swisscare

International student health insurance Europe (EU / EEA)

General Insurance Conditions ISIE-GIC-012023

Insured by

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Insured by

ANKER INSURANCE

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Insured by

ANKER INSURANCE

Important information

The Insurer
Anker Insurance Company n.v., having its registered office at Paterswoldseweg 812 at 9728 BM Groningen, in these policy conditions referred to as "Anker". Anker is registered with the Autoriteit Financiële Markten (AFM) (the Dutch Authority for the Financial Markets) under number 12000661 and is authorised by De Nederlandsche Bank ("DNB").

The Assistance Provider and Alarm Service
B.V. Nederlandse Hulpverleningorganisatie - SOS International, Rietbaan 40, 2908 LP, Capelle aan den IJssel, The Netherlands, is responsible for medical assistance during the insurance period or in the frame of other events enumerated in the insurance contract. The coverage and the conditions are determined by the insurance contract, any additional written agreements, the GIC's as well as the applicable legal provisions in force.

The GIC's are to be applied. On behalf and on request of the insurer, B.V. Nederlandse Hulpverleningorganisatie - SOS International provides emergency assistance and access to the insured persons.

Claims Department
De Goudse Verzekeringen, Bouwmeesterplein 1, 2801 BX Gouda, The Netherlands is responsible for handling the claims on behalf of the insurer.

Compliance
The insurers products and services may not be available in all jurisdictions and are expressly excluded from this policy where prohibited by applicable law, including but not limited to, anti-corruption laws and economic sanctions programs. Any such coverage will be null and void. The Studentpass policy does not replace participation in a state-run or local health insurance scheme or compliance to any other legislative requirements of any country whatsoever.

The insurer and policyholder/insured agree that, except as explicitly stated in the present GIC's of the insurance policy, nothing of value has been offered or provided by either of them or anyone acting on their behalf, in relation with this insurance policy.

Order of precedence of the clauses of the GIC's
The general clauses are only valid insofar as they are not contradicted by or in conflict with the provisions and clauses of the different types of coverage. In case of contradictions or conflict, the clause of the specific coverage shall prevail over the general clause.

1. Definitions

1.1 Who is the insurer?
Anker Insurance Company n.v., having its registered office at Paterswoldseweg 812 at 9728 BM Groningen, in these policy conditions referred to as "Anker". Anker is registered with the Autoriteit Financiële Markten (AFM) (the Dutch Authority for the Financial Markets) under number 12000661 and is authorised by De Nederlandsche Bank ("DNB").

1.2 Who is the policyholder?
The natural person or legal entity applying for and concluding the insurance policy on his/her own behalf or on behalf of a third party, and, who, as a result, is liable to pay the insurance premium.

When the insurance is taken out for a third party the insured is the sole beneficiary. Any commitments the policyholder may have made to third parties have no effect on the parties of the contract, even if those commitments have influenced its signing.

1.3 Who is the insured?
The person who will benefit from insurance coverage.

The generic term "insured" and any correlative terms will be used indiscriminately in the following text to refer to both genders.

The insurance applies solely to persons or groups of persons, who are nominated as beneficiaries in the insurance contract or on a nominative list that is part of the insurance contract. The minimum age of entry is 18 years old and the maximum age of entry is 59 years old.

The insured can be a student, intern, au pair, academic, researcher or a member of his/her family (spouse - children)

who is studying in the EU/EEA or an EU/EEA resident who is studying abroad.

1.4 What is meant by "family"?
Two adults and their children under 18 years of age, as identified in the insurance contract.

1.5 Who is a next of kin?
Relatives by blood and affinity in the first or second degree and the life partner of the insured person.

Relatives by blood or affinity, these refer to:

Consanguinity in the first degree
a. parents and adoptive parents
b. children and adopted children.

Consanguinity in the second degree
a. grandparents
b. grandchildren
c. brothers and sisters.

Affinity in the first degree
a. parents-in-law and adoptive parents-in-law
b. children and adopted children of the life partner
c. the life partner of children and of adopted children.

Affinity in the second degree
a. the grandparents of the life partner
b. the grandchildren of the life partner
c. the brothers and sisters of the life partner.

1.6 What is a third party?
A person who is not in any way related to the insured, is not his/her spouse or flatmate and is not connected to them through work nor functioning as a corporate organ.

1.7 What is an insurance application?
The application submitted by the applicant to the insurer in view of concluding an insurance contract. This application does not signify that the contract has been concluded.

The fact that the insurer has sent out the insurance application form to the applicant does not constitute an offer to take out an insurance nor can it replace an insurance policy.

1.8 What is an insurance certificate?
A document issued by the insurer to the applicant on request so that the applicant can approach authorities (consulates, etc.) in view of completing any necessary procedures. With this document that is issued only after receiving the premium payment, the insurer declares the willingness to enter into an agreement with the applicant provided that all the essential points of the contract are subsequently fulfilled. A confirmation is not an insurance contract. The insurer has the right to give the relevant information to the third parties concerned in case of a reimbursement of premiums.

1.9 What is an insurance contract?
The insurance contract is a statement which has been mutually agreed upon by the applicant and the insurer including all of the essential points of the contractual relationship.

The key points of the insurance contract are mentioned below:
a. review and approval of the GIC's in force;
b. completion and signature of the insurance application form and any potential enclosures;
c. payment of the premium in its entirety by the insured - any fees that may occur by making the payment are at the expense of the insured;
d. acceptance of the application by the insurer and willingness to conclude a contract.

An insurance contract for a third party can never cover nor be interpreted to cover the policyholder or a third party simultaneously.

1.10 What is an insurance policy?
The document that confirms and proves the existence of an insurance contract and records the rights and obligations of the parties.

1.11 Destination and territory
The country of destination is the place where the insured intends to travel to during the trip. The country of origin is the country in which the insured has had permanent or habitual residence before leaving to the country of destination.

The territory is the geographic or political area, as defined in the insurance contract and in the applicable GIC's, in which the contractual obligations come into force and within which the destination can be found.

The insured is covered worldwide including the Schengen area, however, outside the country of origin. Countries such as the USA territories and Canada do not fall under the covered territories and are excluded from any insurance coverage.

1.12 What is a claim?
The unintentional event for which an insurance claim may be made, which occurs within the period and under the conditions specified in the insurance contract and which causes the insurer to fulfil the obligation to provide services to the insured within the legal and contractual constraints.

1.13 What is an accident?
Any sudden, unexpected and involuntary event affecting the human body for which a claim may be made as a result of a violent and external source which causes bodily harm to the insured and can be identified objectively.

1.14 What is a sudden illness?
Any unintended negative change of the insured's health necessitating a medical consultation, treatment or care and which is not the result of an accident and is not due to a pre-existing condition.

1.15 What is a pre-existing condition?
A pre-existing condition is defined as any injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment that, with reasonable medical certainty, existed at the time of application for the insurance or at any time during the six months prior to the effective date of the insurance, whether or not previously manifested or symptomatic, diagnosed, treated, or disclosed prior to the effective date of the insurance, including any subsequent, chronic or recurring complications or consequences related thereto or arising there from. This also applies if there is an aggravation of a pre-existing condition or a medical condition which is caused by a pre-existing condition.

It is strongly recommended that the insured undergoes, at his/her own expense, a thorough medical check-up prior to the taking out an insurance coverage.

1.16 What is an Alarm Service?
This refers to the assistance facilities and the team comprised of doctors, technicians and operators provided by the insurer in order to offer 24/7 service to the insured 365 days a year.

Telephone: +3150 520 9780
Email: alarmservice@anker.nl

1.17 What is a hospitalization?
Admission to a hospital establishment (inpatient) for a period of 24 hours or more for emergency treatment which cannot be postponed. A hospital is an institution for the nursing, examination and treatment of patients and/or injured persons, which is generally recognized as such by the official, legally competent authorities.

1.18 What is an emergency treatment center?
The place where the insured party is taken following an incident in order to be prepared for transfer or repatriation.

1.19 What is meant by "luggage"?
Suitcases or other containers (travel bags, rucksacks, etc.) and the personal effects which they contain.

1.20 What are personal effects?
Items intended for personal use by the insured during the journey, i.e. clothes, shoes, toiletries, etc.

1.21 What is meant by precious items?
Items which are made of or which contain precious metals (platinum, gold, silver), precious stones or pearls or any other valuable substance (ivory, amber, etc.).

1.22 What are valuables?
Items which are not precious items but which still have a market value such as furs, works of art (paintings, statues,

etc.), spectacles, binoculars, cameras, camcorders, audio-visual equipment, computer equipment, videos, sports equipment (skis, tennis rackets, golf clubs, surfboards, etc.).

1.23 What is compensation?
Compensation entails covering the costs of all services which the insurer is required to provide in the event of a claim. The upper limits of the benefits specified by the GIC's as well as the benefits list which apply to each aspect of coverage.

1.24 What is an excess (deductible)?
The fixed amount specified in the policy which is at the expense of the insured in the event of a claim.

1.25 What is Country of Origin?
The country of origin is the country in which the insured has had permanent or habitual residence before leaving to the country of destination.

1.26 Emergency Medical Treatment
This clause covers emergency medical treatments which are medically necessary, and which have occurred during the period of insurance coverage, as a result of the insured sustaining a bodily injury or becoming ill during the period of insurance and which cannot be postponed until the return to the insured's country of origin, and which are not covered by any other source, including any hospital or medical benefit fund. Under medical treatments are to be understood:

a. All necessary emergency medical treatments by doctors and/or surgeons, their prescriptions, examination and similar costs directly connected with the medical treatment;
b. All reasonable medical or surgical treatments in the public ward or semi-private room of a hospital for as long as attendance or treatment in a hospital is necessary;
c. All reasonable journeys of an ambulance to convey the insured to the nearest hospital should the insured be disabled to such an extent, making use of public transport impractical.

A claim under this clause will only be reimbursed if it is prescribed by a registered physician.

2. General Provisions

2.1 Legal basis
The insurance contract is governed by the present GIC's as well as the benefits list which is considered to be an integral part of the insurance contract. The general provisions shall apply provided that the special provisions which are applicable do not specify otherwise.

2.2 Purpose of coverage and insured events
Purpose of coverage:
a. The insurer provides assistance, within the legal and contractual frame in the case of difficult or emergency situations while on a journey or a visit within the territory defined in the insurance contract.
b. In accordance with the contractual obligations, the insurer will provide immediate help, be it in cash or in kind to the insured when the insured encounters difficulties as a result of an insured event, as defined in the insurance contract.
c. Providing emergency assistance does not exclude the possibility of receiving aid according to the insurance contract. However the decision will be made by the insurer only after having received all of the necessary documents and information.
d. This insurance coverage complements the social security insurances as well as other insurances that the insured has concluded and are insufficient. The same goes for other services provided by the affiliation to an association.

Insured events are events which are not excluded by the GIC's that arise outside the country of origin during the policy duration and which are covered by the terms of the insurance contract.

2.3 Policy duration
The policy duration is the period of time, agreed upon beforehand by the parties of the insurance contract, within which the insured may take one or more periods of coverage. A period of coverage is the effective time the insured travels and stays abroad. The entire stay must take place within the policy duration.

The maximum duration of the insurance contract is 12 months.

2.4 Periods of coverage
The period of coverage is according to the insurance contract.

The insurance cover shall enter into force, when the insurer has accepted the application and informed the applicant on which terms the insurance will be issued, and the agreed premium has been paid to the insurer.

The insured must in any case prove the student status by a certificate of immatriculation / registration as well as the status as a temporary resident or the equivalent with a visa or residence permit.

The insured family member (spouse or children) must in any case prove the student status of the dependent by a certificate of immatriculation / registration as well as the status as a temporary resident or the equivalent with a visa or residence permit.

In any case a period of coverage will start at midnight (12 pm) of the start date of the policy duration at the earliest, and will end, at the latest, by midnight (12 pm) on the day of the end of the policy duration.

If an insured person is admitted to hospital and the coverage ends after the policy expires, there is coverage until the first possible date of return to the home country of the insured.

2.5 Emergency cover
All benefits stated in the present insurance conditions and in the benefits overview are covered in case of emergency and / or medical emergency. If the insured is travelling for the purpose of being treated, and the treatments were the sole reason or one of the reasons for commencing the trip, there is no coverage unless there was a prior approval given by the Alarm Service. Planned medical treatments considered as non-emergency are not covered.

2.6 Premiums
Receipt of the premium payment by the insurer is an essential part of the insurance contract, regardless of the payment method.
The payment of the premiums must be made in its entirety, any transaction fees are at the expense of the insured.

The insurance must be applied for and the premium paid no later than at the time of departure.

2.7 Cancellation and reimbursement of the insurance premium
The insurance policy can be cancelled and a refund claimed under the following conditions:

- the insurer is willing to accept the cancellation and reimburse the insurance premium in the event that the insured or a rightful person is able to prove with original medical certificates, death certificate of the insured party, certification that they have been summoned by the authorities (police, judiciary or administrative) or with other original documents that there is an objective impediment to travel or, the insured does not obtain a visa for the country of destination. A visa rejection letter from an embassy or consulate must be sent to the insurer in order to be eligible for a refund;
- the policy can be cancelled and a refund can be claimed only prior to the starting date of the period of coverage stated on the insurance certificate. After the start date, the policy cannot be cancelled and no refund can be claimed;
- Refunding of the insurance premium will be made by the insurer using the same payment method and currency as that used by the insured. Any charges for bank transfer or credit cards are not supported by the insurer.

The policyholder/insured shall have a period of fourteen (14) calendar days to cancel the policy without penalty and without giving any reason. The period right of cancellation shall begin from the day of the conclusion of the online contract. The policyholder/insured will be entitled to the return of the full premium paid, on the condition that no claim has been submitted. The insurance policy cannot be cancelled after the start date of the policy.

For compliance with this deadline it is sufficient for the policyholder/insured to send his/her notice of withdrawal by post or e-mail to the insurer. There is no premium refund after the cancellation-period of fourteen calendar days.

2.8 Partial benefits
If the insured does not use or only uses part of the benefits provided by the insurer, the latter is not required to supply cash compensation or alternative services of any kind whatsoever.

If the costs resulting from a claim are less than the costs specified in the insurance contract, the insured is not entitled to claim the difference.

2.9 Subrogation and Responsible third party
The rights and claims of any natural person or legal entity that benefits in whole or in part from the guarantees provided in the insurance policy as stated in these GIC's against the third party responsible for the event shall pass to the insurer up to the level of the compensation paid by the insurer.

The insurer is subrogated within the limits of the contractual benefits and rights of all natural person and legal

entities, beneficiaries or parties of the insurance guaranties mentioned in the GIC's in the rights and lawsuits of the insured against the third parties responsible for the damage, after providing assistance or paying indemnities.

If, because of the insured, the subrogation can no longer produce its effects in favour of the insurer, the latter may claim restitution from the insured for the indemnity paid, up to the extent of the prejudice suffered.

Except in the case of criminal intent, the insurer shall have no recourse against the descendants, the ancestors, the spouse or next of kin directly related to the insured, nor against any persons living in the latter's home, his/her guests, or members of the domestic staff.

2.10 Subsidiarity of insurance coverage

The insurer will only intervene after the coverage granted by other provident, insurance and assistance organisations or social security services to which the insured is entitled has been exhausted.

2.11 Non-transferability of debts to third parties

No claim or debt stemming from the insurance contract can be transferred. Particularly, the beneficiary cannot transfer any entitlements to a next of kin, hospital, company, policyholder, work colleague, authorities, etc.

2.12 Obligations of the insured

The Alarm Service is for emergency situations only. You can contact us for example in case of the event of repatriation, accidents, (outpatient) clinical treatment in a hospital, hospitalization and your return on medical indication.

Alarm Service

Telephone: +31 50 520 9780
Email: alarmservice@anker.nl

It will be available for you 24/7. We will offer advice concerning the steps to be taken and we will organise the necessary support.

Claim Department

The Claims Department handles your claims. For example damage to your luggage and costs for visiting a doctor when you are ill. You can report a damage in your personal account online at www.swisscare.com or use the app. Always report damage as soon as possible.

Telephone: +3150 520 9974
Email: swisscare@goudse.com

We are available from Monday to Friday during office hours. We will advise on how to report a claim and what details need to be handed over.

What to do in case of an emergency?

In order to benefit from the advice and services of this insurance, the Alarm Service must be contacted immediately after the incident and prior to any consultation.

This prior telephone call has to be made immediately since it is one of the fundamental obligations the insured has to fulfil. The insured hereby acknowledges and agrees, that the insurer, the Alarm Service, or any third party that is mandated by the insurer, will provide advice, and / or other services, such as insurance benefits. Failure to comply with this requirement shall entail a forfeit of the insured's or any beneficiary's rights to claim or benefits.

If the insured is entirely unable to notify the insurer immediately and it can be proven that a personal or indirect contact with the Alarm Service prior to consulting a doctor at the moment of the event was impossible because of the insured's life threatening situation, a reasonable speedy notification by the insured, the policyholder, the police, the hospital or any party to the incident will considered a valid notice.

Advanced payment of all expenses

All expenses for claims must be paid in advance before the insurer will proceed to the reimbursement except:

- Admission in a hospital for inpatient treatments
- Search and rescue

In the above cases, the insurer must be provided immediately with the complete contact details of the hospital or authorities in order to establish a guarantee of payment.

The insurer claims are reimbursed only to bank accounts. The insured is required to mention on the claim form the bank details to which the insurer is to reimburse.

Documents and information to be provided in the case of a claim

Any documents have to be submitted to the insurer as soon as possible, however at the latest 365 days after the occurrence of the incident, proven by postal stamp or official certification, the insured must spontaneously and at his/her own expense, provide the insurer with the requested documents listed below. Beyond the delay of 365 days, no claim shall qualify for reimbursement and consequently the insured forfeits the right for reimbursement. The insured must on his/her own initiative and at his/her own expense provide the insurer with the original requested documents listed below:

a. the accident report and/or statements drawn up by the police authorities, fire departments, or any other emergency service;
b. At the request of the insurer of the medical adviser of the claims handler, the insured person may be asked to issue an authorization for obtaining medical information from the treating physician.
c. prescriptions for any medication or any other prescribed medical aids;
d. original invoices for medical treatment, hospital stay and purchase of medication;
e. original booking/invoice;
f. in the case of death a death certificate from the relevant authorities.

Scanned documents are accepted in good readable quality. The insurer reserves the right to request original documents if deemed necessary.

IMPORTANT: All documents that are to be provided must be translated into English. The insurer reserves the right to refuse refunds if the required documents are not translated.

Furthermore, the insured and the policyholder have to provide the insurer – on their own initiative – with any other information and proof relating to the accident, which might help with clarifying the circumstances of the incident/claim and help with estimating the extent of the consequences, providing the ought to know of this information.

The insurer will not make any payments nor give any guarantee of payment if no insurance certificate is issued after online purchase. The insurer and the insurance broker decline all responsibilities in case of technical errors during the online purchase. For example, a credit card was charged but no policy/certificate has been issued.

It is the responsibility of the applicant to verify that the online purchase was successful, and that the certificate was issued and received by email, the paid amount is correctly charged and information accuracy on the certificate.

Medical confidentiality

At the request of the insurer or the medical adviser of the claims handler, the insured person may be asked to issue an authorization for obtaining medical information from the treating physician.

2.13 Sanctions in case of failure to meet the obligations

a. The policyholder cannot derive any rights from this insurance if he and/or the insured person fail to meet one or more of his or her obligations with respect to Anker and as a result thereof harms Anker's interests. The policyholder and the insured person are in any event obliged to fulfil the obligations incorporated in these policy conditions and in the Claims Procedure.
b. If Anker is not harmed in a reasonable interest as a result of the aforementioned policyholder's and/or insured person's failure to meet obligations, Anker may nevertheless deduct any loss and/or damage sustained, or the costs incurred as a result thereof, from the insurance payment.
c. If the policyholder or the insured person fails to meet his or her obligations with respect to Anker, intending thereby to deceive it, all rights to insurance benefits and/or provision of services will lapse, unless the deception does not justify the loss of rights.

2.14 Double insurance

If the same interest is insured against the same risk and during the same time period by more than one insurer so that the combined insured sums exceed the insurance value, the insured is obliged to inform the insurer without delay and in writing about this fact.

If the insured omitted the notification intentionally or if he/she concluded the double insurance with the intention of

receiving an illegal pecuniary advantage, the insurer is not bound by the insurance contract.

2.15 Failure of disclosure

If the person submitting the insurance application has, while the insurance contract was being concluded, omitted or stated imprecise information of a significant risk factor which the insured new or ought to have known about, the insurer has the right to terminate the insurance contract in writing within the four weeks after the insurer has come to know about the insured's violation of the obligation to notify. Additionally, the obligation of the insurer to indemnify damages that have already occurred terminates, provided that the omitted or incorrect notification of the significant risk factor has influenced the occurrence or extent of damages. If the obligation has already been fulfilled, the insurer is entitled to restitution.

2.16 Aggravation of risk

An aggravation is deemed significant if it affects an important factor of the risk evaluation that has been established during the drafting of the insurance contract. All factors that might influence the decision of the insurer to accept the insurance contract or to accept it under certain conditions are important (especially the insured party's state of health or dangerous activities etc.).

If the insured causes a significant aggravation of risk during the insurance duration, the insurer shall cease to be bound by the insurance contract. The insured has the obligation to inform the insurer immediately by calling the Alarm Center, and then by sending a letter or an e-mail to the insurer.

If the aggravation of risk is not caused by the insured this only leads to an automatic cancellation of the insurance contract if the insured has neglected to notify the insurer as stated in the previous paragraph. If the insured provides such notification the insurer reserves the right to terminate the insurance contract within the 14 days following the notification.

2.17 Extent of expenses covered

The services provided in the context of the GIC's to be effective, appropriate and economical. Each of these three characteristics have to be scientifically proven. Should this not be the case the insurer reserves the right to reasonably reduce indemnification accordingly.

The limitations and maximum sums defined in the insurance contract respectively the benefits list are applicable to each separate coverage.

2.18 General exclusions

The following situations are excluded from the scope of insurance, so that the insurer is relieved of any obligation to provide indemnification or services:

a. if the insured commits a crime or offence that leads to the claim;
b. any health effects resulting from ionising radiation (nuclear irradiation);
c. health or bodily harm stemming from the knowingly or unknowingly manufacturing of chemical, biological or biochemical substances or the use of such or electro-magnetic waves as weapons (notwithstanding eventual collateral causes). All risks stemming from ABC – weapons, nuclear energy and other ionising radiation;
d. any claim stemming from an act of god (force majeure) or a natural disaster deriving from the unusual intensity of a natural agent (e.g. volcanic eruptions, meteorite impact, tidal wave, earthquake). Except of medical cases (broken leg/arm);
e. if the insured undertakes any hazardous activities which would impact the risk evaluation;
f. if the insured participates in high-risk sports (such as parachuting, acrobatics, races involving mechanical or motor vehicles, ski jumping, skiing outside of marked territories (off-piste), paragliding, canyoning, boxing, rugby and martial arts, etc.);
g. war, whether declared or otherwise, and in all cases 48 hours after the Swiss Federal Department of Foreign Affairs or other official authorities have confirmed the start of hostilities;
h. revolution, acts of sabotage, hooliganism or vandalism; strikes, roadblocks established during mass demonstrations and, in general terms, disturbances of any kind and measures taken to re-establish public order;
i. epidemics and pandemics;
j. if the insured party takes drugs and/or alcohol and/or other hallucinogenic products leading or contributing to the incident;
k. suicide or attempted suicide;
l. if an incident occurs in a country which is excluded from the insurance contract or if it happens outside the effective period of coverage.

2.19 General limitation of coverage

Notwithstanding the other exclusions the insurer has the right to refuse indemnification and the provision of services and if deemed necessary, to cancel the contract in the following cases:

1. if the insured or any third party does not report the incident immediately to the Alarm Center of the insurer;

2. if the insurer does not give prior approval before arranging and accepting responsibility for assistance or treatment, hospitalization or the acquisition of medication by the insured;
3. if the insured does not provide the insurer with the necessary information and original documents or does not submit them within the delay;
4. any pre-existing health conditions are not covered;
5. incidents, troubles and complications associated with pregnancy where the risk was known or could reasonably have been foreseen before the date of departure;
6. if the insured does not notify the insurer of the existence of another insurance covering the same risks and in case of non-disclosure;
7. if the insured fails to take measures which might reasonably have been expected to avoid substantial aggravation of the risk and thus prevent the incident from occurring in the first place;
8. any refusal to cooperate.

If the insured or any person making decisions on behalf of the insured declines to accept the contractual services (e.g. offer of repatriation) proposed in the event of an incident, the contract shall be suspended. Any costs incurred as a result of the insured declining the insurer's services shall be assumed entirely by the insured. If the insured changes his/her mind before the end of the coverage period, he/she shall assume any costs in relation with a prior refusal to accept the insurer's benefits (e.g. costs induced by the extension of hospitalization, etc.) as well as if his/her change of mind.

Under penalty of forfeiture of any contractual rights, the insured and the policyholder abstain from interfering with the claim's handling by the insurer without the latter's prior written consent.

2.20 Maximum amount of indemnity per case
Payments of compensation by the insurer per basic event (independent from the number of the thereof directly or indirectly resulting damages) will be limited according to the insurance contract and coverage chosen, standard, comfort or premium and subjected to the limitations of the benefits list.

All damages caused or resulting from a disaster or a natural event which happened within the following 168 consecutive hours (e.g. tsunami, flooding, volcanic eruptions as well as volcanic ash blocking the airspace for planes, landslides, tornados, cyclones or similar events) are considered one damage event independently from the number of the insured afflicted. If the indemnity exceeds the maximum amount of indemnity stipulated in the insurance policy, the beneficiaries will each receive an indemnity pro rata.

2.21 Modification of insurance conditions
The insurer has the right to modify the insurance conditions including those of an already concluded contract if:
a. the public health administration order permanent modifications;
b. administrative or judiciary authorities declare existing conditions as invalid or cancelled;
c. there are changes or abrogations of the laws or regulations on which the conditions of the insurance are based;
d. a change in legislation, in administrative or judiciary practice which affect the interpretation of the conditions and the validity of the contract or some of the clauses;

To avoid a disproportionate loss from both a legal and economic view of the insured, the new conditions will have to be as close as possible to the original ones

The new conditions will be communicated to the insured no later than 3 months prior to their becoming effective, unless there is a case of emergency, force majeure (act of God) or a legal, administrative or judiciary obligation that bears no delay.

In the absence of a termination of the insurance contract by the insured or the policyholder, the new insurance conditions shall be deemed adopted.

It is up to the insurer at any time and without any forewarning to modify the terms or the word choice of the conditions, however only to exclude certain typing errors or obvious material inaccuracies, to get rid of possible uncertainties of interpretation, to explain a certain passage in the text that has already been discussed or in order to change the conditions exclusively in favour of the insured.

2.22 Severability Clause
The present invalidity or the future invalidation of one of the provisions to be found in the insurance conditions and the appearance of a legal gap (lacuna) do not call the validity of the other clauses into question.

In order to replace or add the invalid or missing clause, the insurer will add a clause that makes sense and which will be within the realms of possibility and tolerance and as close as possible to the original contents of the contract between the parties.

2.23 Termination of the contract
In the event of an adjustment of the premiums or any other modification of the insurance conditions that expressly allows for the termination of the contract, the insured has the right to terminate the contract per registered mail sent to the insurance broker within a month after receipt of the notification related to these modifications. In this case the termination will come into force on the date when the foreseen modifications will enter into force.

Besides the legal and contractual clauses that enable declaring/rendering the contract invalid, the retroactive termination, the termination with immediate effect and termination with a different delay, the unintentional misconduct of the policyholder or insured will entitle the insurer to enforce the following consequences:

a. the contract will be terminated within one month from the moment the insurer becomes aware of the culpable behaviour;
b. the insurer may propose to modify the contract retroactively from the date of having become aware of the default, within one month from having become aware of the culpable behaviour. If the other party refuses the proposed modifications or does not accept them within a delay of a fortnight after receipt of the proposal, the insurer may terminate the contract within the delay of the following fortnight.

If in the frame of an insurance contract covering several insured and the conditions for termination for only a few of the insured are met, the right of termination can only be valid for those concerned.

If the policyholder terminates the contract for all of the insured or only for a few of them, the policyholder will have to prove, if he/she wishes to validate the termination, that these insured have been duly informed of this intention and have accepted it. If they wish to reintegrate the insurance regarding their person, they may do so by registered mail to the insurance broker within a delay of 2 months after the termination of the contract by the policyholder.

The insurance contract automatically terminates with the death, bankruptcy and the official insolvency of the policyholder. The insured are however entitled to renew the contract according to the conditions given under paragraph 5. The delay will be 2 months counting from the day of death, bankruptcy, notice of official insolvency of the former policyholder.

2.24 Statute of limitations
Claims that derive from the insurance contract are subjected to a time limit of two years, dated from the fact/event/incident that triggers the obligation to provide indemnification.

2.25 Legal

Applicable law
The parties agree that the insurance policy will be governed by the law of the Netherlands as long as another law which applies according to national regulations does not contain conditions which are not compatible with the law of the Netherlands.

The benefits of this insurance do not hinder the applicability of legal statutes and of the compulsory basic health care legislation pertaining to the host country to which the present conditions of insurance refers to and which are thus part and parcel of the insurance contract within the limits of these references.

Conciliation
Before taking any judicial or arbitral action, each party agrees to contact the other party, in writing, within ten (10) days of the beginning of the dispute, to find an amicable settlement. In the event that the conciliation was unsuccessful, the insurer undertakes to put a free internal opposition proceeding at the insured's disposal. The commencement of this proceeding does however not suspend the course of any legal or contractual delays or deadlines.

Complaints procedure
If you have any complaint regarding the standard of service received under this insurance policy, the following instance can be contacted:

Anker Insurance Company n.v.
P.O. Box 8002
9702 KA Groningen
The Netherlands
Telephone: +3150 520 99 05
E-mail: complaints@anker.nl

Kifid for private policyholders
Has your complaint not been solved to your satisfaction by us? Then you can send your complaint within three months after our final response to your complaint to the independent Financial Services Complaints Institute (Kifid).

Address details:
KIFID
PO Box 93257
2509 AG The Hague
Phone number: +3170 333 8 999
www.kifid.nl

An insured can also submit the difference of opinion to a court of law. Disputes will then be submitted to a competent Court in the Netherlands.

In the event of legal proceedings, the dispute regarding the interpretation and execution of this agreement shall fall within the exclusive jurisdiction of the Netherlands. This does not affect the application of mandatory, conventional or legal provisions regarding the place of jurisdiction. In addition, the parties are free, by written agreement, to make use of the possibility of arbitration by one or three arbitrators.

In case of a judicial procedure, the dispute regarding the interpretation and implementation of this
contract falls under the exclusive jurisdiction of the Netherlands. This does not impair the application of mandatory, conventional or legal, provisions concerning the place of jurisdiction. Moreover, the parties remain free to use, by means of an agreement in writing, the possibility of arbitration of one or three arbitrators.

Sanction clause
The insurer shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the Netherlands, the European Union, United Kingdom or United States of America.

2.26 Validity
The present GIC's shall take effect from **01.2023** and replace all previous versions of the GIC's.

3. Assistance

The insurer will assist the insured within the legal and contractual scope when they find themselves confronted with medical emergencies when travelling outside their country of origin.

Provided that the insurer is immediately informed and has an objective possibility to intervene, the insurer will provide immediate assistance to the insured when the latter finds himself/herself in medical emergencies as a result of an insured event, in the cases and conditions specified in the insurance contract. However, providing emergency assistance does not prejudice the insurers decision concerning the financial coverage according to the GIC's.

This aid may consist of services. The services and benefits of adjoining risk coverage aim to facilitate the main coverage services and benefits.

3.1 Territory
The insured is covered when travelling away from his/her country of origin from the first kilometre on. The territory covered is: the entire world, except the USA Territories and Canada.

3.2 Benefits
The following assistance benefits are covered:

a. Sea and Mountain search and rescue
The insurer indemnifies the costs for search and/or rescue incurred by the competent authorities up to the sum defined in the insurance contract respectively the benefits list.

b. Medical repatriation and evacuation
As soon as the insured's condition requires it and provided the doctors responsible for the insured give their consent, the insurer will pay for the transfer to the nearest appropriate hospital in the case of an accident or medical emergency. The limitations and maximum sums defined in the insurance contract respectively the benefits list are applicable.

As soon as the condition of the insured, who has experienced a sudden illness or an accident, permits and provided the doctors responsible for the insured give their consent, the insurer will arrange and pay for his repatriation to his/her country of origin or country of destination. The limitations and maximum sums defined in the insurance contract respectively the benefits list are applicable.

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If the insured or his/her next of kin decides not to be repatriated to the country of origin or the country of destination, the insurer will organize repatriation to the domicile.

The insurer has the right to choose the means of transportation deemed most appropriate (by air, land or sea).

The insurer will indemnify reasonable and usual repatriation costs actually incurred by the transport. The limitations and maximum sums defined in the insurance contract respectively the benefits list are applicable.

The benefits of medical evacuation and/or if necessary repatriation can only be provided with the approval of the insurers medical team liaising closely with the doctors treating the insured or the doctors in the emergency stabilization center.

c. Repatriation of mortal remains
In the event of the death of the insured party during the journey or visit, the insurer will arrange for the mortal remains to be repatriated – if materially feasible - from the place of his death to the funeral site within his/her country of domicile or habitual residence. The repatriation is carried out in accordance with the applicable national laws and international conventions.

The insurer will cover the transfer costs of the mortal remains up to the maximum sum defined in the insurance contract and benefits list and will take care of all formalities required for the transportation of the mortal remains.

When objectively necessary in order to make transportation possible the insurer will cover the following costs up to a maximum amount of € 5,000.00: related to initial preservation of the body, maintenance, laying in coffin, arrangements specifically related to transportation, preservation services required by law, preparation and coffin costs for the simplest model required for transport and in accordance with local and international laws. Excluded are costs related to embalming, burial, funeral ceremony or other expenses.

d. Medical accompaniment
During transfer or, when necessary repatriation, the insured is accompanied and assisted by medical and/or paramedical staff with the required expertise in order to be able to care for the insured as requested by the medical experts of the insurer.

e. Long-distance medical advice
In the event the insured requires long-distance medical advice of the medical assistance, the insurer cannot be held liable for the opinion provided by the doctor and the consequences that it may entail.

f. Indication of local medical specialists
If an initial examination reveals that the insured is in a critical condition and requires a specialist's intervention, the insurer will supply the insured at his/her request or at the request of the doctor treating the patient at the place where the incident occurred, with the name of a doctor specializing in the relevant medical field - provided that such a specialist exists in the region. The insurer cannot be held liable for the doctor's treatment and its possible consequences.

g. Emergency dispatch of medication
The insurer will arrange and indemnify the dispatch of medication, that has been prescribed by a recognized medical professional, required in order to treat the insured if it cannot be acquired in the country in which the incident took place. This is of course subject to the condition that the medication can be bought in the Netherlands and may be used legally in the country of destination. The costs for the prescription by a certified medical professional are excluded.

h. Transmission of urgent messages
The insurer undertakes to transmit urgent messages free of charge on behalf of the insured to any person in the country of origin or destination of the insured and nominated by the latter if the insured is not capable of communicating with the nominated person.

i. Repatriation of other insured involved in the same incident
The insurer will arrange and indemnify the repatriation costs of any insured involved in the same incident if they are unable to return by the intended means of transport, provided they are also insured with the same insurer for the same coverage.

j. Travel costs of next of kin
If the insured requires hospitalization for at least 7 days prior to transfer or repatriation, the insurer will arrange and indemnify a return journey in economy class for a next of kin to travel to the hospital in question. Maximum reimbursement for the accommodation costs for the latter can be found in the Benefits list.

k. Advance of a sum in the event of an objective impossibility of return

In the event that the insured can prove a force majeure case or another objective and serious reason of hindrance to return to the domicile or habitual residence within the period of coverage and on time, the insurer will advance a maximum of € 1,000.00.

To pay for expenses arising from the involuntary prolongation of the sojourn in the country of destination. The insured will commit to the insurer to refund the advance within 30 days after returning to the domicile or habitual residence.

3.3 Limitations

In addition to the exceptions and exclusions already specified, the insurer will not provide any services or benefits for the consequences of the following situations:

a. if the insured behaves abusively by requesting the insurer to organise a transfer or repatriation whereas he is in fact suffering from a minor affliction or injury which could be treated in situ and which would not prevent the insured from continuing the journey or stay;
b. accidents caused by drugs and alcohol;
c. treatment of patients diagnosed with HIV, regardless of the reason for such treatment;
d. removal or transplants of organs, tissue or cells;
e. consultations related to in vitro fertilisation or similar methods; pregnancy and its consequences;
f. running away and kidnapping;
g. practising sports professionally or as part of an official competition organised by a sporting association for which a licence is issued, plus training in view of entering competitions;
h. ignoring official prohibitions or official rules concerning the safe practice of a given sports and/or leisure activity;
i. taking part in a motor racing at any level, motorcycles powering more than 125 cm3;
j. any type of hunting;
k. costs for meals in restaurants;
l. costs for excess luggage in the event of repatriation on a commercial airline as well as customs costs;
m. if the insured has the intention of becoming established in the territory where the incident took place (asylum request, marriage, family reunion, etc.) .

4. Medical expenses

The insurer will cover emergency medical and hospital costs resulting from a sudden illness or an accident which occurs when the insured is travelling outside his country of origin up to the maximum sums defined in the insurance contract and benefits list

4.1 Benefits

The insurer will indemnify costs for medical emergency expenses resulting from an admission to hospital following an accident or a sudden illness which occurs during travel outside of the country of origin up to the amount specified in the insurance contract.

4.2 Recognition of medical service providers

In case of treatment only invoices by qualified professionals that possess a recognized and valid diploma of the country in which the insured is being treated and where they are authorized to practice will be taken into consideration.

4.3 Inpatient treatment (hospitalization)

The following costs for inpatient care in a hospital, based on the quality of the basic standard of the contractual territory, are covered:

a. inpatient treatment in a public or private medical establishment;
b. admission into a hospital and surgery;
c. medical (and paramedical) costs arising during the hospital stay as an inpatient.

The insured may choose between public or private clinic, which are permanently staffed with qualified medical personnel, that practices anamnesis and that has the necessary diagnostic and therapeutic means at their disposal and work with scientifically recognized methods. The reimbursement of incurred costs is dependent on the insurer and what has been agreed upon in writing when the insured informed the insurer about the intention to undergo treatment that necessitates an inpatient stay at an establishment that does not only offer medical treatment necessary to the insured's health but also health and convalescent resort treatments.

The insurer covers the benefits for medical examinations (after approval of the medical assistance), healing methods and medication generally accepted by conventional medicine. Moreover, the insurer will provide benefits for methods and medication that has proven to be effective in practice when conventional methods or conventional

medication do not exist or cannot be applied. The insurer however can reduce the indemnification and benefits by adapting the amount to what the cost of conventional medication and methods would have cost.

4.4 Laboratory and X-ray expenses
The costs for laboratory examinations, x-rays, MRI's will be indemnified if prescribed by a certified medical professional for valid reasons.

4.5 Medication
Medication approved by the State's authorities are covered.

Medication and wound dressings have to be prescribed by an approved certified medical professional. Medical professionals that are related or next of kin of the insured or policyholder will not be taken into consideration.

Medications that are not prescribed by an approved certified medical professional are not covered. When declaring the costs, you must submit a referral letter / recipe.

The prescribed medication has to be bought at the pharmacy. The purchase of more than one package of the same medication has to be written on the certified medical practitioners prescription.

Products such as pure alcohol for medical use, cotton, sun protection, products for dental care, shampoo, food for a special diet, mineral water, special sorts of wine, fresh or dried glands, contraceptives, cosmetics, sanitary products, anti-hair-loss products, insect repellent spray, etc. are non-medical substances and therefore not covered.

4.6 Prescribed physiotherapy following a hospitalization
The amount covered is defined in the benefits list. Only physiotherapy prescribed by a certified medical professional following and directly causal to an emergency hospitalization is covered. If the hospitalization is longer than 24 hours, this has to be approved by the medical assistance.

4.7 Emergency dental treatment
a. The insurer will reimburse the costs of dental assistance in the event of damage to natural teeth due to an accident. The insurer will only reimburse the costs if the treatment was given within 24 hours after the accident. The maximum reimbursement is stated in the Benefits list. During the entire term of the insurance, the insured amount is insured a maximum of once.

b. The insurer will reimburse urgent dental care to natural teeth if it is necessary to relieve acute pain. The maximum reimbursement is stated in the Benefits list.

Acute pain means that the treatment is necessary immediately. The invoice of the practitioner must show that it concerns an emergency treatment. Not insured are the costs of check-ups and plannable treatments like filling cavities, placing a crown, etc.

4.8 Extent of the insurance benefits
The usual tariffs in the territory of the treatment define the amount and the duration of the insurance benefits.

The insured can be treated by an established and recognized medical professional of choice.

4.9 Limitations and exclusions
The following limitations and exclusions are applicable additionally to the exclusions and limitations already mentioned:

- general medical examinations, analyses or similar investigations as well as any treatment undertaken by the insured, his/her doctor or the hospital establishment to which the insured was admitted and which has not been approved of by the medical staff of the insurer beforehand. Treatment and other services given by persons belonging to his family, a spouse or a next-of-kin are not covered;
- spontaneous consultations with a specialist;
- treatment of symptoms not caused by a properly diagnosed pathological condition;
- treatment of a pre-existing medical condition and any of its consequences or complications;
- disorders of the teeth and jaw, tooth crown, fillings, whitening, replacement of a teeth and related treatments (only in case of emergency treatment);
- treatment of symptoms of an illness or an injury that any reasonable person would have taken care of immediately and prior to the effective starting date of the insurance contract; costs related to an illness or an injury that were not stabilized at the time of departure;
- afflictions of mental, psychological or psychiatric origin as well as their symptoms and consequences;
- complaints occurring during the trip taken for the purpose of diagnosis and/or treatment;
- costs for care and treatment with therapeutic character not recognized under the national jurisdiction of the residency country;

- the consequences of situations bearing the following risks: infection, in the context of epidemics, exposure to infectious biological agents, chemical agents, incapacitating agents, neurotoxins, provided the local or national health authorities of the country of destination or of travel have ordered a quarantine;
- hospital as well as medical expenses from the day on that the insurer would have the possibility and the right to organise the repatriation of the insured;
- acquisition of medication by the insured that has not been prescribed by a doctor who has been approved by the insurer;
- expenses related to contraceptives, interruption of pregnancy and birth;
- expenses related to optical aids (glasses, contact lenses, etc.), optical implants or prosthetics;
- surgery or treatment for aesthetic or similar reasons;
- rehabilitation, physio- and kinesiotherapy, chiropractic costs; thermal cure and thalassotherapy costs;
- expenses associated with the purchase of vaccines and vaccination costs;
- standard vaccination, except in case of emergency.
- sexually transmitted disease (STD) and/or sexually transmitted infection (STI), as well as related laboratory costs.

Furthermore, the insured is not covered:
- if a trip is taken against medical advice;
- after having been diagnosed with a terminal illness;
- if the insured has the intention of obtaining medical treatment for a pre-existing condition;
- if the insured undertakes a journey during an illness or period of inability to work;
- if the insured undertakes a journey during pregnancy exceeding the 7th month since conception;
- if the insured undertakes a journey when a doctor has recommended surgery which has not yet been performed.

This additional coverage complements the obligatory social security insurances as well as other insurances which the insured party may have taken out previously if this has proved to be insufficient. The same goes for other services provided by the affiliation to an association.

5. Delay of luggage

In the event of a delay of luggage, the insurer will indemnify the costs of interim aid for first necessity and essential items (toiletries bag) according to the benefits list.

5.1 Service if delay in luggage

The insurer will indemnify the expenses up to the contractual sum of € 600.00 if the luggage is delayed for over eight hours for:

a. indispensable purchases such as necessary clothing and toiletries should the luggage which was properly registered in the frame of an insured trip and in custody of the airline fail to reappear within an 8 hour delay after the arrival of the insured at the airport;
b. a compensation per case of delay will be increased by € 250.00 if the insured still finds himself/herself without his/her luggage after 48 hours after arrival at the destination. This compensation will be paid less the compensation that would have been paid after 8 hours of delay.

5.2 Limitations and exclusions

The following limitations and exclusions are applicable additionally to the exclusions and limitations already mentioned, in the following situations the insurer is not required to provide any services or benefits:

a. delays of chartered flights. Only regular flights that make their take-off and arrival times public are considered insured and covered. In the event of an objection, the "ABC World Airways Guide" is applicable as a reference of departure and arrival times of airplanes and their correspondences;
b. if there is a delay of luggage when the insured party finds himself back at his country of origin;
c. if the insured does not, within 8 hours after having been informed of the delay or the loss of his luggage, inform the person responsible from the airline;
d. in the event that the customs or government institutions confiscate or keep the luggage;
e. if the insurer has not first made a claim at the airlines company desk.

Furthermore, the insurer declines indemnification for items, if:

a. indispensable purchases as well as clothing and toiletries were bought only two days after the effective arrival at the airport of destination;
b. indispensable purchases as well as clothing and toiletries were bought only after the delayed luggage was delivered by a carrier business to the insured at the destination;
c. the insured does not provide the insurer with documentation proving that a claim announcement has been made at the airlines company desk.

6. Lost or stolen luggage

In the event of unintentional loss, damage, robbery or theft of luggage the insurer will indemnify the insured up to and in accordance with the maximum payable amount as stated in the benefits list. There is a deductible of € 250.00 per claim.

6.1 Compensation

The insurer will pay the following value of the luggage items according to the maximum sums insured as stated in the benefits list:

a. For all items no older than one year: the new value;
b. For items older than one year: the current market value;
c. If the luggage items can be repaired or replaced, the insurer has the right to reimburse the cost of repair or replacement;
d. If items cannot be replaced with equivalent new items, the determination of the damage will be based on the market value;
e. Damage compensation will be granted up to the maximum insured amounts, regardless of the total value of the luggage items;
f. The insured must demonstrate the possession, value, and age of the luggage items, for instance by means of an original purchase invoice. If no original purchase invoice is available, the insurer will reimburse a maximum of 60% of the market value.

6.2 Special limitations of the insurance coverage

The following limitations and exclusions are applicable additionally to the exclusions and limitations already mentioned, in the following situations the insurer does not provide any services or benefits:

a. luggage and personal belongings during their handling by a transportation company. Such claims should be submitted first to the transportation company. For handling the claim we need the notice of loss registered with the conveyor.
b. documents recorded on tape or film, collections, alarm systems, computer material (soft or hardware), telephones, office or professional material, keys, pens, lighters, bikes, trailers, camping cars and all vehicles and means of transport, glasses, contact lenses;
c. passports, identity cards, authorizations of residence and other travel or identity documents;
d. tickets and transportation titles;
e. articles of value that are not locked up or kept safe outside the time when they are being used;
f. jewellery, precious metals and stones, other valuables which are not in a safe when not being used;
g. objects of art with collector's value;
h. all objects bought during the trip including souvenirs;
i. objects left in a vehicle (even locked);
j. banknotes, cheques and travellers' cheques, other marketable security papers, credit cards as well as other means of payment exceeding € 1,000.00;
k. cards for buying petrol, stamps, commercial samples, and commercial goods, tickets for events or performances.

Furthermore, the insurer is not obliged to provide services in the event of:

a. confiscation and withholding of luggage by customs, administration or police authorities;
b. accidents caused by smokers, dribbling or leaking liquids, deterioration or faulty material;
c. accidents caused by insects, other animals or by climatic conditions;
d. indirect damages incurred by a failed right of use, fines.

6.3 Obligations of the insured

In order to obtain the right to indemnification, the insured is obliged to transmit the claim in writing to the insurer immediately by handing in the following documents:

a. the notice of loss registered with the conveyor;
b. the report of the damage signed by the police at the place of the damage;
c. report of any witnesses;
d. a copy of the claim presented to the hotel manager, the conveyor or the keeper of the deposit as to the damaged object;
e. original invoice of the costs of repair;
f. the original invoice proving the acquisition of the object of the claim giving the date and price; the receipt of the acquisition of the foreign currency.

7. Third Party Liability

The insurer will cover the liability in the event of damages the insured incurred during his/her travel outside his/her country of origin according to the insurance contract.

7.1 Coverage
The insurer pays for the financial consequences of liability and compensates the damages inflicted by the insured to a third party during a stay outside of the country of origin concerning:
a. injuries (including death and invalidity), which were brought onto a third party (excluding the insured or a family member of the latter);
b. material damage (incl. loss), that the insured has caused to a movable property (movables) of a third party.

7.2 Explanations
The insurer will, in the event this claim is covered, determine the sum of the claim in view of the sums legally owed in the country in which the event took place.

This coverage is not valid in the USA Territories and Canada.

7.3 Procedure
With this contract the insured gives all rights to the insurer in order to lead a procedure in front of civil jurisdictions, including the right to exercise an appeal.

In the case of criminal action, the insurer has right to intervene and lead the defence of the insured, without any restrictions of rights, the insurer reserves the right to appeal or contest a decision.

If after the claim, the insured failed to meet his/her obligations, the insurer will still indemnify the third party with the damage. However the insurer can claim reimbursement against the insured for the sums that have been paid.

Additional fees (procedural, acknowledgements etc.) are not deducted from the maximum sum insured. In the case of a conviction to the payment of a fee that is higher than the maximum sum insured, the insured will have to cover the costs.

7.4 Conditions of indemnification
Before acknowledging any liability or providing compensation, the insured has to obtain the written approval from the insurer in advance for every case. .

Less the deductible of € 250.00 per event, the compensation for bodily injuries inflicted on a third party cannot exceed the sum of € 500,000.00 In the event of material or/and immaterial damages (damages of an object or an animal or any lost right of use of a chattel) may not exceed the sum of compensation of € 100,000.00.

7.5 Special limitations of the insurance coverage
The following limitations and exclusions are applicable additionally to the exclusions and limitations already mentioned, the insurer is not required to provide any indemnification, services or benefits if the damages is due to or may be referred to:
a. the responsibility of an employee, a member of the family or a next-to-kin of the insured;
b. personal objects of the insured as well as objects left in custody with the insured by another person or objects left in the insured's car while under his/her control;

c. animals and objects either belonging to the third party or left in his/her custody;
d. damage stemming from an intentional act, or from the committal of a fairly serious or even grossly negligent act;
e. as a commercial or professional concern of the insured;
f. matters concerning belongings and/or possession of property or a realty (exception is made for matters concerning a second residence outside of the domicile or habitual country of residence);
g. matters concerning property, possession and the use of vehicles, planes or ships;
h. court fees stemming from lawsuits.

8. Capital in the event of an accident

The insurer indemnifies a lump sum (capital) in the event of an accident resulting in death or invalidity according to the insurance contract.

8.1 Age limit
The paying out of a lump sum for an accident will only be made, if the insured was over 16 and under 60 years of age on the day of the conclusion of the insurance contract.

8.2 Services concerning the payment of a lump sum for an accident
The insurer will pay a lump sum in the event of an accident leading to death or disability.

In the frame of this risk coverage of an accident is defined as follows:

Any unintentional bodily injury caused to the Insured, arising from abrupt, sudden and unexpected action with an external cause, to the exclusion of an acute or chronic illness.

8.3 Payment of the capital in the case of death
The capital stipulated in the insurance policy will be paid provided the insured died from the consequences of the accident within the 12 months following the accident. The maximum indemnity will not exceed the sum mentioned in the insurance contract. As to children aged under 16, the indemnity will not exceed a maximum sum of € 20'000.-.

The capital lump sum will usually be paid to the legal heirs, unless the insured has decided otherwise in a legally binding written will.

In the event the insured has an accident which ends with his/her death, the lump sum stipulated in the policy will be paid less the sum that has already been paid for his/her disability following the same accident.

8.4 Payment of the capital in the case of invalidity
The capital will be calculated according to and based on principles listed below provided the insured suffers within the 12 months that followed the accident from unalterable changes in his/her physical and mental health stemming from this accident.

The capital in case of invalidity is subjected to the maximum sums stated in the insurance policy and is calculated according to the degree of disability:

a. incurable and complete mental illness, total blindness, permanent and complete permanent paralysis, amputation or loss of two limbs 100%;
b. total loss or blindness on one eye 25%;
c. complete and incurable deafness on both ears 40%;
d. complete and incurable deafness on one ear 15%;
e. amputation or complete disability of limbs:
    - arm, lower arm or hand 50%;
    - index 10%;
    - other fingers 5%;
    - two fingers (except thumb and index) 8%.
f. amputation or complete disability of limbs:
    - thigh (over the knee) 50%;
    - part of leg underneath the knee 45%;
    - one foot 40%;
    - big toe 5%;
    - any other toe 1%.

The invalidity is considered to be complete (100%) if the insured is permanently unable to work or cannot take on any paid activity for 12 months after the accident. A partial disability is given when the ability of the insured is considerably restricted while working or following any paid activity.

In case of loss or complete inability of use of one of his/her limbs (hand above wrist, foot above ankle) which means an irrevocable loss of use of one hand, arm or leg, the insurer may calculate the indemnification to be provided on the basis of a lesser degree of the disability.

8.5 Parameters of compensation
Only the effective functional disability of a limb or the affected organ notwithstanding the profession the insured exerts or exerted will be taken into account.

The loss of a member or an organ not functioning properly before the accident will not be indemnified. Damage to limbs or organs not functioning properly before the accident will only be indemnified by paying the difference between the functionality before and after the accident, if existing.

Should more than one part of a limb be damaged by the same accident, the amount of indemnification for each damaged part of the limb cannot exceed the amount that would have been paid for a total loss of a limb.

The physical and psychological damages not listed in the above catalogue will be indemnified according to the following criteria: the physiological condition of the insured; the lack of care and treatment which are due to a certain negligence of the insured; the effects that the accident would have had on a healthy and unharmed person who profits from a sensible medical treatment.

8.6 Limitations

The following limitations and exclusions are applicable additionally to the exclusions and limitations already mentioned, the insurer is not required to provide any services or indemnification if the consequences of the following facts lead to disability or death:

a. an attempted or completed criminal act done by the insured;
b. accidents during a flight (all kinds of airplanes) from the country of origin to the country of destination and from the country of destination to the country of origin;
c. accidents due to practising sports as part of an official competition organised by a sporting association for which a license is issued, plus training in view of entering a competition;
d. accidents due to exercising a manual profession or when hunting;
e. humanitarian missions, warlike situations or war;
f. physical damages stemming from illness;
g. physical damages resulting from tests or from using atomic, chemical or bacteriological weapons, x-rays, radium and radium enrichment as well as its derivatives, unless the wounds were afflicted in the frame of handling a defect apparatus or by mishandling of equipment, or are the consequences of the necessary treatment needed because of the insured accident;
h. in the event of an aneurysm, brain stroke, paralysis or delirium tremens, mental disorder, disease of the brain or disease of the spinal marrow as well as deafness or blindness that already existed;
i. accidents caused by using a motorcycle powering more than 125 cm3
j. accidents caused by using a motorcycle 125 cm3 and lower as a driver or passenger, where one was not wearing a helmet at the time of the accident. In that case the coverage is limited to a maximum of €5.000,-.

8.7 Obligations in case of a claim

a. In the case of disability

In order to have a right to the insurer's services or indemnification the insured must notify the insurer within 5 days after the occurrence of the event. The insurer will reserve the right to order a medical examination by one of their own physicians or a well-known specialist at any time. The resulting costs will be borne by the insurer.

b. In the event of death

The rightful heirs are obliged to notify the insurer of the death and its origins/causes within 24 hours. Furthermore, they will have to agree as soon as possible to an autopsy made by a medical examiner designated by the insurer.

The resulting costs (if any) will be borne by the insurer. The notification of death must be made even though there has already been the notification of the accident or a disability.

c. Documentation that must be provided

The documents have to be sent to the insurer at the latest within 30 days after having been issued. The concerned documents are as follows:

a. a detailed original medical report;
b. the accident report and/or the statements drawn by the authorities;
c. the original death certificate or a legally attested document.

Benefits list

MEDICAL EXPENSES	Standard	Comfort	Premium
Territories covered	Worldwide excluding USA territories and Canada Schengen countries are included		
Maximum sum per event	**€ 50,000.00**	**€ 150,000.00**	**€ 500,000.00**
Inpatient treatment/Hospitalization	included	included	included
Hospital accommodation	semi private room	semi private room	semi private room
Outpatient treatment / ambulatory	included	included	included
Prescription medication and material (inpatient and day-care)	included	included	included
Surgical fees, anaesthesia, and operating theatre charges	included	included	included
Surgical appliances and prosthesis	included	included	included
Rehabilitation services	€ 1,000.00	€ 2,000.00	€ 3,000.00
CT, MRI scan, PET and CT-PET scan (inpatient)	included	included	included
Day-care services and outpatient surgery	included	included	included
Practitioner fees and prescription medication	included	included	included
Specialist fees	included	included	included
Diagnostic fees	included	included	included
Prescribed physiotherapy following hospitalization	Max. € 20.00 per day and max 15 days		
Emergency dental treatment maximum sum per insurance period	€ 300.00	€ 500.00	€ 1,000.00

LUGGAGE	Standard	Comfort	Premium
Territories covered	Worldwide excluding USA territories and Canada Schengen countries are included		
Max. sum per event	**€ 2,000.00**	**€ 2,500.00**	**€ 3,500.00**
Loss, damage, robbery or theft of luggage (Deductible of € 250.00 per claim)	€ 1,000.00	€ 1,500.00	€ 2,500.00
Delayed luggage > 8h	Max. € 600.00	Max. € 600.00	Max. € 600.00
Delayed luggage > 48h	Max. € 250.00	Max. € 250.00	Max. € 250.00

ACCIDENTAL DEATH OR DISABILITY	Standard	Comfort	Premium
Territories covered	Worldwide excluding USA / Canada Schengen countries are included		
Max. sum per event	**€ 50,000.00**	**€ 50,000.00**	**€ 50,000.00**
In case of death	€ 25,000.00	€ 25,000.00	€ 25,000.00
In case of disability	€ 50,000.00	€ 50,000.00	€ 50,000.00

THIRD PARTY LIABILITY	Standard	Comfort	Premium
Territories covered	Worldwide excluding USA territories and Canada Schengen countries are included		
Max. sum per event	**€ 500,000.00**	**€ 500,000.00**	**€ 500,000.00**
Bodily harm of a third party	€ 500,000.00	€ 500,000.00	€ 500,000.00
Material / Immaterial damage	€ 100,000.00	€ 100,000.00	€ 100,000.00

MEDICAL ASSISTANCE	Standard	Comfort	Premium
Territories covered	Worldwide excluding USA territories and Canada Schengen countries are included		
Maximum sum per event	**€ 250,000.00**	**€ 250,000.00**	**€ 250,000.00**
Emergency medical evacuation	€ 150,000.00	€ 150,000.00	€ 150,000.00
Medical repatriation	€ 50,000.00	€ 50,000.00	€ 50,000.00
Local ambulance	€ 5,000.00	€ 5,000.00	€ 5,000.00
Medical assistance during transportation	included	included	included
Sea and mountain search and rescue	€ 30,000.00	€ 30,000.00	€ 30,000.00
Indication of local medical specialists	included	included	included
Repatriation of mortal remains	€ 30,000.00	€ 30,000.00	€ 30,000.00
Expenses for accompanying relative of the repatriated	€ 80.00 per day for a maximum of 7 days		
Accommodation costs for accompanying for next of kin staying at the hospital	€ 500.00	€ 1,000.00	€ 2,000.00
Flight ticket for relative visiting the insured in the hospital	included	included	included
Repatriation of accompanying person travelling with the insured	included	included	included
Advance of emergency funds to be reimbursed by the insured	€ 1,000.00	€ 1,000.00	€ 1,000.00
Dispatch of urgent messages	included	included	included
Long-distance medical advice	100%	100%	100%