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all you need to know
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1 Insurance conditions

1.1 Parties involved

The following meanings apply under this insurance policy:

- the **Company:** AXA Assurances Vie Luxembourg, a Luxembourg insurance company with which this policy is agreed;
- the **Policyholder**: the person(s) taking out the insurance policy and who are obliged to pay premiums. Where there are several policyholders, they are held jointly and severally and indivisibly by all the obligations of the policy.
- the **Insured**: the person(s) with whom rests the risk of the insured event taking place;
- the **Beneficiary**: the person(s) in whose favour are stipulated the insurance services.

1.2 Contractual documents

The insurance policy, hereafter called the policy, comprises the following contractual documents:

- the **insurance proposal** and other **questionnaires** on the insurance characteristics and the risk appraisal elements. It is filled in and signed by the **Policyholder** and **the Insured;**
- the **insurance conditions** setting out the rights and obligations of everyone involved in the policy;
- the **specific terms and conditions** customising each policy and containing mainly the risk appraisal elements such as those relating to the **Policyholder**, the **Insured**, the benefits covered, the sums insured, the duration of the contract, etc.;
- the annex relating to the provisions applicable to **policyholders** who do not reside in Luxembourg, if appropriate;
- the subsequent **endorsements** of any amendments made to the policy.

1.3 Purpose of the policy

The **Company** guarantees the payment to the **Beneficiary** of sums provided for under the **specific terms and conditions**, either if the **Insured** is still living when the policy matures or should he die before the policy expires.

1.4 Formation, effective date and duration of the policy

The policy is formed by **Policyholder** and the **Company** signing the **specific terms and conditions**.

It takes effect on the date stated in the **specific terms and conditions** for the planned duration, but no sooner than on the date when the first premium is paid. The effective and maturity dates extend from midnight to midnight.

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1.5 Renunciation

The **Policyholder** can renounce the effects of the policy within thirty days from the moment when he is advised of the conclusion of the policy.

When the purpose of the policy is to guarantee the reimbursement of a loan granted by the credit establishment in the event of the death of the borrower, the renunciation time is two weeks.

The renunciation, sent to the **Company** by registered post, releases the parties from any obligation in the future resulting from the policy.

The premium paid, having deducted amounts taken up to cover the risk, is reimbursed as soon as the original policy is received.

1.6 Declaration

1.6.1 Declaration when taking out the policy

When taking out the policy, the **Policyholder** and the **Insured** must state exactly all the circumstances constituting risk assessment elements for the **Company**.

In the event of intentional omission or inaccuracy that has misled the **Company** on the risk assessment elements, the policy is invalid and the premiums payable up until the moment when the **Company** becomes aware of the intentional omission or inaccuracy remain due.

In the event of unintentional omission or inaccuracy, the **Company** can, within one year from the policy taking effect, propose amending or terminating it if it can prove that under no circumstances would it have insured the risk or if the proposed amendment to the policy has not been agreed or has even been rejected by the **Policyholder**.

Nevertheless, in the event of an inaccurate statement of the age of the **Insured**, the benefits insured are increased or reduced based on the actual age that should have been taken into consideration.

1.6.2 Declaration during execution of the policy

The **Policyholder** and the **Insured** are obliged to declare during execution of the policy significant long-term changes in circumstance relating to the risk of the insured event occurring, apart from those linked to changes in the state of health of the **Insured**, mainly those involving;

- the change in professional activity of the **Insured**;
- the transfer of residence of the **Policyholder** and the **Insured** to a country outside the European community;
- the change in sporting or leisure activities practised by the **Insured**.

In a change of circumstances such that the **Company** would only have agreed to the insurance under other conditions than the existing ones, it can, within one month from the date on which it became aware of the aggravation, propose an amendment to the contract back-dated to the date of the aggravation of the risk.

Where the **Company** can prove that under no circumstances would it have insured the risk or if the proposed amendment to the policy had not been agreed or had even been rejected by the **Policyholder**, it can terminate the policy in the same timescale.

1.7 Rights of the Policyholder

1.7.1 Designation of the Beneficiary

The **Policyholder** has the option of designating one or more **Beneficiaries.**

The beneficiary order can be changed upon written request from the **Policyholder**. Nevertheless, the **Policyholder** must obtain consent from:

- the **Beneficiary** if the cover has previously been agreed;
- the **Insured** if he is different from the **Policyholder**.

The amendment to the beneficiary order is made official by an **endorsement** to the policy bearing the signatures of the **Company** and the **Policyholder**.

1.7.2 Reduction of the policy

When the reduction value is positive, the **Policyholder** can request in writing the reduction of insured benefits provided he has paid, as policy premium, one or more sums with a total value at least equal to that of the premiums for the first two insurance years.

The reduction is possible at any time for the pension-old age insurance policies.

It releases the **Policyholder** definitively from the payment of premiums, who keeps the benefit of the policy of reduced insured services.

The **Company** determines the reduction value of insured services in accordance with the technical note prepared for each insurance combination and notified to the Insurance Supervisory Authority (Commissariat aux Assurances).

The reduction value is calculated on the date corresponding to the end of the insurance period covered by the last premium paid or split premium paid. The reduction comes into effect on this date.

The reduction in insured services is made official by an **endorsement** bearing the signatures of the **Company** and the **Policyholder**.

1.7.3 Reentry into force of the reduced policy

The **Policyholder** can request in writing the re-entry into force of the reduced policy, provided the **Company** agrees to this in advance. The re-entry into force takes place under the conditions being applied by the **Company** at this time.

The re-entry into force is dictated by the favourable outcome of medical examinations. The charges for these examinations are borne by the **Policyholder**.

1.7.4 Surrender of the policy

When the surrender value is positive, the **Policyholder** can request in writing, supported by a copy of a valid identity card and bank details in the name of the **Policyholder**, the full surrender of the policy provided he has paid, as policy premium, one or more sums with a total value at least equal to that of the premiums for the first two insurance years.

Under no circumstances can the global amount of the surrender value exceed the insured benefit in the event of death at the time of surrender.

The **Company** determines the surrender value in accordance with the technical note prepared for each insurance combination and notified to the Insurance Supervisory Authority.

Any surplus surrender value is converted into a single premium used to finance endowment insurance without reimbursement of premiums, where the insured benefit is payable at the expiry of the policy, determined in the **specific terms and conditions**, if the **Insured** is living on this date.

The surrender takes effect on the day on which the **Policyholder** signs the settlement receipt within thirty days, after which period the settlement receipt expires.

The surrender value is calculated on the date of receipt of the surrender request or the date corresponding to the end of the insurance period covered by the last premium or split premium paid.

Should a benefit be accepted, exercising the right to surrender is dictated by the agreement of the accepting **Beneficiary**.

There is no right of surrender for endowment policies without reimbursement of premiums.

1.7.5 Advance on the benefits

If the **Policyholder** lodges the original policy, he can obtain an interest-bearing advance on the benefits insured under main covers, provided the **Company** agrees to this in advance.

The minimum amount of each advance is set at €500.

The overall amount of advances cannot be higher than 80% of the surrender value and is limited to the insured benefit in the event of death.

The advance is made official by an endorsement stating the modalities and conditions of the advance bearing the signatures of the **Company**, the **Policyholder** and, if appropriate, the accepting **Beneficiary**.

The right to an advance does not exist for temporary insurance in the event of death and the pension-old age insurance.

1.7.6 Transfer of rights

At any time, the **Policyholder** can request the **Company** in writing to transfer all or part of the rights resulting from the policy.

Should a benefit be accepted, exercising the right to transfer is dictated by the agreement of the accepting **Beneficiary**.

The transfer is made by an **endorsement** bearing the signatures of the **Company**, the **Policyholder** and the transferee. The consent of the **Insured** is also required.

The right of transfer does not exist for the pension-old age insurance policies.

1.7.7 Change to the policy

The **Policyholder** can request the **Company** to adapt the **specific terms and conditions** of his policy based on forms issued by the **Company**.

Provided the **Company** agrees in advance, the adaptation is made under the **Company's** conditions in force at this time and may be dictated by the favourable outcome of medical examinations.

The adaptation is made official by an endorsement bearing the signatures of the **Company**, the **Policyholder** and, if appropriate, the accepting **Beneficiary**.

1.8 Premiums

1.8.1 Payment of premiums

In return for the commitments by the **Company**, the **Policyholder** pays the premiums or split premiums for which the payment amount, method and period are stated in the **specific terms and conditions**.

Except for direct debits, the **Company** sends the **Policyholder** an advice of payment for each due date indicating the amount of the premium.

1.8.2 Ceasing to pay premiums

When the **Company** notes the non-payment of a premium or split premium within ten days of it falling due, it sends to the **Policyholder's** last known address, by registered post, an official notification setting out the due date, the amount of unpaid premiums and the consequences of failing to pay the premium or split premium.

If the premium remains unpaid in the thirty days with effect from the day after the registered letter is posted, the **Company**:

- either terminates the policy by paying the surrender value if appropriate;
- or reduces the policy cover.

If the **Policyholder** advises the **Company** in writing of his decision to cease paying the policy premiums, after the due date of an unpaid premium, the **Company** is exempt from the official notification.

1.9 Risks not covered

1.9.1 Risks always excluded

The Company covers all the risks of death of the Insured worldwide, regardless of the cause, with the following exclusions:

- **in the event of death from suicide occurring at least one year after the conclusion of the policy or its re-entry into force; this same principles applies if the insured benefits are increased, up to this increase and during the year following this increase;**
- **in the event of death due to a deliberate act by the Insured or instigated by the Policyholder or a Beneficiary or any other person with a direct or indirect interest in the policy, except in the case of self-defence or lifesaving and the performing of professional duty;**
- **when death is caused by an event of war or acts of a similar nature, if there is a direct or indirect relationship between the death and any offensive or defensive action by a warring power;**
- **death occurring directly or indirectly during civil unrest, even uncoordinated, violent demonstrations, civil disorders or any acts of violence organised clandestinely (including chemical, bacteriological and nuclear terrorism) for ideological, political, economic or social purposes, executed individually or in a group, attacking people or destroying property, whether or not accompanied by rebellion against authority;**
- **death resulting from sentencing to death or immediately or directly caused by a crime or deliberate offence carried out or carried out jointly by the Insured and for which he could have foreseen the consequences;**
- **death caused by the radioactive, toxic and explosive properties of nuclear fuels or radioactive waste;**
- **in the event of death occurring when leaping into the void on an elastic rope (bungee jumping).**

1.9.2 Risks that can be insured

The death of the Insured is excluded from the insurance policy, unless agreed otherwise and provided an additional premium is paid, when it is the result of:

- **an accident to an aerial navigation device where he was on board as pilot or crew member;**
- **the use of an aerial navigation device for competitions or exhibitions, speed trials, raids, training flights, records or record attempts and during any test to participate in one of these activities;**
- **exercising an at-risk sporting activity such as hang-gliding, motorised ultra-light equipment, parascending or automatic opening parachuting.**

In the event of the death of the Insured following the occurrence of an excluded risk, the Company pays the Beneficiary the surrender value, limited to the benefit insured in the event of death.

If the death of the Insured occurs due to an intentional act by the Beneficiary, this surrender value is paid to the other Beneficiaries named in the specific terms and conditions, under the order established therein.

1.10 Settlement of benefits

The **Company** pays the insured benefits against settlement receipt sent to the **Beneficiary** within thirty days of receiving all documents listed below:

- the **specific terms and conditions** signed and any **endorsements** thereto;
- proof of payment of the last premium due and, if appropriate, the last interest payment on an advance;
- a copy of the valid identity card of the **Beneficiary** and a copy of the bank details in the name of the **Beneficiary**;
- a copy of supporting documents attesting to the status of the legal representative when the **Beneficiary** is legally incapable.

In addition, the following should be added:

- in the event of survival of the **Insured**:
  - a certificate of survival at the expiry of the policy.
- in the event of death of the **Insured**:
  - a certified copy of the official death certificate;
  - a medical certificate stating the circumstances and cause of death, prepared by the doctor(s) who treated the **Insured** during his last illness or, in the event of unexpected death, by the doctor who certified the death;
  - an attestation of status indicating the capacities and rights of the **Beneficiaries** when they are not named.

The **Company** reserves the right to request all documents that it deems useful in establishing the right to the benefit.

1.11 Profit sharing and upgrading

Depending on the option chosen by the **Policyholder** when taking out the policy and indicated in the **specific terms and conditions**, the **Company** grants either profit sharing or upgrading.

The **Company** advises the **Policyholder** every year of the profit sharing or upgrading amounts. These amounts are earned definitively and are taken into account when calculation reduction and surrender values.

Before the end of the financial year and the establishment of profit and loss accounts, the **Company** calculates the difference between:

- the revenues and actual expenditure which they will have to face;
- the forecast death rate according to the tables used and the actual death rate;
- the actual interest of investments representative of mathematical reserves and the interest on these reserves calculated at the tariff in force;
- the amount of transferable securities achieved or reimbursed during the financial year and the related purchase price; depreciation will however be taken into account.

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When the sum of these differences is positive, the Board of Directors proposes to the general meeting of shareholders to fix a share to be distributed to the policies meeting the criteria below.

For the policies upgraded, these distributions are made by increasing the mathematical reserves of policies. When the premiums falling due are increased by the same rate, the resulting increase in capital is proportional. When the **Policyholder** renounces the increase in premiums, he benefits only from the free increase of the mathematical reserve considered to be a single valuation premium guaranteeing a lower capital increase.

The following policies do not benefit from these distributions, where:

- neither the life capital,
- nor the annual premium (from which any additional premiums are deducted),

do not achieve the minimum amounts fixed by the Board of Directors. The same applies to the policies that, at the time of distribution, are reduced.

1.12 Communication

The **Policyholder** should address any communication about the insurance policy to the **Company** in writing.

The domicile of the **Policyholder** is elected automatically at the address stated in the **specific terms and conditions.** The notifications from the **Company** are validly made to this address. Should the **Policyholder** change domicile, he must advise the **Company** in writing as quickly as possible.

Where there are several **Policyholders**, any communication sent by the **Company** to the address indicated in the **specific terms and conditions** is enforceable with respect to all of them

1.13 Tax regime applicable to the policy

All future and current taxes and contributions applicable to the policy or the sums due or falling due are borne by the **Policyholder**, his beneficiaries or the **Beneficiary**.

Taxes and any other costs applicable to the benefits are determined by law in the country of residence of the **Beneficiary** and/or by the law in the country of the source of income.

The tax legislation of the country of residence of the deceased and/or the country of residence of the **Beneficiary** are applicable in terms of the inheritance rights.

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1.14 FATCA - Identification of “US Persons”

In accordance with the FATCA legislation (Foreign Account Tax Compliant Act), whereby the American tax authorities (IRS - Internal Revenue Service) has introduced a system to collect information annually from foreign financial institutions on property and income held by American taxpayers outside the United States, the **Company** is obliged to identify its American customers when the policy is taken out and benefits are paid.

When taking out a **Juvena**, **Azzura** or **Equatoria** policy, the **Policyholder** should complete the proposal form allowing the **Company** to detect the signs of American affiliation.

If such an indication exists, the **Policyholder** will be asked by the **Company** to provide certain documents and complete the appropriate form required by the competent tax authorities.

The **Policyholder** is responsible for any false, omitted or erroneous declaration regarding his status in terms of the FATCA regulations and whether or not he is a US Person. Under no circumstances can the **Company** be held liable for damaging consequences resulting from such an omission.

In accordance with the applicable legislation and the intergovernmental agreement signed with Luxembourg, if signs of American affiliation are detected, the **Policyholder** authorises the **Company** expressly to communicate annually the information relating to the **Policyholder** to the competent tax authorities regarding his identity and the assets and income held with the **Company.**

Throughout the duration of the policy, the **Policyholder** is obliged to advise the **Company** immediately of any change in his circumstances. This information should be sent by post to the address of the **Company’s** head office.

The **Company** reserves the right to request at any time any additional document to make sure of the status of the **Policyholder.**

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1.15 Fiscal aspects for pension-old age insurance

1.15.1 Taxation of benefits

The policy is taken out for a minimum of ten years. It provides for the payment of benefits stipulated in **the specific terms and conditions**, at the earliest when the **Policyholder** reaches the age of 60 or the age of 75 at the latest and within the distribution limits as a monthly life annuity or capital provided for under Article 111bis LIR.

When the above conditions are met, the Grand Duchy of Luxembourg taxes the benefit at expiry of the policy in the following manner:

- the reimbursement as capital is taxable as miscellaneous income (Article 99-4 LIT) by application of half the global rate;
- half the life annuity is exempt. The other half of the life annuity is taxable as income from pensions or annuities (Article 96 LIR).

The benefits paid to a **Beneficiary** who is not a resident are taxable in his country of residence.

1.15.2 Taxation of the early surrender

The surrender of the pension-old age policy:

- before the **Policyholder** reaches the age of 60 or
- before the minimum ten year period of the policy

makes the entire early reimbursement of the accumulated savings or the constituent capital of the life annuity taxable under normal conditions.

The payments deducted previously become taxable under the tax year during which the early payment was made. They are considered as miscellaneous income (Article 99-5 LIR). As such, they do not enjoy a preferential tax rate but the full tax rate is applicable to the total amount of payments.

When the early payment takes the form of a live annuity, this is taxable as periodic revenue from pensions or annuities (Article 96 LIR), subject to an exemption of up to 50% (Article 115, number 14a LIR).

When the surrender has taken place for reasons of **invalidity** or serious illness, the reimbursement of the accumulated saving is taxed at a reduced rate (so-called half the global rate system).

It is stated that no right of surrender exists for the insurance formula “Endowment without reimbursement”.

1.16 Bank charges

The costs of transferring sums between the bank accounts of the **Company** and of the **Policyholder** or **Beneficiary** are payable by the **Policyholder** or **Beneficiary** respectively.

1.17 Dispute

If, despite the efforts made by the **Company** to resolve any problems that may occur during the policy, the **Policyholder** is not satisfied by the response, he is invited to send his complaints to the **Company's** Management.

He can also contact the mediation body instituted on the initiative of the Association of Insurance Companies and the Luxembourg Consumer Union or the Insurance Supervisory Authority without prejudice to the possibility of taking legal action.

1.18 Applicable law and competent jurisdiction

The policy is governed by Luxembourg law.

Any dispute relating to this policy is the exclusive competence of the courts of the Grand Duchy of Luxembourg, without prejudice to the application of international treaties or agreements.

1.19 Limitation

Any action deriving from the policy lapses after two years.

The time runs, in terms of the action of the **Beneficiary** of personal insurance, from the day he became aware of the existence of the policy, of his status as **Beneficiary** and of the occurrence of the event on which depends the payability of the insurance benefits.

2 Additional accident risk insurance

In addition to the principal cover the **Policyholder** has the option of taking out accident risk cover.

These provisions are applicable if the **specific terms and conditions** mention the additional accident risk insurance cover (ACCRA).

The **insurance conditions** of the principal cover are applicable to this additional cover, insofar as the provisions below do not set them aside.

2.1 Definitions

The following meanings apply under this additional cover:

2.1.1 Accident

An **accident** is any sudden and fortuitous event caused directly by the action of an external force, beyond the control of the **Insured** and resulting in a physical injury showing objective symptoms.

Accidents include:

- drowning;
- injuries suffered when saving people or goods in peril;
- intoxications, asphyxia and burns resulting either from the involuntary ingestion of toxic or corrosive substances, or from the accidental leakage of gas or vapours;
- complications from initial injuries caused by a covered **accident**;
- rabies, anthrax and tetanus.

Suicide is not an **accident**.

2.1.2 Invalidity

Invalidity designates both **physiological invalidity** and **economic disability.**

Physiological invalidity corresponds to the diminution of physical integrity of the **Insured** following an **accident** or illness. The rate of **physiological invalidity** is fixed on the basis of the "International Invalidity Scale (L. Melennec)" or as assessed by experts.

Economic disability is a diminution of the ability of the **Insured** to work following **physiological invalidity** from which he is suffering. Its **level** is fixed, by medical decision, taking into account the profession exercised by the **Insured** and his possibilities of re-adapting to any professional activity compatible with his knowledge, his abilities and his social position; the appraisal of this **level of disability** is therefore independent of any other economic criterion.

Economic disability is assessed according to normal economic conditions.

Are not considered as **invalidity**, conditions linked to a nervous or mental affliction that cannot be made directly objective through organic repercussions.

2.1.3 Level of invalidity

The level of **invalidity** is determined by the highest of rates adopted for **physiological invalidity** and **economic disability** respectively.

Physiological invalidities and **economic disabilities** existing when this insurance policy starts to run or resulting from an excluded risk cannot play a part in determining the **level of invalidity**.

2.1.4 Permanence of invalidity

The **invalidity** is **permanent** when so deemed by the medical fraternity as per the procedure set out in point 2.7.

The permanent nature cannot be permitted as such before the consolidation of the state of health of the **Insured** and the formal establishment of the permanence of this **invalidity**.

2.1.5 Total, permanent invalidity

Total, permanent invalidity is **invalidity** that has reached a **level** of at least 67%, making it definitively impossible for the **Insured** to pursue his profession or to re-adapt, under normal economic conditions, to any professional activity compatible with his knowledge, his capacities and social position.

2.2 Purpose of the cover

2.2.1 Commitment by the Company

The **Company** undertakes to pay the **Beneficiary** the insured benefits, according to the cover provided for under the **specific terms and conditions**, when the **Insured** is the victim of an **accident** occurring in his private or professional life which causes directly and exclusively, within one year from the date of the accident:

- the death of the **Insured**;
- the **total, permanent invalidity** of the **Insured**.

The **Company** undertakes, where there are several people **Insured**, to execute its obligation at the first death or the first recognition, by the **Company**, of the **total, permanent invalidity** of one of these persons **Insured**.

2.2.2 ACCRA - Single

The **Company** undertakes to pay the **Beneficiary** a capital corresponding to once the death benefit of the main cover.

2.2.3 ACCRA - Double

The **Company** undertakes to pay the **Beneficiary** a capital corresponding to twice the death benefit of the main cover.

2.2.4 ACCRA - Decreasing capital

The **Company** undertakes to pay the **Beneficiary** an amount corresponding to the decreasing insured capital of the main cover under a temporary decreasing capital insurance policy.

2.3 Premiums

2.3.1 Payment of premiums

In return for the additional commitments by the **Company**, the **Policyholder** pays the additional premiums. These premiums are payable at the same due dates and by the same methods as those relating to the main cover.

Their payment cannot be separated from that of the main cover.

2.3.2 Ceasing to pay premiums

At the end of each insurance period, corresponding to the last premium or split premium paid, the **Policyholder** can request in writing to cease paying premiums for the additional **accident** risk cover, independently of the main cover.

Ceasing payment of additional premiums results in the termination of this additional cover, which has no surrender or reduction value.

2.4 Territory covered

The commitments of this additional cover are acquired worldwide, provided that the **Company** can exercise normally the planned medical examination resources and subject to the exclusions described below.

2.5 Risks not covered

2.5.1 Risks always excluded

Apart from the excluded risks planned in the insurance conditions, the additional cover does not cover the accidents resulting from:

- **attempted suicide, throughout the policy;**
- **acrobatics, wagers or challenges and generally any notoriously reckless act in which the Insured has taken part;**
- **the fact that the Insured found himself under the influence of a narcotic, hallucinogenic or other drug, or in a state of inebriation, or in a state of alcohol poisoning unless there is no causal link between the death or the total, permanent invalidity and these circumstances;**
- **a natural disaster.**

2.5.2 Risks that can be insured

Unless agreed otherwise and provided any additional premium is paid, the additional cover does not apply to the accidents occurring during:

- **the exercising of at-risk professions and professional activities, such as, for example:**
  - **seaman (oil tanker, lifeboat, submarine);**
  - **oil platform;**
  - **all underwater work;**
  - **descending into shafts, mines or quarries;**
  - **work on high-voltage installations;**
  - **work that could result in a fall of more than 4 metres;**
  - **work on scaffolding or roofing;**
  - **construction, maintenance or demolition of buildings or structures;**
  - **felling and/or pruning trees;**
  - **firemen;**
  - **special branch or anti-gang or anti-drug police officers;**
  - **armed personnel;**
  - **comprising the manufacture, processing or handling of chemical or biological substances;**
  - **comprising the manufacture, use or handling of fireworks or explosive or corrosive machinery and product parts;**
  - **comprising the transport of flammable or explosive materials;**
- **an accident to an aerial navigation device where the Insured was on board as pilot or crew member;(1)**
- **the use of an aerial navigation device for competitions or exhibitions, speed trials, raids, training flights, records or record attempts and during any test to participate in one of these activities;(1)**
- **the use, as a driver, of a 2- or 3-wheeled motorised vehicle with engine power greater than 50 cc;(1)**
- **the exercising of at-risk sporting activities, such as, for example:**
  - **hunting;**
  - **the use and/or presence on board of a motorised ultra-light equipment, a helicopter, a balloon or an aircraft with less than eight seats;**
  - **practising any sport whatsoever as a professional or paid amateur;**
  - **off-piste skiing; ski jumping; bobsleigh; skeleton;**
  - **sailing or sail or motor yachting more than three nautical miles from the coast;**
  - **mountaineering more than 3000 m above sea level, climbing cliffs or artificial walls without safety pitons, archaeological exploration and potholing;**
  - **scuba diving with autonomous breathing apparatus, beyond 40 m;**

- **participating in or preparing for a sporting event on board any vehicle whatsoever;**[1]
- **automatic opening parachuting, parascending, paragliding, hang-gliding, gliding, parasailing;**[1]
- **practising the following sports, including the preparation, in the context of a competition organised by an official federation or of any trial that is not exclusively for entertainment and occasional;**
  - **motorboating in competition (inshore and offshore);**[1]
  - **competitive riding;**
  - **snow skiing;**
  - **combat sports and martial arts.**

2.6 Obligations in case of a loss

2.6.1 Declaration of a loss

Any **accident** that has caused the death or total, permanent invalidity of the **Insured** must be declared in writing to the **Company's** Secrétariat Médical – Vie Particuliers (Life Private Customers Medical Secretariat)

The declaration must be made within one month with effect from the occurrence of the **accident**, except following unforeseen circumstances or a case of force majeure when the declaration must be made as quickly as can be reasonably achieved, on pain of the benefit being reduced up to the loss suffered by the **Company**.

The declaration must indicate:

- the place, date, time, causes, nature and circumstances of the **accident**;
- names, first names and domiciles of any witnesses.

2.6.2 Information and documents to be supplied

A medical certificate must be attached to this declaration; this is drawn up by the doctor or doctors who treated the **Insured** after the **accident** or who certified the death. This certificate states the exact causes and nature of physical injuries suffered and their likely consequences.

In addition, the **Company** reserves the right to demand the **accident** report raised by the competent authorities.

2.7 Statement of total, permanent invalidity

Based on declarations and the medical certificate, the **Company's** medical advisor assesses the reality and the **total** and **permanent** nature of the **invalidity**.

It is stated that the social security legislation and case law do not apply under this additional cover.

The **Company** reserves the right not to follow the decisions to grant **total, permanent invalidity** laid down by the social security medical control.

[1] Risks that cannot be covered by agreement otherwise and subject to extra premium in the pension-old age insurance policies.

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2.8 Dispute

Any dispute over the state of health of the **Insured** is laid before a medical committee, who will hear both sides, made up of two medical assessors, one appointed by the **Policyholder** and/or the **Insured** and the other by the **Company**.

Failing agreement between these two doctors, they nominate a third medical expert with the role of arbitrating between them.

If one of the parties does not appoint a medical assessor or if the two medical assessors do not agree on the choice of the third, an appointment will be made by the President of the court in the district of the domicile of the **Insured**, at the request of the first party to take action.

Each party pays the fees of his assessor, the fees of the third assessor being shared equally.

2.9 Beneficiary

In the event of the death of the **Insured**, the **Company** pays the benefits insured under the additional cover to the **Beneficiary** designated in the **specific terms and conditions**. In the hypothesis of simultaneous death of two **Insured** parties, the youngest **Insured** person is assumed to have survived.

In the event of an **accident** causing **total, permanent invalidity**, the **Company**, unless stipulated otherwise, pays the insured benefits to the invalid **Insured**.

2.10 Settlement of benefits

The **Company** pays the insured benefits against settlement receipt sent to the **Beneficiary** within thirty days of receiving the supporting documents required to settle benefits.

2.11 Duration of the cover

The right to the additional cover is conditioned by the existence of the main cover.

In the event of termination, reduction, surrender or cancellation of the main cover, the additional cover ends automatically.

The additional premiums relating to the period prior to the end date of the additional cover remain acquired by the **Company** for the financing of the risk covered.

The cover ceases at the maturity fixed in the **specific terms and conditions**, without extending beyond the end of the insurance year during which the **Insured** reaches his 65th birthday.

The payment of benefits insured under this cover puts an end to the additional cover.

(1) Risks that cannot be covered by agreement otherwise and subject to extra premium in the pension-old age insurance policies.

3 Additional invalidity risk insurance linked to Equatoria, Alizea and Domia insurance policies

In addition to the Equatoria, Alizea and Domia principal covers, the **Policyholder** has the option of taking out additional invalidity risk cover.

These provisions are applicable if the **specific terms and conditions** mention the additional invalidity risk insurance cover (ACCRI).

The **insurance conditions** of the principal cover are applicable to this additional cover, insofar as the provisions below do not set them aside.

3.1 Definitions

The following meanings apply under this additional cover:

3.1.1 Accident

An **accident** is any sudden and fortuitous event caused directly by the action of an external force, beyond the control of the **Insured** and resulting in a physical injury showing objective symptoms.

Accidents include:

- drowning;
- injuries suffered when saving people or goods in peril;
- intoxications, asphyxia and burns resulting either from the involuntary ingestion of toxic or corrosive substances, or from the accidental leakage of gas or vapours;
- complications from initial injuries caused by a covered **accident**;
- rabies, anthrax and tetanus.

Suicide is not an **accident**.

3.1.2 Illness

Illness is any non-accidental alteration to the original health that can be checked by a medical examination. Pregnancy is not an illness.

3.1.3 Invalidity

Invalidity designates both **physiological invalidity** and **economic disability.**

Physiological invalidity corresponds to the diminution of physical integrity of the **Insured** following an **accident** or **illness**. The rate of **physiological invalidity** is fixed on the basis of the "International Invalidity Scale (L. Melennec)" or as assessed by experts.

Economic disability is a diminution of the ability of the **Insured** to work following **physiological invalidity** from which he is suffering. Its **level** is fixed, by medical decision, taking into account the profession exercised by the **Insured** and his possibilities of re-adapting to any professional activity compatible with his knowledge, his abilities and his social position; the appraisal of this **level of disability** is therefore independent of any other economic criterion.

Economic disability is assessed according to normal economic conditions.

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3.1.4 Level of invalidity

The level of **invalidity** is determined by the highest of rates adopted for **physiological invalidity** and **economic disability** respectively.

For policies with two Insured persons, under the ACCRI-premiums cover explained below (see 3.2.3), if they both suffer from partial invalidity, the rates are only accumulated provided each one can justify at least 25% partial invalidity. The accumulated rates are only taken into consideration for maximum 100%. Physiological invalidities and economic disabilities existing when this insurance policy starts to run or resulting from an excluded risk cannot play a part in determining the level of invalidity.

3.1.5 Limited cover

the cover is limited if the invalidity is the consequence of:

- burn-out;
- psychiatric disorders of somatic illnesses;
- functional psychic disorders and their consequences that cannot be made directly objective through organic repercussions.

The insured benefit for **invalidity** caused by one of the afflictions mentioned above is allocated after expiry of a waiting period of one year from the consolidation of the state of health. The total indemnity period is limited for all these afflictions to **three years** maximum for the duration of the policy.

In addition, under the “ACCRI - Decreasing capital” cover, invalidity caused by one of the afore-mentioned afflictions is excluded.

3.1.6 Permanence of invalidity

The **invalidity** is **permanent** when so deemed by the medical fraternity as per the procedure set out in point 3.7.

The permanent nature cannot be permitted as such before the consolidation of the state of health of the **Insured** and the formal establishment of the permanence of this **invalidity**.

3.1.7 Total, permanent invalidity

Total, permanent invalidity is **invalidity** that has reached a **level** of at least 67%, making it definitively impossible for the **Insured** to pursue his profession or to re-adapt, under normal economic conditions, to any professional activity compatible with his knowledge, his capacities and social position.

3.1.8 Waiting time

Waiting time is the time starting on the effective date of the additional **invalidity** risk cover, during which the risk is not covered. The **waiting time** is nine months for any **invalidity** due to the aftermath of a pregnancy.

3.1.9 Professional income

For representatives of the professions and other freelancers, the **professional income** is the net income, which is the profit generated by the activity indicated in the insurance proposal (Article 10 points 1 to 3 of the Income Tax Law of 4 December 1967).

For employees, the **professional income** is the gross wages shown on the payslip.

At the request of the **Company**, the **Policyholder** undertakes to provide it with any document it deems useful for certifying his **professional income** or that of the **Insured**.

3.2 Purpose of the cover

3.2.1 Commitment by the Company

The **Company** undertakes to pay the **Beneficiary** the insured benefits, according to the cover(s) provided for under the **specific terms and conditions**, when the **Insured** is the victim of an **accident** or **illness** occurring in his private or professional life which causes directly and exclusively:

- either **total, permanent invalidity**;
- or **partial and permanent invalidity**, provided that this is at a level of at least 25%.

3.2.2 ACCRI - Annuity

The **Company** undertakes to pay the **Insured**, in proportion to the **level of invalidity**, the annual **invalidity** annuity fixed in the **specific terms and conditions.**

The **invalidity** annuity is calculated by quarterly amounts at 30 March, 30 June, 30 September and 30 December and paid the next month.

The **invalidity** annuity is due for any month that has started. In this case, the amount of the monthly annuity is calculated pro rata to the number of days indemnified. The same is true at the end of the **invalidity** or benefit period for an incomplete month, with the annuity being calculated pro rata to the number of days indemnified.

It is stated that a month is deemed to have thirty days.

Unless agreed otherwise, the **invalidity** annuity paid in the event of a loss cannot exceed, on an annual basis, 80% of the average of annual professional income of the **Insured** in the three calendar years preceding the date of the loss. Should this limit be exceeded, the **Company** is authorised to reduce the annuity to this limit and to reduce the premium in proportion, with effect in the month after becoming aware of this overrun. The benefits already paid remain unchanged until the date of reduction. This 80% intervention limit does not, however, apply when the annual annuity insured is no more than €12,500. The **Company** reserves the right to review these limits for any new policy or change to the annuity insured along and the right to determine the minimum and maximum amounts of the annuity insured.

The **Policyholder** is required to advise the **Company** of any non-temporary reduction in income from the professional activity of the person insured below the 80% limit defined above. The adaptation of the insured annuity and the premium takes effect in the month after becoming aware of this reduction.

Any increase in the insured annuity is subject to prior acceptance by the **Company**.

3.2.3 ACCRI - Premiums

The **Company** undertakes to pay, in proportion to the **level of invalidity**, the premiums of the main cover and the additional covers, including taxes and charges. The **Company** reimburses the **Policyholder** with the pro rata of premiums already paid by him, relative to the indemnification period, at the earliest during the months of January, April, July and October. The payment of the premium by the **Company** is due for any month that has commenced. In this case, the amount of the monthly benefit is calculated pro rata to the number of days indemnified. The same is true at the end of the invalidity or benefit period for an incomplete month, with the premium paid being calculated pro rata to the number of days indemnified.

It is stated that a month is deemed to have thirty days.

3.2.4 ACCRI - Decreasing capital

The **Company** undertakes to pay the **Beneficiary** an amount corresponding to the decreasing insured capital of the main cover under a temporary decreasing capital insurance policy in the case of **total or permanent invalidity** of the Insured.

The payment of the insured decreasing capital under this cover puts an end to the main cover.

3.2.5 Additional option

In the case of **total, permanent invalidity** of the **Insured**, he can ask the **Company**, if he requests it expressly, for an advance on the insured benefits when the main cover provides both life and death benefits and that this cover so allows. The **Company** pays the interest.

The amount of this advance is equal to the smallest of the insured benefits.

3.3 Premiums

3.3.1 Payment of premiums

In return for the additional commitments by the **Company**, the **Policyholder** pays the additional premiums. These premiums are payable at the same due dates and by the same methods as those relating to the main cover.

Their payment cannot be separated from that of the main cover.

3.3.2 Ceasing to pay premiums

At the end of each insurance period, corresponding to the last premium or split premium paid, the **Policyholder** can request in writing to cease paying premiums for the additional **invalidity** risk cover, independently of the main cover.

Ceasing payment of additional premiums results in the termination of this additional cover, which has no surrender or reduction value.

3.4 Territory covered

The commitments of this additional cover are acquired worldwide, provided that the **Company** can exercise normally the planned medical examination resources and subject to the exclusions described below.

3.5 Risks not covered

3.5.1 Risks always excluded

Apart from the excluded risks planned in the insurance conditions, the additional cover does not cover the invalidities resulting from:

- **attempted suicide, throughout the policy;**
- **acrobatics, wagers or challenges and generally any notoriously reckless act in which the Insured has taken part;**
- **the fact that the Insured found himself under the influence of a narcotic, hallucinogenic or other drug, or in a state of inebriation, unless there is no causal link between the invalidity and these circumstances;**
- **allergic afflictions;**
- **chronic fatigue syndrome, spasmophilia or fibromyalgia and the accompanying afflictions;**
- **directly or indirectly drug addiction, including alcoholism and the abuse of medications;**
- **aesthetic treatment, unless it is repairing surgery following an accident or cancer;**
- **sterilisation, artificial insemination or in vitro fertilisation.**

3.5.2 Risks that can be insured

Unless agreed otherwise and provided any additional premium is paid, the additional cover does not apply to the invalidities occurring during:

- **the exercising of at-risk professions and professional activities, such as, for example:**
  - **seaman (oil tanker, lifeboat, submarine);**
  - **oil platform;**
  - **all underwater work;**
  - **descending into shafts, mines or quarries;**
  - **work on high-voltage installations;**
  - **work that could result in a fall of more than 4 metres;**
  - **work on scaffolding or roofing;**
  - **construction, maintenance or demolition of buildings or structures;**
  - **felling and/or pruning trees;**
  - **firemen;**
  - **special branch or anti-gang or anti-drug police officers;**
  - **armed personnel;**
  - **comprising the manufacture, processing or handling of chemical or biological substances;**
  - **comprising the manufacture, use or handling of fireworks or explosive or corrosive machinery and product parts;**
  - **comprising the transport of flammable or explosive materials;**
- **an accident to an aerial navigation device where the Insured was on board as pilot or crew member;**
- **the use of an aerial navigation device for competitions or exhibitions, speed trials, raids, training flights, records or record attempts and during any test to participate in one of these activities;**
- **the use, as a driver, of a 2- or 3-wheeled motorised vehicle with engine power greater than 50 cc;**
- **the exercising of at-risk sporting activities, such as, for example:**
  - **hunting;**
  - **the invalidities occurring in an accident of motorised ultra-light equipment, a helicopter, a balloon or an aircraft with less than eight seats on board;**
  - **practising any sport whatsoever as a professional or paid amateur;**
  - **off-piste skiing; ski jumping; bobsleigh; skeleton;**
  - **sailing or sail or motor yachting more than three nautical miles from the coast;**
  - **mountaineering more than 3000 m above sea level, climbing cliffs or artificial walls without safety pitons, archaeological exploration and potholing;**
  - **scuba diving with autonomous breathing apparatus, beyond 40 m;**

- **participating in or preparing for a sporting event on board any vehicle whatsoever;**
- **automatic opening parachuting, parascending, paragliding, hang-gliding, gliding, parasailing;**
- **practising the following sports, including the preparation, in the context of a competition organised by an official federation or of any trial that is not exclusively for entertainment and occasional;**
    - **motorboating in competition (inshore and offshore);**
    - **competitive riding;**
    - **snow skiing;**
    - **combat sports and martial arts.**

3.6 Obligations in case of a loss

3.6.1 Declaration of a loss

Any **accident** or **illness** that has caused the permanent invalidity of the **Insured** must be declared in writing to the **Company's** Secrétariat Médical – Vie Particuliers (Life Private Customers Medical Secretariat).

The declaration must be made within one month with effect from the occurrence of the **accident** or the **illness**, except following unforeseen circumstances or a case of force majeure when the declaration must be made as quickly as can be reasonably achieved, on pain of the benefit being reduced up to the loss suffered by the **Company**.

The declaration must indicate:

- the place, date, time, causes, exact nature and circumstances of the **invalidity**;
- names, first names and domiciles of any witnesses, in the event of an **accident**.

3.6.2 Information and documents to be supplied

The **Policyholder** and/or the **Insured** must attach to the declaration of loss any document, medical certificate or report likely to prove the existence and severity of the claim.

He provides the **Company**, as soon as possible, with the information and documents that it deems necessary to determine the circumstances and fix the extent of the loss. This declaration will be accompanied by an official document and a certificate from the **Insured's** doctor(s), drawn up on the **Company's** standard form, stating the date of occurrence, the causes, the nature, the degree and the permanent character of the **invalidity.** The lack of information and documents requested by the **Company** could lead to it suspending its decision and potentially refusing to settle the claim.

The **Company** reserves the right to have the **Insured** undergo any medical examination required and necessary at any time. He is required to undergo this examination within one month of being notified of this decision.

Except in the case of **total, permanent invalidity** recognised by the **Company**, the **Policyholder** and/or the **Insured** advises it, within thirty days, of any alteration in the level of **invalidity** along with any mitigation of the **invalidity** that allows the **Insured** to return to work, even partially.

In this case, the benefits are adapted from the date of the modification and any sums that the **Company** may have wrongfully paid must be reimbursed.

During **partial invalidity**, the **Company** reserves the right to have the **level of invalidity** of the **Insured** checked by its medical advisor or to request a detailed report from the **Insured's** general practitioner to see whether the **invalidity** still exists and whether or not its **level** has changed.

The costs of this report are paid by the **Company**.

3.7 Statement of permanent invalidity

Based on declarations and the medical certificate, the **Company's** medical advisor assesses the reality, the level and the permanent nature of the **invalidity**.

It is stated that the social security legislation and case law do not apply under this additional cover.

The **Company** reserves the right not to follow the decisions to grant **total, permanent invalidity** laid down by the social security medical control.

The claim will only be settled from the date of consolidation of the state of invalidity of the **Insured**.

3.8 Dispute

Any dispute over the state of health of the **Insured** is laid before a medical committee, who will hear both sides, made up of two medical assessors, one appointed by the **Policyholder** and/or the **Insured** and the other by the **Company**.

Failing agreement between these two doctors, they nominate a third medical expert with the role of arbitrating between them.

If one of the parties does not appoint a medical assessor or if the two medical assessors do not agree on the choice of the third, an appointment will be made by the President of the court in the district of the domicile of the **Insured**, at the request of the first party to take action.

Each party pays the fees of his assessor, the fees of the third assessor being shared equally.

3.9 Beneficiary

In the event of an **accident** or illness causing **permanent invalidity**, the **Company**, unless agreed otherwise, pays the guaranteed benefits to the invalid **Insured**.

The **Company** undertakes, where there are several people **Insured**, to execute its obligation at the first recognition, by the **Company**, of the **permanent invalidity** of one of these persons **Insured**.

3.10 Settlement of benefits

The **Company** pays the insured benefits against settlement receipt sent to the **Beneficiary** within thirty days of receiving the supporting documents required to settle benefits.

3.11 Duration of the cover

The right to the additional cover is conditioned by the existence of the main cover.

In the event of termination, reduction, surrender or cancellation of the main cover, the additional cover ends automatically.

The additional premiums relating to the period prior to the end date of the additional cover remain acquired by the **Company** for the financing of the risk covered.

Unless stated otherwise in the **specific terms and conditions**, the cover ceases without extending beyond the end of the insurance year during which the **Insured** reaches his 65th birthday.

4 Additional invalidity risk insurance linked to the Serena insurance policy

In addition to the Serena principal cover the **Policyholder** has the option of taking out additional invalidity risk cover.

These provisions are applicable if the **specific terms and conditions** mention the additional invalidity risk insurance cover (ACCRI).

The **insurance conditions** of the principal cover are applicable to this additional cover, insofar as the provisions below do not set them aside.

4.1 Definitions

The following meanings apply under this additional cover:

4.1.1 Accident

An **accident** is any sudden and fortuitous event caused directly by the action of an external force, beyond the control of the **Insured** and resulting in a physical injury showing objective symptoms.

Accidents include:

- drowning;
- injuries suffered when saving people or goods in peril;
- intoxications, asphyxia and burns resulting either from the involuntary ingestion of toxic or corrosive substances, or from the accidental leakage of gas or vapours;
- complications from initial injuries caused by a covered **accident**;
- rabies, anthrax and tetanus.

Suicide is not an **accident**.

4.1.2 Illness

Illness is any non-accidental alteration to the original health that can be checked by a medical examination. Pregnancy is not an illness.

4.1.3 Invalidity

Invalidity designates both **physiological invalidity** and **economic disability.**

Physiological invalidity corresponds to the diminution of physical integrity of the **Insured** following an **accident** or **illness**. The rate of **physiological invalidity** is fixed on the basis of the "International Invalidity Scale (L. Melennec)" or as assessed by experts.

Economic disability is a diminution of the ability of the **Insured** to work following **physiological invalidity** from which he is suffering. Its **level** is fixed, by medical decision, taking into account the profession exercised by the **Insured** and his possibilities of re-adapting to any professional activity compatible with his knowledge, his abilities and his social position; the appraisal of this **level of disability** is therefore independent of any other economic criterion.

Economic disability is assessed according to normal economic conditions.

Maternity and paternity leave and any legal period of work ban or of rest are not considered as economic incapacity.

Pregnancy-related complications are covered, as is the **invalidity** resulting from giving birth.

4.1.4 Limited cover

The cover is limited if the **invalidity** is the consequence of:

- burn-out;
- psychiatric disorders of somatic illnesses;
- functional psychic disorders and their consequences that cannot be made directly objective through organic repercussions.

The insured benefit for **invalidity** caused by one of the afflictions mentioned above is allocated after expiry of a waiting period of one year from the consolidation of the state of health. The total indemnity period is limited for all these afflictions to three years maximum for the duration of the policy.

4.1.5 Level of invalidity

The level of **invalidity** is determined by the highest of rates adopted for **physiological invalidity** and **economic disability** respectively.

For policies with two **Insured** persons, under the ACCRI-premiums cover explained below (see 4.2.3), if they both suffer from partial **invalidity**, the rates are only accumulated provided each one can justify at least 25% partial **invalidity**. The accumulated rates are only taken into consideration for maximum 100%.

Physiological invalidities and **economic disabilities** existing when this insurance policy starts to run or resulting from an excluded risk cannot play a part in determining the **level of invalidity**.

4.1.6 Total invalidity, partial invalidity, permanent invalidity, temporary invalidity

The medical fraternity judges the nature of the **invalidity** as per the procedure set out in point 4.7. **Invalidity can be partial or total, temporary or permanent.**

Invalidity is considered total when the level of economic or physiological **invalidity** is at least 67%.

Partial invalidity is when the level is less than 67%.

The permanent nature of the **invalidity** cannot be permitted as such before the consolidation of the state of health of the **Insured** and the formal establishment of the permanence of this **invalidity**.

Temporary invalidity is a non-permanent **invalidity.**

Total, permanent invalidity is **invalidity** that has reached a **level** of at least 67%, making it definitively impossible for the **Insured** to pursue his profession or to re-adapt, under normal economic conditions, to any professional activity compatible with his knowledge, his capacities and social position.

4.1.7 Relapse

Relapse is any new **invalidity** that occurs within the three months after the end of payment for an **invalidity** covered by the insurance and caused by the same illness or **accident.**

4.1.8 Waiting period

The **waiting period** specified in the **specific terms and conditions** is the period from the date on which the **invalidity** started, during which the **Company** is not liable for any benefit.

The right to the benefits opens when the **waiting period** expires.

4.1.8 Waiting time

Waiting time is the time starting on the effective date of the additional **invalidity** risk cover, during which the risk is not covered. The **waiting time** is nine months for any **invalidity** due to the aftermath of a pregnancy.

4.1.10 Professional income

For representatives of the professions and other freelancers, the professional income is the net income, which is the profit generated by the activity indicated in the insurance proposal (Article 10 points 1 to 3 of the Income Tax Law of 4 December 1967).

For employees, the professional income is the gross wages shown on the payslip.

At the request of the **Company**, the **Policyholder** undertakes to provide it with any document it deems useful for certifying his **professional income** or that of the **Insured**.

4.2 Purpose of the cover

4.2.1 Commitment by the Company

The **Company** undertakes to pay the **Beneficiary** the insured benefits, according to the cover(s) provided for under the **specific terms and conditions**, when the **Insured** is the victim of an **accident** or **illness** occurring in his private or professional life which causes directly physiological or economic **invalidity**, provided this reaches a level of at least 25%.

4.2.2 ACCRI - Annuity

Once the waiting period and time have lapsed, the **Company** undertakes to pay the **Insured**, during the **invalidity** and in proportion to its level, an annuity for which the annual amount is fixed in the **specific terms and conditions**.

The **invalidity** annuity is calculated by quarterly amounts at 30 March, 30 June, 30 September and 30 December and paid the next month.

The **invalidity** annuity is due for any month that has started. In this case, the amount of the monthly annuity is calculated pro rata to the number of days indemnified. The same is true at the end of the **invalidity** or benefit period for an incomplete month, with the annuity being calculated pro rata to the number of days indemnified.

It is stated that a month is deemed to have thirty days.

The **Policyholder** can choose a constant annuity or an increasing annuity. The constant annuity remains unchanged during the entire indemnification period. The increasing annuity is indexed on a flat-rate basis during the indemnification period according to a percentage defined in the **specific terms and conditions.** This flat-rate indexing takes place every year, with effect from 30 June, and only applies if at least one year has elapsed since the **invalidity** start date.

Unless agreed otherwise, the **invalidity** annuity paid in the event of a loss cannot exceed, on an annual basis, 80% of the average of annual professional income of the **Insured** in the three calendar years preceding the date of the loss. Should this limit be exceeded, the **Company** is authorised to reduce the annuity to this limit and the premium in proportion, with effect in the month after become aware of this overrun. The benefits already paid remain unchanged until the date of reduction. This 80% intervention limit does not, however, apply when the annual annuity insured is no more than €12,500. The **Company** reserves the right to review these limits for any new policy or change to the annuity insured along and the right to determine the minimum and maximum amounts of the annuity insured.

The **Policyholder** is required to advise the **Company** of any non-temporary reduction in income from the professional activity of the person insured below the 80% limit defined above. The adaptation of the insured annuity and the premium takes effect in the month after becoming aware of this reduction.

Any increase in the insured annuity is subject to prior acceptance by the **Company**.

4.2.3 ACCRI - Premiums

Once the waiting period and time have lapsed, the **Company** undertakes to pay, in proportion to the **level of invalidity**, the premiums of the main cover and the additional covers, including taxes and charges. The **Company** reimburses the **Policyholder** with the pro rata of premiums already paid by him, relative to the indemnification period, at the earliest during the months of January, April, July and October. The payment of the premium by the **Company** is due for any month that has commenced. In this case, the amount of the monthly benefit is calculated pro rata to the number of days indemnified. The same is true at the end of the **invalidity** or benefit period for an incomplete month, with the premium paid being calculated pro rata to the number of days indemnified.

It is stated that a month is deemed to have thirty days.

4.2.4 Relapse

In the event of a **relapse** within three months following the end of the **invalidity** period, if the **waiting period** has lapsed entirely since the start of the initial **invalidity**, the resulting **invalidity** is considered to be a continuation of the first **invalidity**. In this case, the **waiting period** no longer applies and the intervention by the **Company** takes place on the same basis as was used to determine the intervention during the previous **invalidity.**

In the event of a **relapse** within three months following the end of the **invalidity** period and if the **waiting period** has not lapsed entirely since the start of the initial **invalidity**, it continues to apply for the period remaining to run from the date the **relapse** is noted.

In the event of a **relapse** more than three months after the end of the **invalidity** period, the resulting **invalidity** is considered to be a new **invalidity.**

4.3 Premiums

4.3.1 Payment of premiums

In return for the additional commitments by the **Company**, the **Policyholder** pays the additional premiums. These premiums are payable at the same due dates and by the same methods as those relating to the main cover.

Their payment cannot be separated from that of the main cover.

4.3.2 Ceasing to pay premiums

At the end of each insurance period, corresponding to the last premium or split premium paid, the **Policyholder** can request in writing to cease paying premiums for the additional **invalidity** risk cover, independently of the main cover.

Ceasing payment of additional premiums results in the termination of this additional cover, which has no surrender or reduction value.

4.3.3 Tariff

The **Company** reserves the right to increase the tariff of the additional ACCRI premium and ACCRI annuity cover during the policy, in which case it will so advise the **Policyholder** in writing at least three months before the annual due date of the policy. The tariff adjustment takes effect from this annual due date, unless the **Policyholder** decides to cease paying additional premiums in accordance with point 4.3.2.

4.4 Territory covered

The commitments of this additional cover are acquired worldwide, provided that the **Company** can exercise normally the planned medical examination resources and subject to the exclusions described below.

4.5 Risks not covered

4.5.1 Risks always excluded

Apart from the excluded risks planned in the insurance conditions, the additional cover does not cover the invalidities resulting from:

- **attempted suicide, throughout the policy;**
- **acrobatics, wagers or challenges and generally any notoriously reckless act in which the Insured has taken part;**
- **the fact that the Insured found himself under the influence of a narcotic, hallucinogenic or other drug, or in a state of inebriation, unless there is no causal link between the invalidity and these circumstances;**
- **allergic afflictions;**
- **chronic fatigue syndrome, spasmophilia or fibromyalgia and the accompanying afflictions;**
- **directly or indirectly drug addiction, including alcoholism and the abuse of medications;**
- **aesthetic treatment, unless it is repairing surgery following an accident or cancer;**
- **sterilisation, artificial insemination or in vitro fertilisation.**

4.5.2 Risks that can be insured

Unless agreed otherwise and provided any additional premium is paid, the additional cover does not apply to the invalidities occurring during:

- **the exercising of at-risk professions and professional activities, such as, for example:**
  - **seaman (oil tanker, lifeboat, submarine);**
  - **oil platform;**
  - **all underwater work;**
  - **descending into shafts, mines or quarries;**
  - **work on high-voltage installations;**
  - **work that could result in a fall of more than 4 metres;**
  - **work on scaffolding or roofing;**
  - **construction, maintenance or demolition of buildings or structures;**
  - **felling and/or pruning trees;**
  - **firemen;**
  - **special branch or anti-gang or anti-drug police officers;**
  - **armed personnel;**

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- **comprising the manufacture, processing or handling of chemical or biological substances;**
- **comprising the manufacture, use or handling of fireworks or explosive or corrosive machinery and product parts;**
- **comprising the transport of flammable or explosive materials;**

- **an accident to an aerial navigation device where the Insured was on board as pilot or crew member;**
- **the use of an aerial navigation device for competitions or exhibitions, speed trials, raids, training flights, records or record attempts and during any test to participate in one of these activities;**
- **the use, as a driver, of a 2- or 3-wheeled motorised vehicle with engine power greater than 50 cc;**
- **the exercising of at-risk sporting activities, such as, for example:**
  - **hunting;**
  - **the invalidities occurring in an accident of motorised ultra-light equipment, a helicopter, a balloon or an aircraft with less than eight seats on board;**
  - **practising any sport whatsoever as a professional or paid amateur;**
  - **off-piste skiing; ski jumping; bobsleigh; skeleton;**
  - **sailing or sail or motor yachting more than three nautical miles from the coast;**
  - **mountaineering more than 3000 m above sea level, climbing cliffs or artificial walls without safety pitons, archaeological exploration and potholing;**
  - **scuba diving with autonomous breathing apparatus, beyond 40 m;**
  - **participating in or preparing for a sporting event on board any vehicle whatsoever;[1]**
  - **automatic opening parachuting, parascending, paragliding, hang-gliding, gliding, parasailing;**
  - **practising the following sports, including the preparation, in the context of a competition organised by an official federation or of any trial that is not exclusively for entertainment and occasional;**
    - **motorboating in competition (inshore and offshore);**
    - **competitive riding;**
    - **snow skiing;**
    - **combat sports and martial arts.**

4.6 Obligations in case of a loss

4.6.1 Declaration of a loss

Any **accident** or **illness** that has caused the invalidity of the **Insured** must be declared in writing to the **Company's** Secrétariat Médical – Vie Particuliers (Life Private Customers Medical Secretariat).

The declaration must be made within one month with effect from the occurrence of the **accident** or the **illness**, except following unforeseen circumstances or a case of force majeure when the declaration must be made as quickly as can be reasonably achieved, on pain of the benefit being reduced up to the loss suffered by the **Company**.

The declaration must indicate:

- the place, date, time, causes, exact nature and circumstances of the **invalidity**;
- names, first names and domiciles of any witnesses, in the event of an **accident**.

4.6.2 Information and documents to be supplied

The **Policyholder** and/or the **Insured** must attach to the declaration of loss any document, medical certificate or report likely to prove the existence and severity of the claim.

He provides the **Company**, as soon as possible, with the information and documents that it deems necessary to determine the circumstances and fix the extent of the loss. This declaration will be accompanied by an official document and a certificate from the **Insured's** doctor(s), drawn up on the **Company's** standard form, stating the date of occurrence, the causes, the nature, the degree and the presumed duration of the **invalidity.** The lack of information and documents requested by the **Company** could lead to it suspending its decision and potentially refusing to settle the claim.

The **Company** reserves the right to have the **Insured** undergo any medical examination required and necessary at any time. He is required to undergo this examination within one month of being notified of this decision.

Except in the case of **total, permanent invalidity** recognised by the **Company**, the **Policyholder** and/or the **Insured** advises it, within thirty days, of any alteration in the level of **invalidity** along with any mitigation of the **invalidity** that allows the **Insured** to return to work, even partially.

In this case, the benefits are adapted from the date of the modification and any sums that the **Company** may have wrongfully paid must be reimbursed.

During **invalidity**, the **Company** reserves the right to have the **level of invalidity** of the **Insured** checked by its medical advisor or to request a detailed report from the **Insured's** general practitioner to see whether the **invalidity** still exists and whether or not its **level** has changed.

The costs of this report are paid by the **Company**.

4.7 Statement of invalidity

Based on declarations and the medical certificate, the **Company's** medical advisor assesses the reality, the level and the evolution of the **invalidity**.

It is stated that the social security legislation and case law do not apply under this additional cover.

The **Company** reserves the right not to follow the decisions to grant **invalidity** laid down by the social security medical control.

The claim will only be settled from the date of consolidation of the state of invalidity of the **Insured**.

4.8 Dispute

Any dispute over the state of health of the **Insured** is laid before a medical committee, who will hear both sides, made up of two medical assessors, one appointed by the **Policyholder** and/or the **Insured** and the other by the **Company**.

Failing agreement between these two doctors, they nominate a third medical expert with the role of arbitrating between them.

If one of the parties does not appoint a medical assessor or if the two medical assessors do not agree on the choice of the third, an appointment will be made by the President of the court in the district of the domicile of the **Insured**, at the request of the first party to take action.

Each party pays the fees of his assessor, the fees of the third assessor being shared equally.

4.9 Beneficiary

In the event of an **accident** or illness causing **invalidity**, the **Company**, unless agreed otherwise, pays the guaranteed benefits to the invalid **Insured**.

The **Company** undertakes, where there are several people **Insured**, to execute its obligation at the first recognition, by the **Company**, of the **invalidity** of one of these persons **Insured**.

4.10 Settlement of benefits

The **Company** pays the insured benefits against settlement receipt sent to the **Beneficiary** within thirty days of receiving the supporting documents required to settle benefits.

4.11 Duration of the cover

The right to the additional cover is conditioned by the existence of the main cover.

In the event of termination, reduction, surrender or cancellation of the main cover, the additional cover ends automatically.

The additional premiums relating to the period prior to the end date of the additional cover remain acquired by the **Company** for the financing of the risk covered.

Unless stated otherwise in the **specific terms and conditions**, the cover ceases without extending beyond the end of the insurance year during which the **Insured** reaches his 65th birthday.

5. Additional hospitalisation risk insurance

In addition to the principal cover the **Policyholder** has the option of taking out additional hospitalisation risk cover.

These provisions are applicable if the specific terms and conditions mention the additional hospitalisation risk insurance cover (ACCRHo).

The **insurance conditions** of the principal cover are applicable to this additional cover, insofar as the provisions below do not set them aside.

5.1 Definitions

The following meanings apply under this additional cover:

5.1.1 Accident

An **accident** is any sudden and fortuitous event caused directly by the action of an external force, beyond the control of the **Insured** and resulting in a physical injury showing objective symptoms.

Accidents include:

- drowning;
- injuries suffered when saving people or goods in peril;
- intoxications, asphyxia and burns resulting either from the involuntary ingestion of toxic or corrosive substances, or from the accidental leakage of gas or vapours;
- complications from initial injuries caused by a covered **accident**;
- rabies, anthrax and tetanus.

Suicide is not an **accident**.

5.1.2 Hospitalisation

Hospitalisation is any medically-required stay of more than 24 hours in a public or private hospital that has sufficient diagnostic and therapeutic resources and where only scientifically proved investigation and treatment methods are used during curative treatment.

The following are not considered as hospitalisation:

- stays in hospital for care and treatment of a congenital anomaly;
- stays in a hospital that also offers cures or which also admits convalescents, mainly convalescence homes, sanatoriums, nursing homes, spas, health resorts or any other comparable establishment;
- stays in a hospital of more than ninety days during the entire period of this cover, whether or not consecutive, for care and treatment of a tuberculosis-related **illness**, mental illness or comparable affliction;

- stays in a hospital for any reason beyond 180 days, whether or not consecutive;
- stays in hospitals as soon as the curative treatment no longer medically requires this in-patient status, or when the maintaining, keeping or assistance necessitated by the lack of mobility or mental **illness** of the Insured become predominant based on medical observations;
- days attending hospitals and military or prison sick bays whereas the curative treatment no longer medically required this in-patient status, in civilian life.

5.1.3 Pregnancy

Pregnancy covers the state of being pregnant, of giving birth and all the medical consequences and follow-up to childbirth.

5.1.4 Illness

Illness is any non-accidental alteration to the original health that can be checked by a medical examination. Pregnancy is not an illness.

5.2 Purpose of the cover

The **Company** undertakes to pay the **Beneficiary** a daily lump sum for the duration of the **hospitalisation** following an **accident**, **illness** or **pregnancy** before the fixed maturity of the cover, from the first day of **hospitalisation** up to a maximum of 180 days.

The ceiling for the daily indemnity is €50 per **Beneficiary**.

As soon as this cover takes effect, the **Company** covers the **hospitalisations** occurring following an **accident** or **illness.** Nevertheless, in terms of **hospitalisation** relating to childbirth or problems with **pregnancy**, the taking effect is deferred for nine months.

5.3 Limited cover

The cover is limited if the hospitalisation is the consequence of:

- burn-out;
- psychiatric disorders of somatic illnesses;
- functional psychic disorders and their consequences that cannot be made directly objective through organic repercussions.

The benefit insured for the hospitalisation caused by one of the afflictions mentioned above is limited for all these afflictions to ninety days, whether or not consecutive, maximum throughout the entire duration of the policy.

5.4 Premiums

5.4.1 Payment of premiums

In return for the additional commitments by the **Company**, the **Policyholder** pays the additional premiums. These premiums are payable at the same due dates and by the same methods as those relating to the main cover.

Their payment cannot be separated from that of the main cover.

5.4.2 Ceasing to pay premiums

At the end of each insurance period, corresponding to the last premium or split premium paid, the **Policyholder** can request in writing to cease paying premiums for the additional **hospitalisation** risk cover, independently of the main cover.

Ceasing payment of additional premiums results in the termination of this additional cover, which has no surrender or reduction value.

5.5 Territory covered

The commitments of this additional cover are acquired both in the Grand Duchy of Luxembourg and the border countries, provided that the **Company** can exercise normally the planned medical examination resources and subject to the exclusions described below.

5.6 Risks not covered

5.6.1 Risks always excluded

Apart from the excluded risks planned in the insurance conditions, the additional cover does not cover the hospitalisation resulting from:

- **attempted suicide, throughout the policy;**
- **acrobatics, wagers or challenges and generally any notoriously reckless act in which the Insured has taken part;**
- **natural disasters (earthquake, tidal wave, etc.);**
- **an accident occurring to the Insured when under the influence of a narcotic, hallucinogenic or other drug, or in a state of inebriation, or in a state of alcohol poisoning unless there is no causal link between the hospitalisation and these circumstances;**
- **allergic afflictions;**
- **chronic fatigue syndrome, spasmophilia or fibromyalgia and the accompanying afflictions;**
- **directly or indirectly drug addiction, including alcoholism and the abuse of medications;**
- **aesthetic treatment, unless it is repairing surgery following an accident or cancer;**
- **sterilisation, artificial insemination or in vitro fertilisation.**

5.6.2 Risks that can be insured

Unless agreed otherwise and provided any additional premium is paid, the additional cover does not apply to the hospitalisations occurring during:

- **the exercising of at-risk professions and professional activities, such as, for example:**
  - **seaman (oil tanker, lifeboat, submarine);**
  - **oil platform;**
  - **all underwater work;**
  - **descending into shafts, mines or quarries;**
  - **work on high-voltage installations;**
  - **work that could result in a fall of more than 4 metres;**
  - **work on scaffolding or roofing;**
  - **construction, maintenance or demolition of buildings or structures;**
  - **felling and/or pruning trees;**
  - **firemen;**
  - **special branch or anti-gang or anti-drug police officers;**
  - **armed personnel;**
  - **comprising the manufacture, processing or handling of chemical or biological substances;**
  - **comprising the manufacture, use or handling of fireworks or explosive or corrosive machinery and product parts;**
  - **comprising the transport of flammable or explosive materials;**
- **an accident to an aerial navigation device where the Insured was on board as pilot or crew member;**
- **the use of an aerial navigation device for competitions or exhibitions, speed trials, raids, training flights, records or record attempts and during any test to participate in one of these activities;**
- **the use, as a driver, of a 2- or 3-wheeled motorised vehicle with engine power greater than 50 cc;**
- **the exercising of at-risk sporting activities, such as, for example:**
  - **hunting;**
  - **the use and/or presence on board of a motorised ultra-light equipment, a helicopter, a balloon or an aircraft with less than eight seats;**
  - **practising any sport whatsoever as a professional or paid amateur;**
  - **off-piste skiing; ski jumping; bobsleigh; skeleton;**
  - **sailing or sail or motor yachting more than three nautical miles from the coast;**

- **mountaineering more than 3000 m above sea level, climbing cliffs or artificial walls without safety pitons, archaeological exploration and potholing;**
- **scuba diving with autonomous breathing apparatus, beyond 40 m;**
- **participating in or preparing for a sporting event on board any vehicle whatsoever;**[1]
- **automatic opening parachuting, parascending, paragliding, hang-gliding, gliding, parasailing;**
- **practising the following sports, including the preparation, in the context of a competition organised by an official federation or of any trial that is not exclusively for entertainment and occasional;**
    - **motorboating in competition (inshore and offshore);**
    - **competitive riding;**
    - **snow skiing;**
    - **combat sports and martial arts.**

5.7 Obligations in case of a loss

5.7.1 Declaration of a loss

Any **accident** or **illness** or **pregnancy** that has caused the hospitalisation of the **Insured** must be declared in writing to the **Company's** Secrétariat Médical – Vie Particuliers (Life Private Customers Medical Secretariat).

The declaration must be made within one month with effect from the occurrence of the hospitalisation, except following unforeseen circumstances or a case of force majeure when the declaration must be made as quickly as can be reasonably achieved, on pain of the benefit being reduced up to the loss suffered by the **Company**.

5.7.2 Information and documents to be supplied

The declaration is made subject to production of a medical certificate drawn up by the doctor or doctors who treated the **Insured.**

It states:

- the hospital,
- the exact cause,
- and the duration of the **hospitalisation** (admission and discharge dates).

In the event of **hospitalisation** following an **accident**, the medical certificate must be accompanied by a declaration indicating:

- the place, date, time, causes, nature and circumstances of the **accident**;
- names, first names and domiciles of any witnesses.

5.8 Statement of hospitalisation

Based on declarations and the medical certificate, the **Company's** medical advisor assesses the reality of the **hospitalisation**.

The **Company** reserves the option to have the **Insured** undergo any medical examination required and necessary at any time. The **Insured** is required to undergo this examination within one month of being notified of this decision. Should the **Insured** refuse to submit to the verification of his state of health by the **Company's** medical advisor or if the general practitioner's report is rejected, the **Beneficiary** of the cover cannot continue to assert a right to the benefit insured under this cover.

The lack of information and documents requested by the Company could lead to it suspending its decision and potentially refusing to settle the claim.

5.9 Dispute

Any dispute over the state of health of the **Insured** is laid before a medical committee, who will hear both sides, made up of two medical assessors, one appointed by the **Policyholder** and/or the **Insured** and the other by the **Company**. Failing agreement between these two doctors, they nominate a third medical expert with the role of arbitrating between them.

If one of the parties does not appoint a medical assessor or if the two medical assessors do not agree on the choice of the third, an appointment will be made by the President of the court in the district of the domicile of the **Insured**, at the request of the first party to take action.

Each party pays the fees of his assessor, the fees of the third assessor being shared equally.

5.10 Beneficiary

Unless stipulated otherwise, the **Insured** is presumed to be the **Beneficiary** of the daily indemnity granted by the **Company** under the additional **hospitalisation** risk cover.

5.11 Settlement of benefits

The **Company** pays the daily sums falling due within thirty days of receiving the supporting documents required to settle benefits.

5.12 Duration of the cover

The right to the additional cover is conditioned by the existence of the main cover.

In the event of termination, reduction, surrender or cancellation of the main cover, the additional cover ends automatically.

The additional premiums relating to the period prior to the end date of the additional cover remain acquired by the **Company** for the financing of the risk covered.

The cover ceases at the maturity fixed in the **specific terms and conditions**, without extending beyond the end of the insurance year during which the **Insured** reaches his 60th birthday.

6 Funeral repatriation assistance

These provisions are applicable if the specific terms and conditions mention the funeral repatriation assistance cover.

The term **Service Provider** used under this cover should be understood to be:
the assistance company INTER PARTNER ASSISTANCE (marketed under the name of AXA Assistance) European Group SA, approved under code 0487 to practise tourist insurance (Royal Decree of 4 and 13 July 1979 – Belgian Gazette of 14 July 1979), whose head office is at Avenue Louise 166, BP 1, 1050 Brussels, which undertakes to perform all the assistance services covered on behalf of the **Company**.

Personal data about the Insured that are communicated to the insurer under this policy are used for the purposes of insurance management, client management, controlling fraud and dispute management by **AXA Assurances Luxembourg** and by Inter Partner Assistance (marketed under the name of AXA Assistance), Avenue Louise 166, BP 1, 1050 Brussels and are likely to be transferred by it to service providers and sub-contractors that it calls on. These may be located outside the European Union, including, among others, AXA Business Services, for the data it compiles during assistance services.

Service Infoline - Round-the-clock assistance (+352) 45 30 55

6.1 Burial or cremation in the country of residence

If the family of the **Insured** opts for burial or cremation in the country of residence, the **service provider** will organise the repatriation of the mortal remains and pay for the following:

- costs of funeral arrangements;
- costs of placing the body in the bier locally;
- costs of a coffin up to a maximum of €650;
- costs of transporting the mortal remains from the place of death to the place of burial or cremation.

If the **Insured** was travelling abroad alone, the **service provider** organises and pays for the return travel of a family member or close friend to accompany the mortal remains.

The local hotel costs for this person will be paid by the **service provider** up to a maximum of €65 per night and per room for a maximum of two nights.

The costs of a ceremony and burial or cremation are not covered by the **service provider.**

6.2 Burial or cremation abroad

If the family of the **Insured** decides on a burial or cremation abroad, the **service provider** organises and pays for the same services as stated above.

In addition, the **service provider** organises and pays for the return journey of a family member or close friend residing in the country of residence to attend the burial or cremation.

The local hotel costs for this person will be paid by the **service provider** up to a maximum of €65 per night and per room for a maximum of three nights.

In the event of cremation abroad and a ceremony in the country of residence, the **service provider** pays for the costs of repatriating the urn to the country of residence.

The **service provider's** contribution is in any case limited to the assumed costs of repatriating the mortal remains to the country of residence.

The **service provider** has the exclusive right to choose the companies involved in the repatriation process.

6.3 Assistance with formalities

The service provider assists the family of the **Insured** regarding the following matters:

- getting in touch with an undertaker;
- help with writing the announcement of the death;
- help with the necessary formalities, especially with the local administration;
- searching for a real estate agency to deal with property assets.

6.4 Domestic animals

The **service provider** organises and takes charge of returning domestic animals (dog(s) or cat(s)) accompanying the **Insured.**

6.5 Sending urgent messages

If the members of the **Insured's** family so requests, the **service provider** sends urgent messages relating to matters covered by the insurance policy to anyone free of charge.

Generally speaking, sending messages is subject to justification of the request, a clear and explicit expression of the message to be sent and the precise indication of the name, address and telephone number of the person to be contacted.

Any text involving criminal, financial, civil or commercial liability will be sent at the sole responsibility of its author, whom it must be possible to identify. Its content must be subject to Luxembourg and international legislation and may not incur the liability of the **service provider.**

6.6 Minding children less than 16 years old

The **service provider** organises and pays for minding the **Insured's** children under 16 up to €65 per day for four days maximum.

For further details, contact your AXA Agent or your Broker

(+352) 44 24 24-1

www.axa.lu

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