GENERAL CONDITIONS SCHENGEN STANDARD (VERSION 01.01.2013

This agreement shall constitute the general conditions of the travel insurance contract concluded between the insurer and the insured. It shall establish the assistance services which are guaranteed to the insured by the contract.

1. Definitions

Policyholder: the natural person who has taken out the insurance contract.

Insured: the natural person who is named in the policy and who has their principal and main residence outside the Schengen area.

Territoriality: the guarantees apply to residence in the Schengen area.

Insurer: : Inter Partner Assistance SA, insurance company licensed by the National Bank of Belgium under the number 0487 and registered at the crossroads bank for enterprises under the number 0415.591.055, having its registered offices at Avenue Louise 166, 1050 Brussels - member of the AXA Assistance Group, represented by **De Sombe BVBA**, insurance broker, registered under code number 014375A, Stationsstraat 23, 9250 Waasmunster, Belgium.

Events insured against: the following events shall give rise to the travel insurance benefits if they occur and have been noted by a doctor during the period of cover:

- *an accident*: a sudden and unexpected event, occurring due to an external cause and resulting in a bodily injury which requires urgent medical and/or hospital treatment. The injury must result directly and solely from the accident. It must be beyond the control of the insured.

- *an illness*: a serious, sudden and unexpected problem with the organs or functions of the human body, attributable to a cause other than an accident and requiring urgent medical and/or hospital treatment. It must be beyond the control of the insured.

Excess: the amount set by default and remaining payable by the insured in the event of a claim for an event insured against.

Hospital: establishment recognised as such by current regulations in one of the States in the Schengen area and where the insured has been authorised to enter or transit through.

Doctor: person who, in one of the States in the Schengen area and where the insured has been authorised to enter or transit through, is authorised to practise the art of healing in accordance with the regulations of the country in which he primarily practises.

Repatriation for medical reasons: return organised by the insurer to the country of the main and principal residence of the insured who is the victim of an illness or an accident, with a view to receiving there the treatment required by his medical condition.

2. Duration of the insurance policy and period of cover

Events shall be insured if they occurred throughout the duration of the stay or transit of the insured in the territory of one or more State(s) in the Schengen area and where the insured is authorised to enter or transit through. The duration of the stay or transit shall end on the expiry of the number of days stay or transit granted by the visa, at the latest on the date on which the validity of the visa expires, after

midnight or, where appropriate, when the number of entries authorised by the visa has been exhausted. It shall be the responsibility of the insured to prove the date of entry into the territory of the State(s) in the Schengen area and where he is authorised to enter or transit through.

The policy must be concluded for the real duration of the journey, with a minimum of 10 days and a maximum of 90 days. If no return date has been set (with open return ticket), the policy should be adhered to for the entire validity period of the visa with a maximum of 90 uninterrupted days.

If a policy is entered into for a period of 364 days, the coverage will be valid for a maximum of 4 periods of 90 days of continuous residence. After each coverage period for a period of stay of up to 90 days, one should leave the territory consisting of the Schengen area, so that a new coverage period of maximum 90 days can commence.

3. Premium

The premium, including the taxes and contributions, shall be payable in cash when the policyholder subscribes. Coverage only starts after payment of the premium. The premium shall be fixed and held for the duration of the contract. It shall not be returnable unless the insured provides official proof that his or her visa was denied. In that case, the refund will always exclude the transaction costs and the possible money transfer and currency change costs.

4. Benefits

In the territory of the State(s) in the Schengen area and where the insured has been authorised to enter or transit through, cover shall be provided, up to a maximum amount of **50,000 €**, however many contracts are concluded by the insured with the insurer and however many insured events occurred during the period of cover, for the charges and cash disbursements resulting from:

i. <u>the repatriation or transfer of the insured from one hospital to another</u>, according to the following modalities. Any repatriation or transfer for medical reasons shall be preceded by the agreement of the insurer's medical service. The certificate produced locally by the doctor treating the insured shall not be sufficient on its own. Once agreement has been given, the insurer's medical service shall agree the date, the means of transport and any medical accompaniment. The insurer shall organise and pay for transport from the establishment where the insured is located. This transport shall be provided in accordance with the decisions taken by the insurer's medical service and, if necessary, under constant medical or paramedical surveillance, to the main and usual residence of the insured, or to a hospital close to this residence, in which a place shall be reserved for him. Only the medical interests of the policy holder and the respecting of current health regulations shall be taken into consideration when making the decision on transport, the choice of the method of this transport and the choice of the possible place of hospitalisation. Information from the local doctors or the usual attending doctor shall assist the insurer in making the decision which seems the most appropriate. In this respect, it shall be expressly agreed that the final decision to be implemented in the medical interest shall without appeal be that of the insurer's medical service, in order to avoid any conflict of medical authority. Furthermore, in the event that the insured refuses to follow the decision considered by the insurer to be the most appropriate, then the latter shall be expressly absolved of all responsibility, particularly if the insured returns by his own means or if his state of heath worsens.

ii. urgent medical treatment and/or urgent hospital treatment provided to the insured who is the victim of an illness or accident, including:

- medical and surgical fees.
- medicines prescribed by a doctor.
- dental treatment.
- the costs of physiotherapy, physical therapy and chiropractic prescribed by a doctor.
- hospitalisation costs. However, the payment of these costs shall end if the state of health of the insured allows his repatriation and the insured refuses this repatriation or delays it for reasons of personal convenience.
- transport by ambulance, health-service sled (from the piste) or helicopter, ordered by a doctor for a local journey.

An excess of **150 €** shall always be deducted per claim for the costs indicated under ii. and per insured person.

5. Assistance in the event of a claim: process to be followed

The insured party shall be obliged to inform the insurer's support centre of the claim immediately, to comply with the instructions and to provide all the information and/or documents considered necessary.

You may contact the support centre 24 hours a day, 7 days a week, by telephone on + 32 (0)2 550 04 18..

Have as much information ready as possible, such as:

- your name
- your policy number
- your date of arrival
- your address in the host country
- your contact telephone number

6. Exclusions

Without prejudice to Article 4, the following shall not be covered by the travel insurance:

i. a insured whose journey was made for the purposes of a diagnosis and/or medical treatment.

ii. periodical monitoring or observation examinations, as well as the cost of glasses, contact lenses, medical equipment and the purchase or repair of prostheses.

iii. medical check-ups and contraception costs.

iv. preventive medicine.

v. health cures, convalescence, physical therapy and physiotherapy stays and treatments.

vi. aesthetic and dietetic treatments, as well as all the costs of diagnosis or treatments not officially recognised (homeopathy, acupuncture, etc.).

vii. vaccines and vaccinations.

viii. repatriation due to minor injuries or illnesses which can be treated locally and which do not prevent the insured from continuing his assignment or stay.

ix. depressive conditions and/or mental illnesses.

x. Illnesses, medical and pathological conditions known to the insured or existing before departure, and their consequences (such as relapse, complications or sudden aggravation).

xi. optional or non-urgent treatment, even if it is provided following an urgent situation.

xii. repatriation for organ transplant.

xiii. the diagnosis, monitoring or treatment of a pregnancy, unless there is a clear and unforeseen complication before 28 weeks.

xiv. births and terminations of pregnancy.

xv. an illness or accident which is the result of the use of alcohol, drugs, narcotics or the abusive consumption of medicines or any other substance not prescribed by a doctor and which modifies behaviour.

xvi. conditions resulting from a suicide attempt.

xvii. an illness or accident caused intentionally by the insured.

xviii. an illness or accident occurring as a result of an illegal activity (bets, crimes, brawls, unless for legitimate defence) or an unauthorised activity.

xix. competition sports practised at professional level.

xx. an accident which occurred during a motorised trial, in which the insured takes part as a competitor or competition assistant.

xxi. terrorist attacks, insurrections, riots, civil wars and all the consequences of the exclusions mentioned above.

xxii. benefits for which the agreement of the insurer has not been requested in advance, except for urgent medical costs and/or costs of urgent hospitalisation, in which case the claim should be filed as soon as possible.

7. Prescription

Any action or claim resulting from this agreement shall lapse after three years from the date of the event which gave rise to it.

8. Subrogation

The insurer shall be subrogated, to a maximum of the amounts he has paid out, in the rights and actions of the insured to all liable third parties.

The insurer shall also be subrogated in the rights and actions of the insured, with regard to any other company or institution covering the same risks as those guaranteed by this agreement.

Furthermore, the insurer may, if appropriate, claim the reimbursement of his benefits from the natural person or legal entity who supported the insured on the occasion of his stay and for whom the insured now declares that he stands surety.

9. Applicable law and jurisdiction

Current insurance contract is governed by Belgian law.

Any dispute relating to this agreement shall come under the exclusive jurisdiction of the courts of Brussels.

10. Protection of private life with Respect to Personal Data Processing

Personal data relating to the insured which is provided to the insurer in the context of this policy is processed for the purposes of administering insurances, client base management, direct marketing, statistical and actuary studies, to combat fraud/money laundering/the financing of terrorism and dispute management by DE SOMBE BVBA, Stationsstraat 23, 9250 Waasmunster and AXA Assistance (Inter Partner Assistance SA), Avenue Louise 166/1, 1050 Bruxelles

Personal data relating to insured can be, among other things, data in relation to identity, residence, personal status and in the case of medical assistance, his bank account, data relating to health.

These personal data are to be processed in compliance with the Law dated 8 December 1992 relating to the protection of private life with respect to the processing of personal data and its implementing decree.

The categories of persons having access to this personal data are members of staff of the controller, members of staff of the service providers and processors to whom she appeals and, as appropriate, other companies of the group of which the controller forms part.

These personal data are susceptible to be transferred by AXA Assistance to the service providers and processors to whom she appeals, situated in the European Economic Area or outside of it, as well as to the other branches of the group of which AXA Assistance forms part. In order to offer the most appropriate services, this personal data may as well be provided to other companies in the group of which the controller forms part, situated in the European Economic Area or outside of it.

In the event of transfer of personal data as provided for above, all administrative, technical and security measures are taken and, if necessary, adapted contractual provision with the third party company concerned are concluded, to ensure these data transfers are done in compliance with applicable legislation.

Any person may access this data relating to them which are processed. For this purpose, the insured may send a written request by letter or e-mail to: AXA Assistance, Legal Department – Data Privacy Officer, Avenue Louise 166/1, 1050 Brussels, legal.bnl@axa-assistance.com.

Any person has the right to object, on request and free of charge, to the processing of personal data relating to him which the controller anticipates being processed for the purposes of direct marketing.

11. Client satisfaction

In the event of a complaint concerning insurance services, the policyholder may contact the Quality Service of AXA ASSISTANCE:

- By e-mail: customer.care.bnl@axa-assistance.com
- By letter: AXA ASSISTANCE
  Customer Care

  Avenue Louise 166 PO Box 1

  1050 Brussels

The complaint will be examined as quickly as possible by the Quality Service of AXA ASSISTANCE and processed as per the following timeframes.

- A confirmation of receipt of the complaint will be sent within three working days with an explanation of further proceeding, unless a response is given within one week.
- Within five days, a definitive response is sent to the policyholder, except in the case of complex problems, in which case the matter is dealt with within one month.
- If this is impossible, the problem is analysed and a valid reason is given for the non-respect of the usual timeframes, with an indication within one month, of the length of time before a definitive response can be expected.

The policyholder may contact the Ombudsman of the Insurances (Insurance Mediator Service) (by letter: Square de Meeûs, 35, 1000 Brussels; by telephone: +32 (0)2 / 547 58 71; by fax: +32 (0)2 / 547 59 75; by e-mail: info@ombudsman.as), without the policyholder waiving the right to take legal proceedings. The Insurance Mediator Service and its team examines insurance disputes between consumers and insurance companies or insurance intermediaries.