledgement by the debtor of the right of the person against whom they were seeking interruption of the limitation period (Article 2245 of the French Civil Code);
- a summons served on the principal debtor or their acknowledgement in cases of limitation periods applicable to sureties (Article 2246 of the French Civil Code).

9.4. SUBROGATION

It is stipulated that the insurer does not waive the rights and actions that they possess by virtue of Article L.121-12 of the French Insurance Code relating to the summary remedy it may seek for third party liability.

If You are involved in a road traffic Accident (involving a motorised vehicle), You must communicate to the insurance provider of the person having caused the Accident, when requested, the name of your third party healthcare provider. Failure to do so may invalidate your insurance cover.

9.5. AUDIT

The insurer reserves the right to request any documentation from you which is required to carry out an accurate assessment of the cover, in particular through the production of medical certificates or post-operative reports and/or by obtaining a second opinion from the insurer's doctor.

9.6. COMPLAINTS – MEDIATION

Quality of service is at the heart of our commitments, but if *You* do wish to make a complaint about the services provided by our company,*You* can do so through your usual contact.
If *You* are not satisfied with the response provided, *You* can contact our Customer Service department at:
Postal address : APRIL International Care France - Service Courrier (Mail service) - 1, rue du Mont - CS 80010 - 81700 Blan – FRANCE
Our office: APRIL International Care France- 14, rue Gerty Archimède - 75012 PARIS – FRANCE
Email:complain.expat@april-international.com.
For your information, our insurance partners Groupama Gan Vie (8-10 rue d'Astorg, 75383 Paris Cedex 8, FRANCE) and Chubb European Group SE (La Tour Carpe Diem, 31 Place des Corolles, Esplanade Nord, 92400 Courbevoie, FRANCE), have entrusted us with the handling of complaints.

We will do our utmost to respond to your complaint within a maximum period of 48 working hours and are committed to keeping Youinformed of the progress of your complaint within the same timescale if, for reasons beyond our control, it needs to be extended.If the dispute persists and if no amicable solution can be found, *You* may, without prejudice to the other legal remedies available to you, contact the French Insurance Ombudsman - "La Médiation de l'Assurance" - TSA 50110 - 75441 Paris Cedex 09 - FRANCE.If this plan was purchased remotely via the Internet, *You* can also apply to the relevant ombudsman by lodging a complaint on the European Commission's dispute resolution website at the following address: http://ec.europa.eu/consumers/odr/.
We would inform You that the data collected in order to handle your complaint will be processed electronically by our company for the purposes of complaint monitoring and will be passed on for this purpose only to the insurer, their reinsurers and the APRIL holding company as well as to our partner service providers for the implementation of your insurance cover. The information collected is essential for the registration, administration and activation of membership applications by APRIL International Care France, the insurers or their agents. *You* have the right to access and query your personal information and to have this information corrected or deleted (see paragraph 10.7).

9.7. DATA PROTECTION AND FREEDOM OF INFORMATION

In the course of our relationship, we are required to collect personal data about you. Information on how the data is processed and how you can exercise your rights in respect of this data can be found in the Data Protection Notice provided to you. This document is also available from our advisors and on our website www.april-international.com.

If you want to waive your insurance, you can use the tear-off form below And send it to APRIL International Care France – Service Courrier (Mail service) 1, rue du Mont - CS 80010 - 81700 Blan – FRANCE

CANCELLATION

Article L.112-9 and Article L. 132-5-1 of the French insurance code

Article L.112-9: "Any person who is canvassed at their home or residence or place of work, or by means of distance communication such as telephone or internet, even at their own request, and who signs an insurance proposal or contract for a purpose which is not related to their commercial or professional activity, may cancel this agreement by sending a registered letter with proof of receipt during a period of 14 days from the day on which you entered into the insurance contract, without requiring to specify the reason for the cancellation or being subject to penalties."

Article L.132-5-1: "Any individual who has signed a life insurance or endowment proposal or contract has the option of cancelling it by registered letter or registered email with requested proof of delivery within 30 calendar days from the time they are informed that the contract has been concluded. This cancellation period expires at midnight on the last day. If it expires on a Saturday, Sunday or a public holiday or non-business day, it is not extended.
The cancellation triggers the refund by the insurance or endowment company of all the sums paid by the contracting party within a maximum period of thirty calendar days following receipt of the registered letter or registered email. Beyond this period, any sums which have not been refunded automatically generate interest at the legal rate increased by one half for two months and then, on expiry of this two-month period, at twice the legal rate."

Conditions: If you wish to cancel your insurance, please fill in and sign this tear-off slip. You should then send it in a sealed envelope by registered letter with proof of receipt to the above address. It must be sent no later than 14 days (or 30 days for a life insurance) from the day following the day on which you entered into the insurance contract or, where the deadline expires on a Saturday, Sunday or a bank holiday or other non-working day, on the next working day.

I, the undersigned, wish to cancel my application for insurance under the following plan:

Plan name: **MyHealth International Ref. MHI Cov 22A**

Date of signature of Application form: .....
Member's last name: .....
Member's first name: .....
Member's address: .....
Postcode:.....Town:.....Country: .....
Telephone number: .....
Name of the insurance consultant: .....
Address of the insurance consultant: .....
Postcode:.....Town:.....Country:.....
Telephone number:.....

Date and member's signature

Reserved to APRIL International Care France: Client reference number C_____

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APRIL International Care France Head Office:
14 rue Gerty Archimède - 75012 Paris - FRANCE
Tel: +33 (0)1 73 02 93 93 - Fax: +33 (0)1 73 02 93 90
Email: info.expat@april-international.com - www.april-international.com

A French simplified joint-stock company (S.A.S.) with capital of €200,000 - RCS Paris 309 707 727
Insurance intermediary - Registered with ORIAS under number 07 008 000 (www.orias.fr)
Prudential Supervision and Resolution Authority 4 place de Budapest - CS 92459 - 75436 PARIS CEDEX 09 - FRANCE.

April International
INSURANCE MADE EASY

APPENDIX

TABLE OF BENEFITS

april International
INSURANCE MADE EASY

MYHEALTH INTERNATIONAL

April International

MEDICAL EXPENSES BENEFITS SCHEDULE

Some important information before going any further:

Medical expenses are covered within the limits of Actual costs and the Usual and customary rates charged in the country where the treatment is provided. All treatments in excess of €/$ 2,000 are subject to Prior agreement. To continue to provide you with sustainable levels of cover and premiums, we closely monitor the rates charged by healthcare professionals and check they are in line with typical pricing in that area.

What is outpatient care?
Outpatient surgery is defined as "day hospitalisation" in a healthcare facility for a period of less than 12 hours. Outpatient care, also known as ambulatory care, means all care provided by healthcare professionals without the need for hospitalisation or overnight accommodation in a healthcare facility.

What is cover for COVID-19?
COVID-19 is covered under the same conditions as any other disease, with no special restrictions (within the overall annual limit of the selected plan). All care and treatment will be covered as set out in the Table of Benefits.

COVID-19 covered

IMPORTANT
In the Hospitalisation and basic Repatriation assistance package, outpatient care (including dental care and prostheses - excluding dentures and dental implants) is also covered **in case of accident** and on presentation of a medical certificate, **up to €/$ 75/treatment or procedure and €/$ 1,500/year/Insured**.

** All hospitalisation is subject to Prior agreement. A **deductible of 20%** will be applied if this procedure is not followed prior to hospitalisation.*
*** Subject to Prior agreement.*
**** The waiting period does not apply if you had an equivalent or higher level of cover which was cancelled less than one month previously. Proof of this previous insurance and the Certificate of cancellation from that plan must be produced.*

PACKAGE	EMERGENCY	BASIC	ESSENTIAL	COMFORT	PREMIUM
Maximum amount of medical expenses per insurance year and per insured individual	€/$ 250,000	€/$ 500,000	€/$ 1,000,000	€/$ 1,500,000	€/$ 3,000,000
HOSPITALISATION* (excluding outpatient care, maternity and vision-dental)					
Medical, surgical or day hospitalisation: Transport by ambulance (if hospitalisation is covered by APRIL International) Hospital room and board Medical and surgical fees Pathology, diagnostic tests and drugs, Medical procedures	100% in case of accident or medical emergency only	100%	100%	100%	100%
Hospital room	two-bed room	two-bed room	standard private room up to €/$75 per day	standard private room (including television and internet charges)	standard private room (including television and internet charges)

Advanced medical imaging (MRI and scans) during hospitalisation	up to €/$ 4,000 per year	100%	100%	100%	100%
Outpatient consultations, treatments, diagnostic tests and medical procedures related to hospitalisation/outpatient surgery 30 days before and after hospitalisation (hospital certificate required)	100% only following hospitalisation covered by APRIL International	100%	100%	100%	100%
Home hospitalisation	not covered	100%	100%	100%	100%
Visitor's bed (for children under 18)	not covered	not covered	not covered	100%	100%
Hospitalisation for the treatment of mental or nervous disorders	not covered	not covered	not covered	up to €/$ 8,000/year and a maximum of 15 days/year	up to 30 days/year
Rehabilitation directly related to and following hospitalisation covered by APRIL International (up to 3 month following hospitalisation)	up to 20 days	up to 20 days	up to 20 days	up to 30 days	up to 60 days
Reconstructive dental surgery following an accident	100%	100%	100%	100%	100%
Cancer treatment (hospitalisation, chemotherapy, radiotherapy, oncology, diagnostic tests and drugs as an inpatient, in day care or as an outpatient)	not covered	100%	100%	100%	100%
Organ transplant	100%	100%	100%	100%	100%
Kidney dialysis	not covered	100%	100%	100%	100%
Palliative care centres and palliative care	up to €/$ 10,000	up to €/$ 25,000	up to €/$ 50,000	100%	100%
Internal devices and prostheses during hospitalisation	up to €/$ 1,000 per hospitalisation	100%	100%	100%	100%

BASIC REPATRIATION ASSISTANCE

Medical repatriation or medical transport to the most suitable hospital or to the country of nationality	100%	100%	100%	100%	100%
Repatriation of other plan beneficiaries if the insurant is repatriated	one-way ticket by air in economy class or by train in 1st class	one-way ticket by air in economy class or by train in 1st class	one-way ticket by air in economy class or by train in 1st class	one-way ticket by air in economy class or by train in 1st class	one-way ticket by air in economy class or by train in 1st class
Accompanying children	round-trip ticket by air in economy class or by train in 1st class	round-trip ticket by air in economy class or by train in 1st class	round-trip ticket by air in economy class or by train in 1st class	round-trip ticket by air in economy class or by train in 1st class	round-trip ticket by air in economy class or by train in 1st class

OUTPATIENT CARE (optional)

PACKAGE	EMERGENCY	BASIC	ESSENTIAL	COMFORT	PREMIUM
OUTPATIENT BENEFITS (excluding maternity, medically-assisted procreation and dental treatment)					
Medical teleconsultation 24/7	unlimited	unlimited	unlimited	unlimited	unlimited
Consultations with GPs and specialists including for the monitoring of chronic illnesses	not covered	2 consultations per year covered at 100%. From the 3rd consultation onwards, covered up to €/$ 80 per consultation.	5 consultations per year covered at 100%. From the 6th consultation onwards, covered up to €/$ 100 per consultation.	10 consultations per year covered at 100%. From the 11th consultation onwards, covered up to €/$ 200 per consultation.	100%
Psychiatrists, psychologists and psychotherapist		not covered	up to 4 consultations/ year and a maximum of €/$ 60 per consultation	up to 5 consultations/ year and a maximum of €/$ 200 per consultation	up to 20 consultations/ year and a maximum of €/$ 200 per consultation
Speech therapists, orthoptists, chiropodists/ podiatrists and language therapists		up to 10 consultations / year	up to 15 consultations / year	100%	100%
Physiotherapy, osteopaths, chiropractors, nursing care, occupational therapy and psychomotor therapy		up to €/$ 1,000 per year	up to €/$ 2,000 per year	up to €/$ 4,000 per year	100%
Consultations with homeopaths, etiopaths, acupuncturists and phytotherapists and traditional Chinese medicine	not covered	not covered	up to €/$ 500 per year	up to €/$ 1,000 per year	up to €/$ 2,000 per year
Drugs prescribed during hospitalisation for home use or for chronic illnesses		100%	100%	100%	100%
Drugs prescribed on an outpatient basis (including contraception, homeopathy, phytotherapy and antimalarial vaccines and treatments)		up to €/$ 2,500 per year	100%	100%	100%
Diagnostic tests, X-rays and other technical medical procedures performed outside the hospital environment		100%	100%	100%	100%
Advanced medical imaging (MRI and scans) on an outpatient basis		up to €/$ 2,000 per year	up to €/$ 4,000 per year	up to €/$ 8,000 per year	100%
External devices and prostheses including hearing aids (excluding dentures)		up to €/$ 1,000 per year	up to €/$ 2,000 per year	up to €/$ 3,500 per year	up to €/$ 5,000 per year

PREVENTION

Screening (cancer, hepatitis B, HIV testing etc.)	not covered	100%	100%	100%	100%
Self-medication package (non-prescription pharmacy items and smoking cessation aids)		not covered	up to €/$ 50 per year	up to €/$ 150 per year	up to €/$ 300 per year
Health check-up and hearing test (one check-up every two years)		not covered	up to €/$ 200	up to €/$ 800	up to €/$ 2,000
Consultations with dieticians		not covered	not covered	not covered	up to 5 consultations per year

MATERNITY** (optional)

12 month *Waiting period*

› Maternity benefits under the Essential package are only available if you choose cover in zones 3, 4 or 5. For more information on the countries included, please refer to paragraph 2.2 of the General Conditions.

PACKAGE	EMERGENCY	BASIC	ESSENTIAL	COMFORT	PREMIUM
Childbirth fees: hospitalisation, private room and board and medical and surgical fees	not covered	not covered	up to €/$ 3,000/ pregnancy (increased to €/$ 6,000/ pregnancy for surgical delivery) Pregnancy and childbirth complications and new-born care are fully covered.	up to €/$ 6,000/ pregnancy (increased to €/$ 12,000/ pregnancy for surgical delivery) Pregnancy and childbirth complications and new-born care are fully covered.	up to €/$ 12,000/ pregnancy (increased to €/$ 20,000/ pregnancy for surgical delivery) Pregnancy and childbirth complications and new-born care are fully covered
Home births					
Pre and post-natal consultations, pharmacy items, examinations and care					
Pre-natal classes (held by a doctor or midwife)					
Diagnosis of chromosomal abnormalities					
Neonatal screening					

MEDICALLY-ASSISTED PROCREATION

12 month *Waiting period*

Pharmacy items, in vitro fertilisation, diagnostic tests and follow-up examinations	not covered			up to €/$ 1,500 per attempt	up to €/$ 2,500 per attempt

OPTICAL & DENTAL (optional)

PACKAGE	EMERGENCY	BASIC	ESSENTIAL	COMFORT	PREMIUM
DENTAL *Waiting period* of 3 months*** for preventive and routine dental treatment and 6 months*** for major dental reconstruction and orthodontics					
Upper limit per year	not covered	€/$ 500	€/$ 1,000	1st & 2nd years: €/$ 2,000 From the 3rd year onwards: €/$ 3,000	1st & 2nd years: €/$ 4,000 From the 3rd year onwards: €/$ 5,000
Preventive dental care (dental check-ups, x-rays, scale and polish and mouth guards)	not covered	100%	100%	100%	100%
Routine dental care (extractions, treatment of tooth decay, periodontics, endodontics etc.)		100%	100%	100%	100%
Major reconstructive dental treatment (dentures, crowns and implants)		100%	100%	100%	100%
Orthodontics up to age 18 (treatment begun before age 16)		not covered	not covered	up to €/$ 1,000 per year and a maximum of 3 years	up to €/$ 1,500 per year and a maximum of 3 years
OPTICAL 6 month *Waiting period****					
Laser treatment for vision correction (myopia, hyperopia, astigmatism and keratoconus)	not covered	not covered	not covered	up to €/$ 500	up to €/$ 700
Frames and lenses (maximum 1 pair every 2 years)		up to €/$ 150	up to €/$ 250		
Contact lenses			up to €/$ 200	up to €/$ 300	up to €/$ 400

OPTIONAL BENEFITS

To benefit from all-round international protection, we offer the following optional benefits to supplement your Healthcare cover:

- Comprehensive repatriation assistance and personal liability (private capacity);
- Death and total and irreversible loss of autonomy lump sum;
- Income protection during periods of sick leave from work

COMPREHENSIVE REPATRIATION ASSISTANCE AND PERSONAL LIABILITY (PRIVATE CAPACITY) – BENEFITS SCHEDULE

COMPREHENSIVE REPATRIATION ASSISTANCE	
TYPE OF BENEFIT	**LEVEL**
In case of Accident or illness:	
Search and rescue costs	up to €/$ 5,000 per person, up to €/$ 15,000 per event
Returning the insured to the country of expatriation following stabilisation	one-way ticket by air in economy class or by train in 1st class
Presence of a family member if the insurant is hospitalised for more than 6 days and was expatriated alone	round-trip ticket by air in economy class or by train in 1st class and €/$ 80 per night for 10 nights
Sourcing and sending medication not available locally	100%
Care of dependent children under the age of 18	reimbursed up to 20 hours per year and a maximum of €/$ 500
Returning or caring for a pet if all family members are repatriated	up to €/$ 500 per year
Home help	reimbursed up to 10 hours and a maximum of €/$ 250
Death of the insured:	
Returning the body or the ashes to the home	100%
Cost of a transport coffin for repatriation of the body by air	up to €/$1,500
Presence of a relative or friend at the burial abroad if the deceased plan member was expatriated alone	round-trip ticket by air in economy class or by train in 1st class and €/$ 50 per night for 4 nights
Repatriation of other plan beneficiaries: family members, spouse and children living with the insurant	one-way ticket by air in economy class or by train in 1st class
Attack or natural disaster:	
Repatriation in case of an act of terrorism or sabotage, attack or assault	100%
Early return in case of a terrorist attack, political unrest or natural disaster.	one-way ticket by air in economy class or by train in 1st class
Loss or theft of identity documents, baggage, or travel documents:	
Loss, damage or destruction of personal baggage	up to €/$ 1,000
Advance of funds abroad	up to €/$ 1,500
Advance of a new ticket abroad	one-way ticket by air in economy class or by train in 1st class
Theft of mobile phones, smartphones or tablets during an assault or mugging	up to €/$ 500
Fraudulent use of a SIM card by a third party	100%
Sending urgent messages	100%

Travel incidents:	
Enforced stay abroad	€/$ 80 per night, maximum 14 nights
Flight delays or cancellation, or denied boarding	up to €/$ 300
Missed connection	up to €/$ 300
Reimbursement of trip expenses in the event of an early return home following the Insured's medical repatriation	on a pro rata basis up to €/$ 5 000 actual costs up to €/$250 per day, maximum €/$5,000
Death or hospitalisation of a family member:	
Early return in case of the death of a family member in the country of nationality	round-trip ticket by air in economy class or by train in 1st class
Early return in case of hospitalisation of a family member lasting more than 5 days	round-trip ticket by air in economy class or by train in 1st class
Unintentional violation of the laws of a country:	
Legal fees abroad	up to €/$ 1,500 per event
Advance of bail abroad	up to €/$ 15,000 per event
Language difficulties:	
Translation of legal or administrative documents	up to €/$ 500 per year
Psychological support:	
Interview with a psychologist	up to €/$ 2 000 per event

PERSONAL LIABILITY (PRIVATE CAPACITY)

TYPE OF BENEFIT	LEVEL
Bodily injury, material damage and consequential financial loss	up to €/$ 7,500,000 per claim and per insurance year
including:	
Material damage and consequential financial loss	up to €/$ 750,000 per claim and per insurance year (deductible of €/$ 150 per claim)
Damage (including fire, explosion and water damage to property which the insurant has leased or borrowed for the organisation of family ceremonies)	up to €/$ 150,000 per claim and per insurance year (excess of €/$ 150 per claim)

DEATH AND TOTAL AND IRREVERSIBLE LOSS OF AUTONOMY

In the event of death due to illness, this benefit pays a lump sum to the beneficiary or beneficiaries designated when you enrolled in the plan. The amount of the lump sum payable in case of death due to illness can be set at any amount between **€/$ 20,000 and €/$ 500,000.**
The amount of the lump sum is **doubled if the death is caused by an accident.**
The full amount of the lump sum is also payable in case of total and irreversible loss of autonomy *see definition*.

MEDICAL FORMALITIES:
Depending on the amount of the lump sum selected, you will need to complete the following medical formalities:

AGE	€/$ 20,000 to 150,000	€/$ 150,001 to 250,000	€/$ 250,001 to 350,000	€/$ 350,001 to 500,000
≤ 45	1	1	1	2
46 to 55	1	1	2	2
56 to 65	1	2	2	3

1: Health questionnaire
2: Health questionnaire + Medical report* + Blood tests* (cholesterol, triglycerides, SGO and SGP transaminases, HIV 1 and 2 and anti-HCV test for hepatitis C)
3: Health questionnaire + Medical report* + ECG* + Blood tests* (blood count, blood platelets, ESR, blood glucose, cholesterol, HDL, triglycerides, creatinine, gamma GT, SGO and SGP transaminases, HIV 1 and 2, anti-HCV test for hepatitis C and PSA test for men ≥ 55)

**reimbursed by APRIL International subject to approval and implementation of the plan*

The amounts payable in respect of the death benefit are exempt from inheritance tax in France subject to the legislation in force.

DEFINITION
> Total and irreversible loss of autonomy: where the insured is totally and permanently medically unfit for any gainful employment and requires the assistance of a third party to carry out basic daily tasks.

INCOME PROTECTION DURING PERIODS OF SICK LEAVE

The daily benefit and disability pension protect you from the impact of an illness or accident on your earnings. With these benefits, a portion of your salary will continue to be paid for a fixed period.
You can only opt for this benefit if you have already selected a death lump sum.

You are free to choose the level of daily benefit (between €/$20 and €/$500) provided if you comply with the following rules:

- The amount of daily benefit paid over one month must not exceed 100% of your monthly net salary (limited to 70% of your monthly net income if you started or took over a business within the last year). If you have CFE or French Social Security top-up cover, the monthly total of daily benefits you receive from the basic scheme and from the My Health International plan cannot exceed 100% of your monthly net salary (limited to 70% of your monthly net income if you started or took over a business within the last year).

- The amount of the daily benefit depends on the amount of the selected death lump sum: for a daily benefit of €/$20, the selected lump sum must be at least €/$20,000. The medical formalities required are the ones specified for the level of death lump sum selected.

You must be in paid employment to benefit from income protection cover.

DEFINITIONS

Daily benefit:

Daily benefits may be paid from the 31st or the 61st day depending on the option selected and for a maximum of 3 years. The number of days on which the benefit is payable per month is 30. By selecting a daily benefit, you are no longer required to pay the premium from the 31st or the 61st day. This means that, if you are experiencing financial difficulties caused by your absence for sick leave from work and are entitled to the daily benefit, you will receive free social protection cover. This benefit comes to an end when you reach the age of 65.

Disability pension:

A disability pension provides protection if you are disabled through illness or as the result of an accident. When the daily benefit has been in payment for a maximum of 3 years, it is converted to an annual pension. The annual pension is paid once your condition has stabilised and until you reach retirement age, 65 at the latest. The amount of the annual pension is set in proportion to the degree of disability determined according to the following disability scale (see paragraph 7.5 in the General Conditions).

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Insurance intermediary - Registered with ORIAS under number 07 008 000 (www.orias.fr)
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ASSOCIATION DES ASSURÉS APRIL
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STATUTES

ASSOCIATION DES ASSURES APRIL

Updated 17th April 2018

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Association des Assurés APRIL
Association governed by the French Act of 1st July 1901 and the Decree of 16th August 1901
Registered with the Prefecture of the Rhône department under n° W691060414

TITLE I – CREATION – PURPOSE – HEADQUARTERS – DURATION

Article 1. CREATION AND NAME

An Association named the "Association des Assurés APRIL", or abbreviated to Association 3A, was founded by private deed in Lyon on 1st January 1984. It is governed by the French Act of 1st July 1901 and the Decree of 16th August 1901.

It is a non-profit association.

On 27th April 2018 the Extraordinary General Meeting of the Association des Assurés APRIL recorded the effective completion of the merger of the Association des Assurés d'APRIL INTERNATIONAL with the Association des Assurés APRIL and the automatic dissolution without liquidation of the Association des Assurés APRIL INTERNATIONAL.

Article 2. PURPOSE

The purpose of this Association is:

- to study, research, arrange and develop all types of insurance and assistance products and services, particularly in the field of death & disability, health and retirement, in order to optimise for its Members, the purchase of supplementary or additional voluntary benefits, or benefits from the 1st euro, as required in addition to the benefits provided by the mandatory schemes, in particular by the signing of group insurance contracts with optional or compulsory membership;

- to raise awareness amongst its Members of the essential aspects of prevention in order to enable them to take care of their health on the one hand and, on the other hand, to obtain preferential terms from insurance companies which take into account the responsible behaviour of its Members in matters of health;

- to carry out statistical studies and analyses on the day-to-day behaviour of its Members in the field of health and personal risk insurance;

- to implement actions in respect of prevention, support and assistance to the Insured through an Outreach Fund.

Article 3. HEAD OFFICE

The head office is located in the 3rd district of Lyon at 114 boulevard Marius Vivier Merle.

It may be transferred by decision of the Board which has the power to amend the statutes for this purpose.

Article 4. DURATION

The association is formed for an unlimited period. It ceases to exist, however, in the event of voluntary, statutory or judicial dissolution.

TITLE II – MEMBERS AND CONDITIONS OF MEMBERSHIP

Article 5. COMPOSITION

The Association is made up of Members broken down into:

- Members;

- Members with non-salaried status;

- Group Members (companies, organisations or other legal entities) who have signed up to one of the agreements entered into by the Association on behalf of their employees.

To be a Member of the Association, you must be covered by the insurance under one of the agreements entered into by the Association and have paid the membership fee.

Member status is acquired from the date of receipt of the application for membership and payment of the membership fee, subject to acceptance of membership of the insurance agreement by the insurer. If the application for membership is not accepted, the membership fee will be refunded no later than thirty days after notification of refusal by the insurer.

The following are also Members, but without voting rights, by decision of the Board:

- Persons or legal entities that serve or have served the Association with distinction. They are known as honorary members or members of honour;

- Persons or legal entities that have made a donation or bequest to the Association. They are known as supporting members.

Article 6. LOSS OF MEMBERSHIP STATUS

Membership is lost in the following cases:

- death, disappearance or absence for individuals;

- voluntary or legal liquidation or dissolution for legal entities;

- expulsion decided by the Board for breaches of these statutes or if conduct is found to conflict with the financial and moral interests of the Association;

- loss of insured status under one of the agreements entered into by the Association (termination, disenrollment or cancellation);

- resignation submitted to the Chairman at the Association's registered office by registered letter with proof of receipt. A copy of the letter issued by the administrator of the plan(s) confirming the termination of their insurance must be enclosed with this letter; these terminations must meet the conditions stipulated in the information notice(s) serving as the general conditions of the plan(s).

In all cases, any membership fees charged for the year in which the loss of membership status occurs will be retained by the Association.

TITLE III – LIABILITY OF AND ENFORCEABILITY ON MEMBERS

Article 7. LIABILITY OF MEMBERS

Members who have signed up to the agreements entered into by the Association are in no way personally liable for commitments made by the Association with liability being limited to the assets of the Association.

Article 8. ENFORCEABILITY ON MEMBERS

Any membership of the Association falls within the framework of the insurance agreements entered into by the Association and the insurers. The content of these agreements, in particular the conditions and consequences of termination of the agreements by the Association or the insurer, is given to Members when they join the Association and the plan in the form of an information notice serving as the general conditions.

TITLE IV – RESOURCES - EXPENSES

Article 9. ASSOCIATION RESOURCES

The Association's resources are made up of:

- the membership fees paid by Members;
- income from its property;
- sums received in return for services provided by the Association;
- grants or payments authorised by law;
- any other resources not prohibited by law.

Article 10. EXPENSES

The expenses of the Association consist of all sums necessary for its operation and representation. They are ordered by the Board or by any other person appointed by the Board for this purpose.

TITLE V – SOCIAL OUTREACH

Article 11. OUTREACH FUND

An Outreach Fund has been created for the purpose of financing support and assistance to Members.

The amount allocated annually to the Outreach Fund is decided by the Board which sets out the guidelines, missions and operating rules.

The various Outreach Actions carried out by the Association and their conditions of access and award are set out in the Association Rules and Regulations.

TITLE VI – ADMINISTRATION AND OPERATION

Article 12. BOARD OF DIRECTORS

1. Composition

The Association is managed by a Board of Directors consisting of a minimum of six (6) members and a maximum of fifteen (15) members appointed for six (6) years. The members of the Board of Directors are appointed by the General Assembly and are chosen from among the Members of the Association.

More than half of the Board members must be Members who do not hold, or have not held in the two years preceding their appointment, any interest or office in the insurance companies having signed the insurance agreements entered into by the Association and who do not receive or have not received, during the same period, any remuneration from these same insurers.

Any current Directors who take up office in, or receive any remuneration whatsoever from, one of the insurance companies having signed an insurance agreement with the Association agree to immediately notify the Chairman by registered letter with proof of receipt.

If this declaration were to reduce the number of Directors who do not, or did not during the two years preceding their appointment, hold any interest or office in the insurance organisations having signed the insurance agreements entered into by the Association and who do not or did not during the same period receive any remuneration from these insurance companies, to less than 51%, the Director in question will automatically forfeit

his or her role as Director and will be replaced in accordance with article 12 of the statutes. In the event of a vacancy arising due to a death, a resignation, a Board member reaching the upper age limit or any other cause, the Board will provisionally replace these members. They will be permanently replaced at the next General Assembly. The term of office of any member elected in this way will come to an end when the term of office of the member they replaced would normally have expired.

If they are not ratified, the deliberations and actions of the Board during the period since the provisional appointment will nonetheless remain valid.

A third of the Board is renewed every 2 years. Outgoing members are eligible for re-election. The order of outgoing members is determined by the length of their term of office.

Any person aged 18 or over on the day of the election who is a Member of the Association and has paid the membership fee is eligible for Board membership.

The age limit for the position of Director is 70. If this age is reached during the term of office, the term of office will automatically end on the Director's anniversary date.

Any new application must be brought to the attention of the Chairman of the Board by registered letter received at least thirty days before the date of the General Assembly, together with:

- a copy of an identity document;
- a sworn declaration that no criminal convictions are held or no measures referred to in paragraphs 1 to 5 of Article L322-2 of the French Insurance Code apply;
- a certificate indicating the existence or absence of any office held with or remuneration received from any of the insurance organisations having signed an insurance agreement with the Association.

No-one can be a member of the Board of the Association, either directly or indirectly or by proxy, or administer, direct or manage the Association in any capacity whatsoever, or have the authority to sign on behalf of the Association if he or she has held any of the convictions or been subject to any of the measures referred to in paragraphs 1 to 5 of Article L322-2 of the French Insurance Code.

Each year the Board elects an executive committee by secret ballot of its members by a majority vote. This executive committee consists of a Chairman, a Vice-Chairman, a Secretary, a Treasurer and any deputies. Outgoing members of the executive committee are eligible for re-election. The Board may be assisted by any person it deems useful, whether or not they are members of the Association.

2. Board meetings

The Board meets as often as the interests of the Association require when convened by the Chairman. The Board may be convened by any means at his or her convenience.

The deliberations of the Board are minuted and recorded in a register signed by the Chairman and at least one Director.

The Board will be valid only if more than half of the Directors are present.

Decisions of the Board are taken by a majority of the Directors present. In the event of a tie, the Chairman has the casting vote. Only items on the agenda may be put to a vote.

Any member of the Board who, without justification, fails to attend three consecutive meetings may be excluded by the Board, having first been given the opportunity to comment.

3. Remuneration

Directorships are not remunerated. However, expenses and disbursements incurred in the performance of their duties are reimbursed on the basis of documentary evidence. The financial report presented at the Ordinary General Assembly must state the amount of expenses and disbursements reimbursed to Directors.

4. Powers

The Board is vested generally with the widest powers to act on behalf of the Association. It sets the amount of the membership fee payable by members of the Association.

It can delegate authority to the Chairman or to a member of the executive committee.

5. Functions and powers of the Chairman – Functions of the Secretary and the Treasurer

The members of the executive committee are specially entrusted with the following responsibilities:

1. The **Chairman** directs the work of the Board and is responsible for the running of the Association. He or she is the Association's representative in legal proceedings and in all civil acts. He or she has full authority in this respect. He or she may delegate his or her authority to another Director. In his or her absence, the Vice-Chairman will deputise.

2. The **Secretary** is responsible for correspondence, in particular for sending out the various notices to attend meetings. He or she drafts the minutes of proceedings and transcribes them in the records and carries out all formalities required by law.

3. The **Treasurer** is responsible for managing the Association's assets and accounts. He or she collects revenue and makes payments under the supervision of the Chairman. He or she submits an annual administration report to the General Assembly in order that it may rule on the accounts.

   The duties of the members of the Executive Committee may not be remunerated in any form whatsoever.

Article 13. GENERAL ASSEMBLIES

1. General Assemblies

1.1. Ordinary General Assembly

At least once a year, Members are invited to attend the Ordinary General Assembly in accordance with the procedure described above.

The General Assembly hears:

- the management report prepared by the Board covering the operation of insurance agreements entered into by the Association. This report is made available to Members who request it;
- the auditor's reports;
- the chairman's report;
- the financial report.

The General Assembly, having deliberated and ruled on the various reports, approves the accounts for the previous financial year (calendar year) and deliberates on all other points on the agenda.

It provides for the renewal of Board members under the conditions set out in Article 12 of these statutes.

1.2. Extraordinary General Assembly

Extraordinary General Assemblies are convened under the conditions set out above.

The Extraordinary General Assembly rules on matters within its exclusive jurisdiction: amendments to the statutes and mergers or dissolutions.

2. Notices to attend

2.1. Notices to attend the Ordinary and Extraordinary General Assemblies

Members of the Association, as defined in article 5 who are members on the day of the decision to issue notices to attend and who have paid their membership fee, meet at least once a year at the Ordinary General Assembly and as required at an Extraordinary General Assembly.

Meetings of Ordinary General Assemblies and Extraordinary General Assemblies consist of all Members of the Association who have paid their membership fee.

The invitation is personal and is valid if extended by the Board:

- either by letter or email sent at least sixty calendar days before the date of the General Assembly;

- or by an announcement in a publication sent out to all Members.

General Assemblies are convened by the Chairman of the Association or, for Extraordinary General Assemblies, at the request of at least 10% of Members. In this case, notices to attend the Extraordinary General Assembly must be sent out within eight days of filing the request and the Extraordinary General Assembly must be held within thirty days of these notices being sent out.

Notices to attend must specify the date, time, place and agenda planned and drawn up by the Board.

Draft resolutions signed by at least one hundred Members are also included on the agenda, if they are sent by registered letter to the Chairman of the Board at least forty-five days before the date set for the General Assembly.

Only resolutions passed by the General Assembly on items on the agenda will be considered valid.

Notices to attend must also state that, in the absence of a quorum, they serve as notices to attend a second General Assembly.

3. Voting rights

3.1. Voting rights at Ordinary and Extraordinary General Assemblies

Each Member of the Association has voting rights and one vote at Ordinary and Extraordinary General Assemblies.

Legal entity members of the Association are represented by their legal representative.

Each individual Member has the right to name another Member or his or her spouse as their proxy. A single Member cannot hold more than 5% of voting rights. The proxy vote applies to only one General Assembly, or two if a quorum is not reached at the first meeting, or if two Assemblies – one Ordinary and one Extraordinary – are held on the same day.

Blank proxy forms returned to the Association are allocated to the Chairman or to his or her delegate on the Board and enable a vote to be held on the adoption of draft resolutions presented or approved by the Board.

3.1.1. Ordinary General Assembly

Decisions of the Ordinary General Assembly are adopted by a majority vote.

All decisions are taken by a show of hands.

However, if at least a quarter of Members in attendance make the request, votes can be cast by secret ballot.

For the election of Board members, a secret ballot is compulsory.

3.1.1. Extraordinary General Assembly

Decisions of the Extraordinary General Assembly must be taken by a two-thirds majority of Members in attendance or represented.

Votes are held by a show of hands unless at least a quarter of Members in attendance request voting by secret ballot.

4. Meetings of the Assemblies

Assemblies are chaired by the Chairman of the Association who may delegate his or her duties to the Vice-Chairman or to another Director.

Proceedings are recorded in the minutes, entered in a special register and signed by the Chairman and the Secretary. The minutes are available at the Association headquarters.

An attendance sheet is completed and certified by the Chairman and the Secretary.

All Members, including those who are absent, are bound by the decisions of the General Assembly within the limits of the powers conferred by these statutes.

4.1. Meetings of the Ordinary and Extraordinary General Assemblies

Ordinary and Extraordinary General Assemblies cannot validly deliberate unless at least one thousand Members are present or represented. If, at the first meeting, the General Assembly does not reach a quorum, a second meeting of the General Assembly is convened. The meeting can then deliberate validly regardless of the number of Members present or represented.

If a quorum is not reached, the second General Assembly may be held following the first with the same agenda.

By decision of the Chairman, the Ordinary and Extraordinary General Assemblies may be held remotely using electronic voting.

Article 14. ASSOCIATION RULES AND REGULATIONS

Association rules and regulations may be drawn up by the Board of Directors to supplement the statutory provisions.

Article 15. DISSOLUTION – MERGER – TRANSFER OF ASSETS

The dissolution of the Association or its merger or union with another organisation can only be approved if proposed by the Board at an Extraordinary General Assembly, in accordance with the conditions set out above.

In accordance with Article L140-6 of the French Insurance Code, in the event of the liquidation or dissolution of the Association, memberships of group insurance agreements which are active on the date of the dissolution or liquidation will continue as of right.

Article 16. LANGUAGE

These statutes are in French. If they are translated into other languages, only the French version is binding.

Pierre-Henry MICHAUD
Chairman

Jean-Louis FAVROT
Secretary