Life Insurance

General Conditions Provident Insurance

January 2019

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UNDERSTANDING YOUR GENERAL CONDITIONS

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1. PREAMBLE AND PRODUCT NAME

These Terms and Conditions are intended to inform you about the terms and conditions that apply to the Provident Policy "BIL Protection Prêt Immo by AXA", hereafter called "**the Policy**" throughout these General Conditions.

2. PURPOSE OF THE POLICY

The main purpose of the Policy is to provide benefits in the event of the death of the Insured occurring during the period of cover of this risk (hereinafter "The Main Benefits").
The "BIL Protection Prêt Immo by AXA" Policy is a so-called "remaining balance" term whole-life insurance policy which primarily provides the payment of a decreasing capital sum in case of the death of the Insured, generally intended to provide the repayment of a loan the residual value of which is decreasing.
Supplementary Cover is also available as an option within the Policy in order to cover the Insured against the risk of accident or disability, against the risk of total or partial permanent disability. Depending on the cover taken out, a capital sum and/or an annuity is paid to the Beneficiary(ies) nominated in the Policy.

3. DATA SUBJECTS

The Policy is intended for Insurance Policyholders residing in the Grand Duchy of Luxembourg. It may also be offered to cross-border workers in the Grand Duchy of Luxembourg who are residents of France, Germany or Belgium.

4. THE LEGAL FRAMEWORK OF THIS POLICY

4.1. Regulatory and contractual framework

The Policy is a "temporary whole-life"-type life insurance policy.
It is governed by Luxembourg law (except in the case of application of another law) and falls under branch I. "Life, whole-life, insurance other than marriage and birth, not related to investment funds, as well as Supplementary Insurance for such insurance policies," of Annex II ("Classification by life insurance branch") of the Luxembourg Insurance Industry Law.
This Policy consists of the following documents:

- the Insurance Application Form together with all its annexes and any medical questionnaires, including the characteristics of the selected benefits and the risk assessment elements. It is completed and signed by the Policyholder (and the Insured if different)
- needs analysis: document accompanying the Insurance Proposal, specifying the Policyholder's needs and requirements and containing the recommendation of the Intermediary or the Company if applicable
- the General Terms and Conditions defining the terms and conditions that apply to the Policy, as well as the rights and obligations of each party to the Policy
- the Specific Conditions which specify the characteristics of the Policy and the cover taken out. These form the Policy and are signed by the Policyholder (and the Insured if different)
- if applicable, the Annex or the Information Note relating to provisions that apply to Insurance Policyholders who do not reside in Luxembourg
- any subsequent Amendment recognising any changes made to the Policy

4.2. Parties to the Policy

4.2.1. The Policyholder

The policy can be taken out by natural persons and – under certain conditions – legal persons.
When the Policyholder is also the Insured, the age limits set for the Insured (See 4.2.2) apply to the Policyholder.
If the policy is to be taken out in joint names the insurance application is to be completed and signed by both Policyholders.
If the policy is to be taken out in joint names the Policyholders jointly exercise all rights pertaining to the Policy. In the event of the death of one of the Policyholders, the Policy is settled on the first death if the Policyholders are also the Insured parties. Otherwise, the Policy shall continue until the death of the Insured, and all rights in the Policy shall be exercised by the surviving Policyholder.

4.2.2. The Insured

The Insured is the natural person upon whose life the covered risk is based. In general, the Insured is also the Policyholder.
If the Insured is not the Policyholder, his/her written consent is required for the Policy to be taken out. The same consent is required for any subsequent amendment to the Policy, under the penalty of invalidating the Policy.
If the Insured is a minor or incapable, his/her consent is validly given by his/her legal representative, it being specified that this authorisation does not exempt the personal consent of the incapable person when it is legally required.
The Policy can be taken out on the life of two Insured Persons. **In this case, it will be settled when the first Insured Person dies.**

4.2.3. The Beneficiary

The Beneficiary(ies) are the persons nominated in the Policy to receive the benefits owed by the Company in case of death or disability of the Insured Person.

4.2.4. The Company

The Insurance Company AXA Assurances Vie Luxembourg SA, located at 1 place de l'Étoile, L-1479 Luxembourg, which provides the insurance cover taken out under the Policy.

4.3. Obligations of the Insured Person

4.3.1. When taking out the policy

In order to enter into the Insurance Contract, the Policyholder (and the Insured Person if different) must complete and send an Insurance Application to the Company's registered office. This must contain his/her application, any health questionnaire(s) that may be applicable, and any other annex to enter into the Contract, accompanied by a copy of their valid, certified identity document.
He/she undertakes to declare exactly all circumstances which for the Company constitute elements for risk assessment.
He/she undertakes in particular to declare (without this list being exhaustive):

- his/her date and place of birth, his/her place of habitual residence, his/her profession and the conditions for practising this, his/her risky activities and sports
- functional sicknesses or disabilities with which he/she is affected
- Insurance Policy(ies) of the same nature that he/she has taken out elsewhere

Any intentional omission or inaccuracy that has misled the Company about for risk assessment shall invalidate the Policy taken out in accordance with the Insurance Policy Act. In addition, premiums due up to the moment the Company became aware of this omission or inaccuracy remain owed to it.
Where the omission or inaccuracy is not intentional, the Policy is not void. The Company may, within one month of becoming aware of the omission or inaccuracy, propose an amendment to the Policy, subject to a surcharge if applicable. On the other hand, if the Company provides proof that in any way it would not have insured the risk, it may terminate the Policy within the same period.

If at the end of a period of one month following receipt of the proposed amendment to the Policy, the Policyholder has not agreed to it, or if he/she refuses the proposed amendment, the Company may then terminate the Policy within fifteen days.
In the event of an incorrect declaration as to the age of the Insured, the benefits provided are maintained, but will be increased or reduced according to the actual age that should have been taken into consideration.

The Company may invoke any unintentional omission or inaccuracy in accordance with the principles described above, for a period of one year from the effective date of the Policy. Beyond this period, the Policy cannot be disputed by the Company.

4.3.2. During the Policy

During the Policy, the Insured agrees to notify the Company of any significant and lasting change (other than his/her state of health) affecting his/her situation and thus the insured risk, including:

- if he/she changes his/her profession, his/her activities or if he/she practices his/her profession under conditions other than those declared for taking out the Policy;
- if he/she practices risky activities and sports that are known to affect the insured risk;
- if he/she transfers his/her residence to a country outside the European Economic Area;
- if he/she travels to countries at risk (Point 4.4 Territorial Extent)

The provisions of the Insurance Policy Act apply in case of increased risk
If, during the period of validity of the Policy, the insured risk is exacerbated so that, if the exacerbation had existed at the time when the Policy was taken out the Company would only have agreed to the insurance under other conditions, it must, within one month from the day upon which it became aware of the exacerbation, propose that the Policy be amended retroactively to the day of the exacerbated. If, on the other hand, the Company provides proof that in any way it would not have insured the exacerbated insurance risk, it may terminate the Policy within the same period.

If, at the end of a period of one month following receipt of the proposed amendment to the Policy, the Policyholder has not agreed, or if he/she refuses the proposed amendment, the Insurer may then terminate the Policy within fifteen days.

4.4. Territorial Extent

The Principal and Supplementary Cover are provided throughout the world, provided that the Company can exercise medical monitoring methods and subject to the exclusions provided for in these General Conditions.
However, if the Insured is required to travel for business reasons to countries at risk, he/she must first inform the Company so that it can determine the conditions of coverage for these trips.
Similarly, if the Insured travels for personal reasons to countries at risk or for a continuous period of more than 60 days per year, other than the following countries: European Union countries, Australia, Canada, Japan, Switzerland, the United States, he/she must inform the Company so that it can determine the conditions of coverage for these trips.

5. EFFECTIVE DATE AND TERM OF THE POLICY

The Policy is formed by the signing of the Specific Conditions by the Policyholder and the Company.
A signed copy must be returned to the Company by the Policyholder. **If the Specific Conditions are not returned signed while premium(s) have been paid, the Policy shall be deemed formally accepted by the Policyholder and validly entered into.**
The Policy takes effect on the effective date indicated in the Specific Conditions, subject to the actual payment of the first premium and the acceptance of the risks (and subject to the application of a waiting period, if applicable).
The term of the Policy and the benefits it entails are set in the Specific Conditions.

6. RIGHTS OF THE POLICYHOLDER

6.1. Nomination and acceptance of the Beneficiary

Nomination

The Policyholder may, upon taking out the Policy, appoint one or more Beneficiaries in the event of the death of the Insured. Where the Beneficiary is named, the Policyholder may indicate their details, which will be used in the event of the death of the Insured.
As long as the Beneficiary has not accepted his/her nomination, the Policyholder may request a change to his/her beneficiary clause if it is no longer appropriate. However, the Policyholder must obtain consent:

- from the Beneficiary if the benefit has been previously accepted
- from the Insured if he/she is not the same as the Policyholder

Acceptance

The Beneficiary may formally accept his/her nomination. This right belongs to the Beneficiary alone and cannot be exercised by either his/her spouse or his/her creditors. **Acceptance by the Beneficiary renders his/her appointment irrevocable, such that the Policyholder may no longer revoke or amend his/her nomination without the prior consent of the accepting Beneficiary. More generally, he/she will not be able to carry out any operation on the Policy without the agreement of the accepting Beneficiary.**
The benefit is accepted by a tripartite endorsement to the Policy signed by the Insurer, the Policyholder (the Insured if different) and the accepting Beneficiary.

Default attribution rules for Beneficiary rights
In accordance with the provisions of the Insurance Policy Act, in the event of there being no Beneficiaries appointed by the Policyholder or if the clause chosen by the Policyholder becomes inapplicable, the insurance benefits will be owed by default to the Policyholder (if different from the Insured), or in case of death of the Policyholder, to his/her estate.
If more than one Beneficiary is appointed without the rules for assigning rights between them being specified and if one of them predeceases the other, the following rules shall apply:

- these are equal Beneficiaries
- in the event of a beneficiary's death, his/her share will be returned to his/her descendants based on the representation of heirs, and if there are no descendants so that representation does not apply, his/her share will be acquired by the surviving Beneficiary(ies) in equal portions

6.2. Right of redemption

At any time after the expiry of the withdrawal period, the Policyholder may request the total redemption of his/her Policy. To this end, he/she will send a written request to the Company accompanied by a copy of a valid identity card and a bank statement prepared in his/her name.
Redemption takes effect on the day the Policyholder makes the redemption request within a period of 30 days.
The surrender value is calculated on the date of receipt of the redemption request, except in the case of a monthly premium, in which case the surrender value will be calculated on the date of the end of the insurance period covered by the last premium paid or fraction of premium paid.
If a benefit has been accepted, the exercising of the right of redemption is conditional on the agreement of the accepting Beneficiary.
The total redemption terminates the Policy and all the benefits it contains.

6.3. Transfer of Rights

At any time, the Policyholder may request in writing to the Company that he/she transfer all or part of the rights resulting from the Policy taken out. If a benefit has been accepted, the exercising of the right of transfer is subject to the agreement of the accepting Beneficiary.
The transfer is effected by an amendment bearing the signatures of the Company, the Policyholder and the transferee. The consent of the Insured is also required.

6.4. Amendments to the Policy

The Policyholder may request that the Company amend the cover or features of his/her Policy based on forms issued by the Company.
Subject to the Company's prior approval, the amendment is made under the conditions in effect at the Company at that time and may be conditioned on the favourable outcome of medical examinations.
The amendment shall be endorsed by an endorsement bearing the signatures of the Company, the Policyholder and, where applicable, the Insured and/or the accepting Beneficiary.

7. PROVIDENT COVER

The Policy offers Principal Cover and optional Supplementary Cover.

7.1. Principal Cover

The Main Cover offered when each Policy is taken out is a **cover for the risk of death.**
Under the "BIL Protection Prêt Immo by AXA" Policy, in the event of the death of the Insured before the expiry date of the Policy, and before the Insured reaches the age limit of 80, the Company guarantees the payment of a death benefit to the appointed Beneficiary(ies). The guaranteed capital is a decreasing "outstanding balance" capital sum specified in the Specific Conditions.

7.2. Supplementary Cover

In addition to the Principal Cover, the Insured may take out one or more Supplementary Cover under the following conditions:

7.2.1. General rules

The right to purchase Supplementary Cover is conditional on the existence of the Principal Cover.
In the event of cancellation, redemption or cancellation of the Principal Cover, the Supplementary Cover automatically expires.
Supplementary Premiums relating to the period prior to the end date of the Supplementary Cover remain with the Company for the purpose of financing the hedged risk.
The Supplementary Cover ceases at the end of the Specific Conditions, without being able to exceed the date upon which the Insured reaches the age of 65.
Payment of benefits **as a capital sum** insured as Supplementary Cover terminates this Supplementary Cover.

7.2.2. Supplementary Accident Cover

In addition to the Principal Cover, the Policyholder has the option of taking out cover against the risk of Accident. These provisions apply if the Specific Conditions mention the Supplementary Cover for Accidents.

Purpose of the cover

The Company undertakes to pay to the appointed Beneficiary(ies) either of the following supplementary benefits, depending on the coverage taken out, where the Insured is the victim of an accident occurring either in his/her private or professional life, caused directly and exclusively from the accident, within one year:

- **the death of the Insured**
- **the total and permanent disability of the Insured**

In the event of a disability, insured benefits will only be paid:

- if the state of permanent disability is found while the coverage is in progress, i.e. at the latest before the Insured reaches the age limit of 65 years
- if the degree of disability retained is greater than or equal to 67%

The Company undertakes, if there is more than one Insured, to fulfil its obligation on the first death or the first recognition by the Company of the state of total and permanent disability of one of these Insured Persons.

Beneficiary

In the event of the death of the Insured, the Company pays the benefits insured under the Supplementary Cover to the Beneficiary(ies) appointed in the Policy. In the event of the simultaneous death of the two Insured Persons, the youngest Insured is presumed to have survived the oldest Insured.
In the event of an accident resulting in the total and permanent disability of the Insured, the Company proceeds, unless otherwise stipulated, with the payment of the insured benefits to the appointed Beneficiary. If there is more than one Insured, the insured benefit goes to the appointed Beneficiary as soon as the state of total and permanent disability is ascertained.

7.2.3. Supplementary Disability Risk Cover

In addition to the Principal Cover, the Policyholder has the option of taking out disability risk cover, the extent of which depends on the Policy taken out. These provisions apply if the Specific Conditions mention the Supplementary Disability Risk Cover.

Disability coverage available

Coverage available under the BIL Protection Prêt Immo by AXA

The Company undertakes to pay to the Beneficiary(ies) appointed in the Policy the insured benefits according to the formula provided for in the Specific Conditions, where the Insured is the victim of an accident or sickness which has occurred during either his/her private or professional life and resulting directly and exclusively from:

- **either total and permanent disability**
- **or partial and permanent disability, provided that it reaches a level equal to at least 25%.**

General rules

Regardless of the form of the Cover taken out, the insured benefits will only be paid in the event of the occurrence of a state of disability if:

- the state of disability is noted while the Coverage is in progress, i.e. before the date of expiry of the Policy and at the latest before the Insured reaches the age limit of 65 years
- in the event of permanent disability, the state of disability is consolidated

Physiological disabilities and economic incapacity already existing at the time the Supplementary Cover is taken out or resulting from an excluded risk cannot be taken into account for determining the degree of disability.

For Policies with two Insured persons, if both Insured persons are partially disabled, the levels are only accumulated insofar as each of the Insured persons can prove partial disability of at least 25%. Cumulative levels are only taken into consideration for a maximum of 100%.

The various forms of cover

a) Disability Annuity Cover

As part of this formula, the Company undertakes to pay an annual disability annuity to the Insured Person who, as a result of an accident or sickness, is suffering from a disability covered by his/her Policy.
The disability annuity is determined in proportion to the Insured Person's degree of disability.
In the event of permanent disability, the annuity does not take effect until the date of consolidation of the state of disability.
Unless otherwise agreed, the disability annuity paid may not exceed, on an annual basis, 80% of the average annual professional income of the Insured for the 3 calendar years preceding the date of the incident. If this limit is exceeded, the Company is entitled to reduce the annuity up to this limit and to reduce the premium proportionally, with effect within one month after becoming aware of this excess. The benefits already paid remain unchanged up to the date of reduction.
This 80% intervention limit is however not applicable if the annual insured annuity is less than or equal to €12,500.
The Company reserves the right to review these limits for any newly taken out policy or if there is an adjustment to the insured annuity, as well as the right to determine the minimum and maximum amounts of insured annuity.
The Policyholder is obliged to inform the Company in the event of a non-temporary decrease in income from the insured person's professional activity below the 80% limit defined above. The adjustment to the insured annuity and the premium take effect the month following acknowledgement of this reduction.
Any increase in the insured annuity is subject to prior acceptance by the Company.
The payment of the annuity ceases as closely as possible to the following dates:

- policy expiry date
- when the Insured reaches the age limit of 65

b) ACCRI – Waiver of Premiums

Under this formula, when the Insured suffers from a disability covered by his/her Policy due to an accident or sickness, the Company undertakes to pay premiums in proportion to the degree of disability in connection with the Principal Cover and any other Supplementary Cover, including taxes and fees.
The prorated premiums already paid by the Policyholder, relating to the indemnity period, are reimbursed by the Company at the earliest during the months of January, April, July or October.
The premium is due to the Company for any month started. In this case, a prorated amount of the monthly benefit is calculated according to the number of days compensated. The same occurs at the end of the period of disability or benefit for a month that is not completed, the calculation of the premium being due in proportion to the number of days indemnified. It is specified that a month is considered as containing thirty days.

c) Disability Cover decreasing Capital

Under this formula, when the Insured is permanently disabled as a result of an accident or sickness the Company agrees to pay to the appointed Beneficiary(ies) an amount corresponding to the decreasing insured capital of the Primary Cover.
The payment of the decreasing insured amount under this Supplementary Cover terminates the Primary Cover and the Policy.

Beneficiary

In the event of an accident or sickness resulting in a state of disability covered by the Policy, the Company shall, unless otherwise agreed, proceed with the payment of the guaranteed benefits to the appointed Beneficiary.
The Company undertakes, if there is more than one Insured, to fulfil its obligation as soon as the Company ascertains the state of disability of one of the Insured persons.

8. EXCLUSIONS AND LIMITATIONS OF COVER

8.1. Exclusions from death and disability risks (see Annex 1)

The Company covers all risks of death and disability of the Insured throughout the world subject to the **exclusions described in Annex 1**.
In the event of the death of the Insured as a result of the occurrence of an excluded risk, the Company pays the Beneficiary the surrender value, limited to the insured benefit in the event of death.
If the death of the Insured results from the intentional act of a Beneficiary, this surrender value is paid to the other Beneficiaries named in the Specific Conditions, according to the order established therein.

9. BENEFITS PROCESSING

9.1. Formalities to be completed in case of a claim

9.1.1. In case of death

a) Declaration of incident

The death of the Insured must be declared in writing to the Company's "Acceptation médicale Vie Particuliers" (Life Individuals medical acceptance) team.
In case of death by accident, the declaration must contain:

- the place, date, time, causes, nature and circumstances of the accident
- the surnames, first names and addresses of any witnesses
- any document likely to prove the cause-and-effect relationship between the accident and the death (police report, gendarmerie report, etc.)

In case of death by accident, the declaration must also be made within one month of the occurrence of the accident, except as a result of unforeseeable circumstances or force majeure making compliance with this deadline impossible, in which case the declaration must be made as quickly as reasonably possible, otherwise the benefits will be reduced to the extent of the loss suffered by the Company.

b) Documents and additional information to be provided

- a copy of the Insured person's death certificate,
- a post-mortem medical certificate mentioning the circumstances and the cause of death, written by the doctor(s) who treated the Insured after the accident or during his/her last sickness or, in the event of unexpected death, by the doctor who declared the death. If applicable, the certificate will mention the exact nature of the bodily injuries suffered as well as their probable consequences.
- an affidavit indicating the qualities and rights of the Beneficiaries if they have not been appointed by name
- in the event of an accident, the Company reserves the right to require the report recording the accident, as drawn up by the competent authorities

The Company reserves the right to request any documents it deems useful to establish the right to the benefit.

9.1.2. In case of disability of the Insured

a) Declaration of incident

Any accident or sickness that has caused the permanent disability of the Insured must be declared in writing to the Company's "Acceptation médicale Vie Particuliers" team.
The declaration must also be made **within one month** of the occurrence of the accident or sickness, except as a result of unforeseeable circumstances or force majeure making compliance with this deadline impossible, in which case the

declaration must be made as quickly as reasonably possible, otherwise the benefits will be reduced to the extent of the loss suffered by the Company.

The declaration shall indicate:
- the place, date, time, causes, exact nature and circumstances of the disability;
- the surnames, first names and addresses of any witnesses in the event of an accident.

b) Documents and additional information to be provided

The Policyholder and/or the Insured must attach to the declaration of incident any document, medical certificate or report likely to prove the existence and the degree of seriousness of the incident, in particular:
- a medical certificate from the Insured person's treating doctor(s), drawn up on the Company's standard form, specifying the date of occurrence, the causes, the nature, the degree and the presumed duration of the disability
- if the disability results from an accident, any document likely to prove the cause-and-effect relationship between the accident and the disability (police report, minutes of the competent authorities, etc.)
- in the event of permanent disability, the disability consolidation certificate
- as well as any other document requested by the Company to constitute the file.

In the absence of the information and documents requested by the Company, it may suspend its decision and possibly refuse to take charge of the incident.

c) During disability

Except in the case of total and permanent disability recognised by the Company, the Policyholder and/or the Insured shall notify it within thirty days of any change in their level of disability as well as any reduction in disability allowing the Insured to resume work, even partially.
In this case, the benefits are adjusted from the date of change and any sums that the Company may have paid wrongly must be paid back.

9.2. Medical examination

The Company reserves the right to require the Insured to undergo any medically necessary examination at any time. The Insured must attend it within one month of notification of this decision.
In the event of unjustified refusal by the Insured to undergo an examination, the Company may refuse payment of any benefits (future or current). The same applies if the Insured or the Beneficiaries use inaccurate documents or information, intended to mislead the insurer as to the causes, circumstances or consequences of an event.
During the period of disability, the Company reserves the right to have the Insured person's degree of disability verified through his/her medical adviser or to request a detailed report from the doctor treating the Insured in order to ascertain whether the disability still exists and its degree has not changed.
The costs of this report are borne by the Company.

9.3. Statement of disability

On the basis of the declarations of the Insured and the medical report provided by his/her doctor, the Company's medical adviser assesses the reality, the degree and development of the disability, as well as its permanent character.
It is specified that social security legislation and case law do not apply in the framework of Supplementary Insurance against the risk of disability. **The Company therefore reserves the right not to follow the decisions granting a permanent disability, whether partial or total, awarded by the social security medical examination.**
In the event of permanent disability, the settlement of the claim can only occur from the date of consolidation of the Insured person's state of disability.

9.4. Disputes

In the event of disagreement between the Company's medical adviser and that of the Insured as to the Insured person's degree of disability or more generally in the event of a dispute over the state of health of the Insured, the dispute is subject to a medical board composed of two medical experts, one appointed by the Policyholder and/or the Insured,

and the other by the Company. In the absence of agreement between these two doctors, they appoint a third medical expert whose role will be to decide between them.
If one of the parties does not appoint its expert or if the two experts do not agree on the choice of the third, the appointment is made by the President of the district court of the Insured person's domicile, upon request from either party.
Each party pays its expert's fees; the third expert's fees are divided in two.

9.5. Terms of payment of benefits

Capital benefits

The Company pays the insured benefits, against a payment receipt sent to the Beneficiary, within thirty days of receipt of the supporting documents necessary for the payment of benefits, and subject to the Insured person's compliance with the reporting period.

Benefits as disability annuity

Subject to receipt by the Company of all the supporting documents necessary for the payment of benefits, the disability annuity is calculated quarterly on 31 March, 30 June, 30 September and 31 December, and is paid the following month.
The disability annuity is due for any month that has started. In this case, a prorated amount of the monthly annuity is calculated according to the number of days compensated. The same occurs at the end of the period of disability or benefit for a month that is not completed, the calculation of the annuity being in proportion to the number of days indemnified.
It is specified that a month is considered as containing thirty days.

10. EVERYTHING ELSE YOU NEED TO KNOW

10.1. Termination of the Policy and termination of cover

10.1.1. Termination of the Policy

The Policyholder may terminate the Policy that has been taken out at any time by submitting a written request for redemption to the Company, in which case the Company will reimburse the Cash Value of the Policy and terminate the cover it includes.
The Insurer has the right to terminate a Policy in case of omission or aggravation of the risk under the conditions defined in article 1.5, or in case of non-payment of premiums relating to the Principal Cover, in the conditions referred to in Article 2.3 below

10.1.2. End of cover

Cover terminates upon the exercise by the Policyholder of his/her right of withdrawal, in the event of reaching the Insured person's age limit, in the event of death, in the event of total surrender, for the supplementary Insurance in the event of non-payment of insurance premiums, and in all the specific cases foreseen in connection with taking out a supplementary coverage (ACCRI Decreasing Capital in particular).

10.2. Premium payments

10.2.1. Determining premiums

In consideration of the Company's commitments, the Policyholder pays the premiums or fractions of premiums for which the amount, the method of payment and the duration of payment are specified in the Specific Conditions.

10.2.2. Premium payments

Principal Cover

Premiums are payable within ten days of the due dates specified in the Specific Conditions. The frequency of the premiums may be, at the option of the Policyholder, monthly, quarterly, semi-annually or annually.

Supplementary Cover

In return for the Company's additional commitments, the Policyholder pays additional premiums. These premiums are subject to the same deadlines and under the same conditions as those relating to the Principal Cover. Their payment is inseparable from those relating to the Principal Cover.

10.2.3. Cessation of payment of premiums

General rules

If the Company notes the non-payment of a premium or fraction of a premium within a period of 10 days following its due date, it shall send a formal notice by registered letter to the Policyholder's last known address reminding the Policyholder of the due date, the amount of unpaid premiums and the consequences of non-payment of the premium or fraction of the premium.
If the premium remains unpaid within 30 days of sending of the notice, the Company proceeds:

- either with the termination of the Policy by paying the surrender value if applicable (upon expiry of a 10-day period)
- or with a reduction in the cover provided by the Policy

If the Policyholder informs the Company in writing of his/her decision to cease payment of Policy premiums after the due date of an unpaid premium, the Company is exempt from formal notice.

Supplementary Cover

At the end of each insurance period, corresponding to the last premium or fraction of the premium paid, the Policyholder may request in writing to terminate the payment of the premiums for the Supplementary Cover that he/she has taken out, regardless of the Principal Cover.
The cessation of payment of premiums in relation to a Supplementary Cover entails the termination of the Supplementary Cover concerned whose redemption or reduction value is nil. The Principal Cover remains in effect.

10.2.4. Changes to premiums

Premiums may be adjusted during the Policy at the request of the Policyholder based on changes in the reported risk and the cover taken out. Apart from these situations, premiums may be subject to change in the event of legislative, regulatory and/or tax developments.

10.3. Incidental expenses and applicable taxes

Premiums are not subject to any tax in Luxembourg. For non-resident policyholders in the Grand Duchy of Luxembourg, premiums may however be subject to specific taxes depending on the legislation applicable in the Policyholder's country of residence. The Policyholder shall consult his/her intermediary or tax adviser before taking out any cover.

10.4. Information and communication

10.4.1. How do we keep you informed?

After acceptance of the Policy, the Company sends the Policyholder the Specific Conditions specifying the name of the Policy and the cover taken out.

10.4.2. Communication with the Company

All correspondence in connection with the Policy entered into is in principle done by written letter addressed to the Company's registered office.
All correspondence sent to the Policyholder by the Company will be sent by post to the address indicated in the Specific Conditions, or if applicable to the last home address which the Company has been notified of by post.
Unless otherwise instructed in writing, the Company may also communicate with the Policyholder, the Insured or the Beneficiary(ies) by e-mail if they have a valid e-mail address and have sent it to the Company for communication purposes. However, the Company can never guarantee the security and reliability of electronic communications, and reserves the right not to use such means of communication when it deems it inappropriate or not secure enough.
The Policyholder is obliged to inform the Company in writing as soon as possible in the event of a change in his/her personal situation, such as a change of tax residence, or a change of postal or electronic address, providing any supporting documents required by the Company.
If there is more than one Policyholder, any communication made to the address indicated in the Specific Conditions by the Company, or to the last home address which it has been informed of, is enforceable with respect to all Policyholders.

10.5. Redemption Values, Reduction Values and Policy Loans

The Supplementary Cover taken out does not include any Redemption or Reduction Value, with the exception of Disability Risk Insurance, Decreasing Capital formula (ACCRI Decreasing Capital).
The Principal Cover in the event of death and the ACCRI Decreasing Capital Supplementary Cover have a surrender value, the amount of which is included in the Specific Conditions. The Company determines the surrender value in accordance with the technical note prepared for each Policy and notified to the Commissariat aux Assurances. The Company does not make any advance on the Policy.

10.6. Right of withdrawal

If the Subscribed Policy has a duration of more than 6 months, the Policyholder may withdraw from the effects of the Policy within a period of 30 days from the moment he/she is informed of the conclusion thereof. The Policyholder is deemed to be informed of the conclusion of the Policy on the day he/she receives his/her Specific Conditions.
The withdrawal, addressed to the Company by registered letter with acknowledgement of receipt, has the effect of freeing the parties for the future from any obligation arising from the Policy.
The premium paid, less the amounts used to cover the risk, is reimbursed within 30 days of the date of receipt by the Company of the withdrawal request.

10.7. Limitation

The limitation period for any proceedings deriving from the Insurance Policy is three years. The period runs from the day of the event that opens the proceedings. However, when the person to whom the proceedings belong proves that he/she was not aware of this event until a later date, the period does not begin to run until that date, without being able to exceed five years from the date of the event, cases of fraud excepted.
With regard to the Beneficiary's proceedings, the limitation period runs only from the day on which he/she becomes aware of both the existence of the Policy, his/her status as Beneficiary and the occurrence of the event on which the payment of insurance benefits depends.

The Insurer's proceedings for recourse against the Insured or the Beneficiary is limited to three years from the date of payment by the Insurer, cases of fraud excepted.

10.8. Complaints

If, in spite of the efforts made by the Company to resolve any problems that may arise during the Policy, the Policyholder has not obtained a satisfactory answer, he/she is invited to submit his/her complaints in writing to the Company's General Manager at 1 place de l'Étoile, L-1479 Luxembourg.
He/she may also apply to the mediation body set up on the initiative of the Association of Insurance Companies at the following address: ACA – c/o Médiateur en Assurance – BP448 L-2014 Luxembourg, or directly to the Commissariat aux Assurances, 7 boulevard Joseph II, L-1840 Luxembourg, without prejudice to the possibility of taking legal action.

10.9. Applicable law and competent jurisdiction

Policies are in principle governed by Luxembourg law.
Any legal action relating to Policies is the exclusive jurisdiction of the Courts of and in Luxembourg, without prejudice to the application of international treaties and agreements.

10.10. Language of the Policies

The Policy and the documents relating thereto are in one of the official languages of the Grand Duchy of Luxembourg (French or German). However, they may be written in English if the Policyholder so requests in writing.

10.11. Applicable tax regime

All taxes, duties and contributions, present or future, that are applicable to the Policies or amounts due or to be due, are payable by the Policyholder, his/her successors in title or the Beneficiary.
The tax regime applicable to the Policies depends on the law applicable in the Policyholder's country of residence. If the Policyholder is resident in the Grand Duchy of Luxembourg, the Luxembourg tax system applies to the Policies.
The Company makes a Tax Notice describing the Luxembourg tax regime applicable to the Policies available to the Policyholder. This leaflet is provided as an indication in accordance with the legislation in force and does not claim to be exhaustive. For any further information, it is recommended that the Policyholder **take advice from a tax advisor**.

11. PERSONAL DATA PROTECTION

The data controller

AXA Assurances Vie Luxembourg SA is responsible for the processing of personal data that is communicated to it in connection with taking out / accepting the Insurance Policy or later in the context of the execution of the Insurance Policy. It has appointed a Data Protection Officer specifically responsible for all data protection matters within the Company.

Processing of data of a personal nature or personal data

The processing of personal data generally refers to all transactions carried out by the Company or not, using automated processes and applied to data or sets of personal data, such as the collection, recording, organisation, structuring, preservation, adaptation or modification, extraction, consultation, use, communication by transmission, dissemination or any other form of provision, reconciliation or interconnection, limitation, erasure or destruction. All personal data will be processed in accordance with applicable Luxembourg law and European regulations concerning the protection of the individual with regard to the processing of personal data.

Data subjects

The Company may process the personal data of the following persons or categories of data subjects:

- persons interested in the Insurance Policy: in particular Policyholders, the Insured or Affiliates, Beneficiaries, rightful claimants, third parties, heirs, guardians, administrators, controllers, etc.
- the parties to the Policy: in particular insurance intermediaries (insurance agents, insurance brokers, intermediaries on an ancillary basis), managers, service providers (experts, doctors, lawyers, etc.)

This list is not exhaustive. Only the Company's register is authentic.

Categories of personal data

The Company may process all the data that is generally necessary and relevant to the assessment of risk, evaluation of the damage, or the proper performance of the purposes of the processing, and in particular, depending on the nature of the Insurance Policy taken out, the main categories of personal data:

- data to identify the data subjects (identity, marital status, address, country of tax residence, tax number, nationality, etc.);
- supplementary data relating to the personal, family, economic and financial situation of the Policyholder and/or the Insured/Affiliate, data relating to his/her lifestyle (sports activities, leisure, travel, etc.) as well as data concerning his/her professional situation;
- sensitive data concerning the physical and/or mental health of the Insured/Affiliate.

This list is not exhaustive. Only the Company's register is authentic.

Purposes of processing and legal basis of processing

Purposes (non-exhaustive list - only the Company's register is authentic)
Personal data is collected and processed in particular for the purpose of:

- customer needs and requirements analysis
- risk assessment;
- the preparation, conclusion and management of Policies;
- executing Policies;
- the settlement of claims;
- prevention of fraud;
- the development of statistics and actuarial studies;
- the management of complaints, claims and litigation;
- customer management and commercial prospecting where applicable;
- compliance with and the fulfilment of legal obligations with regard to the regulatory and administrative provisions in force (in particular the fight against money laundering and the financing of terrorism, tax levies, regulatory reporting, etc.).

Legal bases of processing

The processing of personal data for the purposes described above is based on at least one of the following legal bases:

- the processing is necessary for the execution of the Insurance Policy to which the data subjects are parties or involved, or for the performance of pre-contractual measures taken at the request of the data subject or subjects;
- the processing is necessary to meet legal obligations to which the Company is subject;
- the processing is necessary to safeguard the vital interests of the data subjects or another natural person;
- consent in the cases specified below.

The consent of the data subject is also required for:

- the processing of data relating to the health of the data subject for all the purposes described above;
- the processing of data for commercial prospecting purposes.

Recipients or categories of recipients of personal data

Personal data may be transmitted to the following categories of persons, subject to the strict limits and conditions laid down by the Luxembourg law on the confidentiality of insurance (see Article 300 of the law of 7 December 2015 on the insurance sector):

- insurance intermediaries (insurance agents, insurance brokers and intermediaries on an ancillary basis) and other partners of the Company;
- the Company's service providers and subcontractors, to the extent necessary to perform the tasks assigned to them;
- other entities of the insurance group to which the Company belongs;
- the Company's reinsurer(s), statutory auditors and auditors;
- people involved in the insurance Policy such as lawyers, experts, medical advisers, etc.;
- and more generally any person or authority (administrative, fiscal or judicial) to whom the law imposes or authorises the transmission of personal data, under the conditions and limits prescribed by law.

This list is not exhaustive. Only the Company's register is authentic.

Transfer of data outside the European Union

Personal data may be transferred to a country outside the European Union in the following permitted cases, and within the strict limits and conditions laid down by the Luxembourg law on insurance secrecy:

- the transfer is made to a country providing an adequate level of protection as endorsed by the European Commission or assessed by a competent authority;
- the transfer is governed by the standard contractual clauses adopted by the European Commission;
- the transfer is made to an AXA Group entity that has signed the binding corporate rules that guarantee a sufficient level of protection;
- the transfer is authorised under one of the exceptions set out in Article 49 of the European Data Protection Regulation (particularly in the case of the data subject's express consent, for the performance of the Insurance Policies, for the safeguarding of human life, for the recognition, exercising or defence of rights in court).

Only relevant data can be transferred with regard to the purpose pursued by the transfer.
In order to guarantee the legitimate processing of personal data, the Company undertakes before any transfer or upon request of the data subjects, to provide complete information on the purpose, the nature of the data, and the recipient country or countries.

Subcontracting certain processing operations abroad

In accordance with the principles described above, and in compliance with the conditions and limits set by the law on the insurance sector, you are informed that the Company may subcontract the following processing services and operations to external or intra-group service providers:

- the filtering of the customer name databases (policy applicants, Insured persons and Beneficiaries) in the light of the monitoring lists put in place as part of the fight against money laundering and the financing of terrorism, in accordance with the legal obligations incumbent on the Company
- type of provider: intra-group companies
- type of data provided to providers: personal data identifying the data subjects
- country where the providers are established: intra-group (France and Belgium) and outside the European Union (India)

The outsourcing of the transactions described above is always subject to the signature by each provider of a confidentiality agreement concerning the personal data to which it has access. Any subsequent modification in connection with the outsourcing of the operations described above or any new data transfer to a subcontractor located abroad which would be necessary in view of the purpose of the processing, will be the subject of a written communication from the Company, either by way of an addendum to the General Terms and Conditions or by separate notification, in accordance with the general communication principles referred to above.

Register of personal data

The Company maintains a register listing data subjects, the categories of personal data subject to processing, the recipients and categories of recipients, and the purposes of the processing. In the event of a discrepancy between the provisions of this clause and the contents of the register, the latter shall prevail.

Duration of data conservation

The personal data will be kept by the Company in a form allowing the identification of the data subjects for the duration required for the purposes for which they are collected and processed. In general, they will be kept as long as necessary to allow the Company to comply with its legal obligations, to respect the limitation periods resulting from applicable laws, and more generally to find, exercise or defend its rights in court.
The Company shall take the necessary measures to ensure the security of the processing of personal data.

Rights of data subjects

Data subjects have the right to access their personal data, to request its correction or under certain conditions its erasure, the limitation of its processing as well as its portability.

a. Right of access and modification

Any data subject has the right to access his/her personal data held by the Company as well as a reminder of all the following information: the purposes of the processing, the categories of personal data concerned; the recipients or categories of recipients to whom the data has been or will be communicated, the length of time the data is stored, and all the rights of the data subject in relation to that data.
The Company will always verify the identity of the person requesting access to his/her data before responding to a request.
Any data subject also has the ability to request, without undue delay, the rectification of data that proves to be inaccurate or to have incomplete data completed.
The Company will ensure that the desired information is provided or that the desired change is made within one month of receipt of the request.
The right of access and/or modification is in principle free of charge for data subjects unless this represents too heavy a burden for the Company in which case payment may be required.

b. Right to withdraw consent

Anyone who has expressly consented to the processing of his/her personal data, in particular in the situations referred to in the section on the “legal bases of processing”, may withdraw this consent at any time. The withdrawal of consent does not have retroactive effect and does not call into question processing based on consent made prior to the withdrawal.

c. Right to be forgotten

Any data subject has the ability to get the Company to delete the data of which he/she is the subject without undue delay when:

- the data is no longer necessary for the purpose of the processing
- the data subject withdraws the consent upon which the processing was based (and there is no longer any other legal basis for the processing of the data)
- erasure is necessary to comply with a legal obligation incumbent upon the Company

The Company shall notify the data subject of any deletion of personal data.

d. Right to restriction of processing

Any data subject may request that the processing of his/her personal data be limited in the following cases:

- the data subject disputes the accuracy of the data in question and requests suspension of processing in order to enable the data controller to verify the quality of the data
- the data subject does not wish to have the data deleted, but merely to restrict its use
- the data is obsolete but is needed by the data subject to establish, exercise or defend his/her rights in court

The Company will notify the data subject of any limitation to his/her personal data.

e. Right to data portability

Any data subject has the right to receive personal data of which he/she is the subject in a structured, commonly used and machine-readable format, and has the right to transfer this data to another controller without the Company being able to oppose this.
They may also request that their personal data be transmitted directly by the
Company to another controller, where technically possible.

f. Exercising of rights

Any data subject may exercise these rights by sending to the Company, for the attention of the Delegate for the Protection of Personal Data, either a written, dated and signed request, accompanied by a copy of the front and back of his/her currently valid identity document, or an e-mail to the following address: dpo@axa.lu.

Complaints

Any complaint in connection with the processing of personal data may be addressed to the National Commission on the Protection of Personal Data (CNPD), Complaints Service, 1 avenue du Rock'n'Roll, L-4361 Esch Sur Alzette.

12. CONFLICTS OF INTEREST

A conflict of interest may be defined as "any professional situation in which the discretion or decision of a person, firm or organisation may be influenced or impaired in its independence or integrity by personal considerations or by a power of pressure from a third party."
For the purpose of detecting conflicts of interest that may arise in the course of its business, including in the context of the distribution of insurance and which involve the risk of harming the interests of a customer (Policyholder, Insured or Beneficiary), the Company is required to assess whether it, its officers and staff, its insurance agents or any person directly or indirectly related to it by a control relationship, have an interest in the result of this activity when this interest:
1) is distinct from the customer's interest
2) or may potentially influence the outcome of distribution activities to the detriment of the customer.
The Company must proceed in the same manner to identify conflicts of interest between one customer and another.
In this context, the Company has put in place a set of organisational and administrative measures to identify, prevent, monitor and manage all conflict of interest situations that may adversely affect the interests of its customers, including – but not exclusively – when marketing an Insurance Policy.
When it is determined that certain organisational and administrative measures are not sufficient to ensure that a conflict of interest will be avoided or that it is not possible to effectively manage the conflict of interest, the Company will undertake to inform the Customer of the nature and source of the conflict of interest concerned in good time before the conclusion of the Insurance Policy.
The conflict of interest policy put in place by the Company is available on request or can be consulted directly on the website www.axa.lu.

13. REMUNERATION, COMMISSIONS AND BENEFITS

General principle

The Company undertakes that the remuneration policy put in place for the benefit of its staff, its insurance agents and, more generally, the intermediaries in charge of the distribution of its insurance products, does not impair their ability to act in the best interests of its Customers, or dissuade them from making an appropriate recommendation or presenting information in an impartial, clear way that does not mislead.

Commissions and benefits

The Policyholders and Insured Parties are informed prior to the conclusion of a Policy of the nature of the remuneration received by the insurance intermediaries in connection with the distribution of an Insurance Product, or by Company staff in the case of direct sale.
In particular, insurance intermediaries may receive remuneration in the form of an insurance commission generally included in the insurance premium in relation to the Policies it markets.
In the case of direct sales, the Company's staff is paid in the form of a salary. They receive no commission directly related to the sale of an Insurance Policy.
Insurance intermediaries and the Company's staff are otherwise likely to receive other forms of remuneration, in the form of monetary or non-monetary benefits, subject to compliance with the general principle referred to above.

14. COMPANY CREDIT REPORT

The report on the solvency and financial position of the Company, as required under the Insurance Industry Act, is available upon request from the Company.

ANNEX 1: EXCLUSIONS

1. GENERAL EXCLUSIONS

The death or disability of the Insured are always excluded from the Principal (Death) and Supplementary (Accident and Disability) Cover when this results:

- from the suicide of the Insured less than one year after the conclusion of the Policy or its reinstatement; the same principle applies in the event of an increase in the insured benefits, when this increase occurs and during the year following this increase
- from an intentional act by the Insured or on the Instigation of the Policyholder or a Beneficiary or any other person directly or indirectly having any interest in the Policy, except in the case of self-defence or the fulfilment of a professional duty
- from war or similar events, if there is a direct or indirect relationship between the death and/or disability of the Insured and any offensive or defensive action by a belligerent power
- directly or indirectly from riots even if unplanned, violent demonstrations, civil unrest or any organised acts of violence (including nuclear, bacteriological or chemical terrorism) for ideological, political, economic or social purposes, carried out individually or in groups, damaging or destroying property, with or without rebellion against the authorities
- from any judicial conviction leading to the death penalty or being immediately and directly responsible for an intentional offence or crime which the Insured committed or jointly committed and whose consequences he/she was able to foresee
- from the consequences of the radioactive, toxic and explosive properties of nuclear fuels or radioactive waste
- from bungee-jumping

2. SUPPLEMENTARY EXCLUSIONS IN RELATION TO ACCIDENT COVER

The death or total and permanent disability of the Insured are excluded from the Supplementary Accident Risk Cover when this results:

- from an attempt by the Insured to commit suicide, throughout the duration of the Policy
- from the consequences of acrobatic exercises, betting or challenges and generally of any act known to be reckless in which the Insured may have participated
- from the fact that the Insured was either under the influence of a narcotic drug, hallucinogen or other drug, or was drunk or otherwise intoxicated by alcohol unless there was no causal relationship between death or total and permanent disability and these circumstances
- natural disasters

3. SUPPLEMENTARY EXCLUSIONS RELATING TO THE DISABILITY COVER

The Insured party's disability is excluded from the Supplementary Disability Risk Cover, when it results:

- from an attempt by the Insured to commit suicide, throughout the duration of the Policy
- from the consequences of acrobatic exercises, betting or challenges and generally of any act known to be reckless in which the Insured may have participated
- from the fact that the Insured was either under the influence of a narcotic drug, hallucinogen or other drug, or was drunk or otherwise intoxicated by alcohol unless there was no causal relationship between death or total and permanent disability and these circumstances

- allergic conditions
- chronic fatigue syndrome, hyperventilation syndrome, or fybromyalgia and associated conditions
- plastic surgery, unless this is restorative surgery following an accident or cancer
- sterilisation, artificial insemination or in-vitro fertilisation

Psychological disorders cannot give rise to any cover for total and permanent disability.

4. RISKS GENERALLY EXCLUDED FROM THE PRINCIPAL COVER (DEATH) BUT WHICH MAY BE COVERED

The death of the Insured is excluded from the principal death cover as a result of the following risks and events, except in case of express agreement by the Company, and against payment of a premium surcharge

- an accident to an aircraft on board which he/she has taken a seat as a pilot or a member of the crew
- the use of an aircraft for competition or exhibition purposes, speed tests, raids, training flights, records or record attempts, and during any attempt to participate in any of these activities
- the exercising of a risky sport such as hang-gliding, microlight flying, parascending or parachuting

5. RISKS GENERALLY EXCLUDED FROM COVER BUT WHICH MAY BE COVERED

Death, accident or disability are excluded, as are death or disability resulting from the following risks and events, except with the express agreement of the Company, and against payment of a premium surcharge:

- the practice of risky occupations and professional activities such as, for example:
  - marine (tanker, lifeboat, submarine);
  - oil rig;
  - any work under water;
  - descent into wells, mines or quarries;
  - work at high voltage installations;
  - work that may result in a fall of more than 4 metres;
  - work on scaffolding or roofing;
  - the construction, maintenance or demolition of buildings or structures;
  - tree felling and/or pruning;
  - firefighters;
  - special brigade, anti-gang or anti-drug police officers;
  - armed personnel;
  - involving the manufacture, processing or handling of chemical or biological substances;
  - involving the manufacture, use or handling of fireworks or explosive or corrosive devices and products;
  - involving the carriage of flammable or explosive materials.
- an accident to an aircraft on board which the Insured has taken a seat as a pilot or a member of the crew
- the use of an aircraft for competition or exhibition purposes, speed tests, raids, training flights, records or record attempts, and during any attempt to participate in any of these activities
- the use, as a driver, of a self-propelled vehicle with two or three wheels, the cubic capacity is greater than 50cc
- the exercising of risky sports activities such as, for example:
  - hunting;
  - the use and/or presence on board a microlight, helicopter, hot-air balloon or aeroplane with fewer than eight seats;
  - the practising of any sport as a professional or paid amateur;
  - off-piste skiing; ski jumping; bobsleigh; skeleton bob;

- sailing, yachting or motor yachting more than three nautical miles from shore;
- mountaineering higher than 3000m above sea level, climbing cliffs or artificial walls without safety hooks, archaeological and cave exploration;
- scuba diving with a self-contained breathing apparatus, below 40m;
- participation in or preparation for a sporting event in any vehicle;
- parachuting with automatic opening, parachuting, parascending, paragliding, hang gliding; gliding, para-sailing;
- the practising of the following sports, including preparation, as part of a competition organised by an official federation or as part of any event that is not of a purely recreational and occasional nature;
- competitive motor boating (inshore and offshore);
- competitive horse riding;
- skiing on snow;
- combat sports and martial arts.

ANNEX 2: DEFINITIONS

Accident

An accident is any sudden and unforeseen event caused directly by the action of an external force, foreign to the will of the Insured and causing a bodily injury with objective symptoms.
The following are deemed to be accidents:

- drowning
- injuries sustained while rescuing people or property in danger
- poisoning, asphyxiation and burns resulting from the involuntary absorption of toxic or corrosive substances or the accidental release of gases or vapours
- complications to initial injuries produced by an accident that is covered
- rabies, anthrax and tetanus

Suicide is not an accident.

ACCRA

Supplementary insurance against the risk of accident.

ACCRI

Supplementary insurance against the risk of disability.

Insured person

The person on whom the risk of the insured event is based.

Insurer

The company AXA Assurances Vie Luxembourg SA, 1 place de l'Étoile, L-1479 Luxembourg, with which the Policy is concluded.

Beneficiary

The person or persons appointed in the Policy to receive the benefits provided in the event of death or disability.

Policy

The Policy refers to the "BIL Protection Prêt Immo by AXA" insurance Policy.

Consolidation

Stabilisation of a state of health after an accident or sickness, leaving residual effects and no longer susceptible to aggravation or significant change, thus giving it a permanent character. Consolidation is established by the Company's medical adviser.

Waiting period

Period beginning on the effective date of the Supplementary Disability Risk Cover during which the risk is not covered.

Delay period

Period between the date of recognition of the disability giving the right to compensation and the actual commencement of such compensation.

Legal address

The legal address is the main and usual place of residence of the Policyholder and/or the Insured (Luxembourg, France, Belgium, Germany).

Intermediary

The natural or legal person with authorisation to act as an insurance agent or insurance broker, involved in the conclusion and/or management of the Policy.

Disability

Any physical or mental condition of the Insured, resulting from an accident or sickness, completely or partially reducing his/her work capacity assessed according to his/her profession, declared in the Specific Conditions and always exercised at the time of the incident.
Disability refers to both physiological disability and economic incapacity.

Degree of Disability

The degree of disability is determined by the highest of the rates selected for physiological disability and economic disability respectively.

Physiological disability

Physiological disability corresponds to a decrease in the physical integrity of the Insured resulting from an accident or sickness. The physiological disability rate is set as determined by experts.

Economic (or professional) incapacity

Economic incapacity is a reduction in the Insured person's working capacity, as a result of the physiological disability he/she is suffering from. Its degree is determined by medical decision taking into account the Insured person's profession and his/her possibilities of rehabilitation in any professional activity compatible with his/her knowledge, experience and aptitudes. The assessment of this degree of disability is therefore independent of any other economic criteria.
Economic incapacity is assessed according to normal economic conditions.
Maternity and paternity leave, and any statutory period banning work or imposing rest are not considered an economic disability. Complications related to pregnancy are covered, as well as disability that may result from childbirth.

Partial Disability

Partial disability is where the degree of economic or physiological disability is less than 67%. We only consider disability if it reaches at least 25%.

Full disability

Disability is considered total when the degree of economic or physiological disability reaches at least 67%.

Permanent disability

Any physical or mental condition of the Insured resulting from an accident or sickness, partially reducing or totally eliminating his/her capacity to work in a permanent manner and in a manner presumed to be definitive, assessed according to his/her profession declared at the time of taking out the Policy and still exercised at the time of the incident.
The permanent character of the disability cannot be admitted as such before the consolidation of the Insured person's state of health and the formal establishment of the permanence of this disability by the Company's medical adviser.

Permanent total disability

Total and permanent disability is a disability, the degree of which reaches at least 67%, making it impossible for the Insured to continue practising his/her profession or to rehabilitate himself, under normal economic conditions, to any profession corresponding to his/her knowledge, experience and abilities.

Sickness

Sickness is any change to health of a non-accidental origin that can be assessed by a medical examination. The state of pregnancy is not a sickness.

Pre-insurance

Insurance cover granted during the period between the effective date of the loan and the date of the first repayment of the loan.

Premium(s)

Payment(s) made by the Policyholder in consideration for the commitments made by the Company under the Policy.

Limitation

Termination of a right after a specified time.

Relapse

Relapse is any new disability that occurs within three months after the end of coverage for a temporary disability covered by the insurance and caused by the same sickness or accident.

Reduction

Reduction of the amount of the Principal Cover in case of cessation of payment of premiums.

Professional income

For professionals and other self-employed persons, professional income is the net income, which is the profit generated by the activity indicated in the Insurance Application (see the income tax law of 04/12/1967). For employees, professional income is the gross remuneration included on the salary certificate.

Your contact person at AXA

Find all of your policy documents
and services at **MYAXA**
axa.lu

AXA answers your questions here:

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