General Insurance Conditions for Life Insurance of MEDLIFE INSURANCE LTD. LV90111 / 07

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General Insurance Conditions for
Life Insurance and Personal Accident Insurance
of MEDLIFE Insurance Ltd.
LV90111/07

Section 1: GENERAL TERMS OF CONTRACT

Article 1: Definition of terms

The insurer is MedLife Insurance Ltd.

The policy holder is the person concluding the insurance contract with the insurer.

The insured person is the person whose life is insured or who is insured against accidents.

The person to whom the insured sum has to be paid (beneficiary) is the person who is designated for receiving the benefit.

Article 2: Insurance contract

The insurance proposal, the insurance policy and the agreed-upon insurance conditions of the insurer together constitute the structure which is the legal basis of the relationship of insurer and policy holder and which will hereinafter be called insurance contract for short.

The provisions of Section 3 to Section 6 do only apply if the additional insurances in question are in force.

Article 3: Policy holder's change of address

(1) If the policy holder has changed address, but has failed to inform the insurer of this change, it is adequate to send a registered letter to the address last known to the insurer in the case of a declaration of intention to be made to the policy holder. This declaration takes effect as of the date at which the declaration would have been received by the policy holder via normal conveyance of mail if no change of address had occurred.

(2) If the policy holder has taken out the insurance in his business enterprise the provisions as per par. 1 are to apply analogously in the event of the place of business being relocated.

(3) If the policy holder establishes his residence outside Europe he must designate an authorized recipient in Europe towards the insurer, failing which the above regulations will apply.

Article 4: Maturity of the insurance benefit

(1) The insurer is only liable to the amount of the amount insured and has to pay the benefit in cash.

(2) Cash benefits on the part of the insurer are

- not due until the inquiries necessary for determining the insurance contingency and the scope of the benefit have been completed,
- not due before submission of an official photo identification of the beneficiary,
- if requested by the insurer, not due before submission of a declaration of the beneficiary, which contains data according article 4B, plus submission of probable further evidence.

The place of payment is the insurer's headquarters.

Remittance of benefits to the beneficiary are made at the beneficiary's expense and risk.

(3) Running of the periods is suspended and maturity does not occur as long as inquiries necessary for determining the insurance contingency and the scope of the benefit are impeded due to fault on the part of the policy holder, the insured person or the beneficiary.

(4) The insurer is entitled to postpone payment until required proof has been produced if there is any doubt as to the entitlement of the policy holder, the insured person or the beneficiary to receipt of payment. If an official investigation or an investigation by a criminal court has been initiated against any of the above-mentioned persons concerning the insurance contingency the insurer can postpone payment until this investigation has been completed.

Article 4A: Contractual currency

(1) When the contract is concluded, the policyholder is entitled to choose the currency of his contract to be USD or EUR. The currency chosen on conclusion of the contract cannot be changed later on, but must remain the same for the whole period of the contract.

(2) The contractual currency is stated in the insurance policy and applies to all amounts insured, insurance proceeds, premium amounts and charges.

(3) All amounts and limits stated in the insurance conditions remain valid and apply to both contractual currencies, USD and EUR, likewise.

Article 4B: Disclosures relating to the tax liability

(1) The policy holder is required to provide the insurer with any information relevant for the determination of his/her tax residency or, in the case of a payout, the tax residency of the account holder. If circumstances change and any of the information provided becomes incorrect, the policy holder is obliged to inform the insurer immediately.

(2) If the policy holder or the account holder is a natural person, the following information is considered as relevant according to point (1) of this article:

a) name,

b) date, place and country of birth,

c) address of permanent residence,

d) country/countries in which the policy holder/account holder is liable for tax,

e) tax identification number(s),

f) relevant data of any trustors.

(3) If the policy holder or the account holder is an Entity, the following information is considered as relevant according to point (1) of this article:

a) company name,

b) address of the registered office,

c) place of effective management,

d) country/countries in which the Entity is subject to taxation,

e) tax identification number(s),

f) information about the ownership structure relevant for the determination of the tax residency, in particular the names of the controlling persons according to Cyprus Decree for the Assessment and Collection of Taxes 2016 (Exchange for Information) regarding the automatic international exchange of tax information in accordance with the OECD standard), further abbreviated as “Decree” and art. 1 lit mm of the FATCA (Foreign Account Tax Compliance Act) Agreement between Cyprus and the USA, in their currently valid versions, and, for all controlling persons who are subject to reporting in accordance with the “Decree”, the full information required by point (2) of this article,

g) its status as an active or passive Non-Financial Entity (NFE) as defined in the “Decree”, as well as its status as an active or passive Non-Financial Foreign Entity (NFFE) as defined in points VI lit. B Z. 2 – 4 of the FATCA Agreement.

(4) Insurance payouts will be made by the insurer only upon identification of the recipient of the payment and in cases, where the insurer requires this, upon presentation of a declaration by the account holder containing the information stated in points (1) – (3) of this article with supporting documents attached (in particular an official identification document).

(5) If and to the extent that there is a risk for the insurer of paying tax liabilities, he may withhold the corresponding amount of the insurance proceeds until this risk ceases to exist and transfer the funds to the relevant competent national or foreign tax authority. The insurer is not obliged to compensate the account holder for any costs resulting from obtaining a refund of paid taxes from tax authorities.

Article 4C: Provision of documentation for fulfilment of anti-money laundering regulations

(1) The insurer is subject the national regulations in Cyprus for combating money laundering and terrorist financing. He must in particular ascertain and verify the identity of the policyholder, as well as obtain and verify information about the origin of funds for the premium payment. The policyholder is obliged to provide the insurer on request prior to business relationship and also during ongoing business relationship with all information and documents that the insurer requires in order to fulfil his due diligence obligations in connection with the combat against money laundering and terrorist financing.
This includes in particular the transmission of copies of official IDs, documents which verify the residence of the policyholder (e.g. so-called "Utility bills") and documents proving the source of funds.

(2) If the policyholder fails to fulfil his obligation under par. 1 within a reasonable period of time despite being requested to do so by the insurer, the insurer is released from the obligation to pay benefits from the insurance contract until the policyholder has fulfilled this obligation. Furthermore, the insurer is entitled to terminate the insurance contract at the end of the month, subject to one months´ notice, as long as the policyholder is in default in accordance with par 1.
In this case, the policyholder has right to payment of the surrender value in accordance with Art. 15 par. 4. The provisions as per par. 1 and 2 are also applicable to the persons insured in this contract.

Article 5: Statute of limitations

(1) The claims from the insurance contract are subject to a 3-year limitation period.

(2) The insurer is released from the obligation to perform if the benefit claim is not enforced by legal action within one year. The period shall not begin to run until the insurer has rejected the entered claim towards the beneficiary stating the legal consequence pertaining to the expiry of the period in writing and specifying a fact substantiating the rejection and a legal or contractual provision.

(3) Once a claim was filed, the limitation period suspends until a written statement is delivered to the beneficiary in which the insurer defines the reasons for his decision. The limitation period ends in any case after ten years.

Article 6: Obligation to give notice as at conclusion of the contract

(1) The policy holder must notify the insurer in the proposal or as at conclusion of the contract of all circumstances known to him which are relevant to assuming the risk. Of relevance are those risk circumstances that are of such nature as to exercise influence on the decision of the insurer to conclude the contract at all or under the agreed-upon provisions. A circumstance that the insurer has asked about expressly and in writing is relevant at all events.

(2) If notification of a relevant circumstance has not been made contrary to this provision the insurer can rescind the contract. The same applies if notification of a relevant circumstance has not been made because the policy holder has fraudulently evaded knowledge of this circumstance.
(3) Rescission is precluded if the insurer knew the unnotified circumstance. The insurer can also rescind the contract if a relevant circumstance has been incorrectly notified.

(4) The rescission must be explained to the policy holder. If the insurer rescinds after a contingency has occurred he is released from the obligation to perform and benefits already received must be paid back to the insurer. Interest is to be paid on an amount of money as of the date of receipt.
If the insurer rescinds after a contingency has occurred his liability to perform continues to exist, if the circumstance, in regard of which the obligation to give notice was violated, has had no influence on the occurrence of the insurance contingency or on the scope of the benefit incumbent on the insurer.

(5) If the insurer was not properly notified of circumstances pertaining to the health of the insured person as at the conclusion of the contract as defined by the above provisions, the insurer's liability does nevertheless continue to exist if the circumstance, regarding which the obligation to give notice was violated, has had no influence on the occurrence of the insurance contingency or on the scope of the benefit incumbent on the insurer. The beneficiary entitled to receive the benefit must prove that these requirements for the insurer's liability are fulfilled.

(6) If the relationship of insurer and policy holder is terminated by rescission on the part of the insurer due to a violation of the obligation to give notice as at the conclusion of the contract or if the insurance contract is challenged by the insurer, the premium for the duration of the contract that has so far elapsed is nevertheless due to the insurer. In the event of rescission or challenge the insurer must allow surrender.

Article 7: Participation of third parties

(1) If the insurance is concluded on the life of another person or if an insurance is taken out against accidents happening to another person, the written consent of this other person is required for validifying the contract.

(2) If the contract is concluded by an agent or representative without power of representation, not only the knowledge and fraudulent intent of the representative, but also the knowledge and fraudulent intent of the policy holder is taken into consideration with regard to the insurer's right of rescission and release from the obligation to perform.

(3) All provisions made with regard to the policy holder also apply analogously to insured persons and persons asserting a claim from the insurance contract. These persons are responsible along with the policy holder for fulfilling all obligations resulting from the insurance contract with the exception of the obligation of paying premiums. In the event of these persons neglecting to comply with obligations as well as in the event of the policy holder himself neglecting to comply with obligations the legal consequences provided shall ensue.

(4) After an insurance contingency has occurred, the insurer can also pronounce a rejection, a declaration of rescission or a challenge with legal effect towards an authorized third party.

Article 8: Premium

(1) The premium is set in accordance with the rate and the age of the insured person. The age is the difference between the calendar year as per inception of insurance coverage and the year of birth.

(2) The premiums are single or annual premiums. If, in the event of an insurance contingency occurring, instalments of the current annual premium have not been paid or if the insurer finds himself obliged to sue for the outstanding premiums due to default in premium payment, all instalments of the current annual premium fall due immediately and can be deducted from any benefit incumbent on the insurer even if the benefit is not owed to the policy holder but to a third party.

(3) The payment of the initial premium or single premium is precondition for the printing and delivery of the insurance policy. If the initial or single premium is not paid within 6 weeks after arrival of proposal at the insurer, the contract is deemed not to have been concluded and the insurer rejects the proposal.

(4) Renewal premiums fall due and must be paid immediately at the beginning of each new term.

(5) Postponement of premium payment is only possible by written agreement with the insurer's headquarters.

(6) The policy holder commits himself to pay for all additional expenses incurred through his behaviour (money order costs, postage expenses etc.)

In the event of delay in payment of premium the insurer will request payment of the outstanding amounts from the policy holder in an appropriate and customary fashion, out of court at first. The policy holder must reimburse the thus incurred additional expenses, charged as dunning costs, to the insurer.

(7) If the premium has not been paid or has not been paid in full by the due date interest must be paid on the outstanding amounts at an interest rate of one per cent per month as of the due date and until the obligation of payment has been completely fulfilled, regardless of any other consequences of non-payment.

(8) For the event of early termination of contract the policy holder commits himself to reimburse a business charge to the insurer.
This business charge amounts to fifteen per cent of the annual premium for combined endowment and life insurances respectively to fifty per cent of the annual premium for term insurances, to a minimum of USD 50, to a maximum of USD 300.

(9) The policy holder must transmit the premiums to the insurer at his own risk and expense. The date of receipt of payment into the insurer's account is decisive for the timeliness of premium payment.

Article 8A : Change of policyholder

(1) A change of the policy holder is a change of a contractual party and therefore requires the explicit approval of the insurer.

(2) The insurer will not approve a change of policy holder within the last 3 years of the contract period or in case of a single premium contract.

(3) After a change of policy holder, the new policy holder has no right to terminate the contract within 3 years from the date on which the change of the policy holder became effective.

Article 9: Inception and end of insurance coverage

(1) An insurance contract is only brought about if the insurer gives written confirmation of the acceptance of the proposal or delivers a policy to the policy holder.
With this precondition, insurance coverage begins as of the date indicated in the policy if the policy holder pays the initial or single premium in good time. If the initial or single premium is not paid in good time, insurance coverage begins as of the date of the late premium payment.

(2) The insurance coverage ends, except for in the case of rescission, termination, challenge and expiry of the agreed-upon contract period, if a renewal premium or an instalment of a renewal premium is not paid, after the insurer has sent a reminder stating the legal consequences, within the grace period of 14 days.

Article 10: Written form

(1) All agreements, notifications, proposals and representations pertaining to the insurance contract must be effected in writing. Declarations by the policy holder, the person insured and the beneficiary do not take effect until they have reached the insurer's headquarters.

Commitments on the part of the insurer are only valid if they are issued bearing the signature by an authorized officer from the insurer's headquarters.

(2) The insurer may demand supplements and amplifications (especially the results of medical examinations) after receiving the proposal. In this case the proposal is not regarded as having been received by the insurer until he has received the desired supplements and amplifications.

(3) All documents and supporting documents addressed or presented to the insurer should be written in English or German. In as far as this is not the case, the policy holder commits himself to pay the insurer the thus resulting costs of translation.

Article 11: Right to the insurance benefit

(1) The policy holder must designate a beneficiary when the contract is concluded. The beneficiary acquires the right to the benefit in the event of the contingency occurring. Until then, the policy holder can change the right to insurance benefit at any time. Regulation concerning premium credits in the event of death: If a policyholder dies who is at the same time insured under the same contract, the beneficiary nominated by him to receive the insurance benefit shall receive also any premium credits from this contract.

(2) The policy holder can also rule that the beneficiary is to acquire the right to the future benefit irrevocably and thus immediately. In this case the right to the insurance benefit may only be changed with the beneficiary's consent.

(3) If several persons are designated as beneficiaries without specification of their quotas, they are entitled to the insurance benefit in equal parts; the share not acquired by a beneficiary accrues to the other beneficiaries proportionately to their quotas.

(4) If the right to the benefit of the insurer is not acquired by the beneficiary, it is due to the policy holder.

(5) Changing the right to the insurance benefit is not binding for the insurer until he has received written notification hereof by the policy holder.

(6) If the bearer (holder) of the policy is entitled to claim the insurer may demand that he proves his entitlement.

Article 11A: Pledging

(1) As long as no other agreement has been made, the policyholder is entitled to dispose of his life insurance policy. He can pledge his contract.

(2) Pledging is only valid, if it has been applied for with the corresponding pledging form of the insurer

Article 12: Loss of policy

(1) Any loss or destruction of the policy is to be reported to the insurer immediately. The insurer will issue a replacement policy upon application.

(2) In the event of the loss or destruction of a bearer policy, the policy holder must have the cancellation by means of legal public notice procedure carried out at his own expense and present the insurer the cancellation notification before a replacement policy can be issued.

Article 13: Applicable law and agreement on jurisdiction

(1) Disputes pertaining to this relationship of insurer and policy holder are to be dealt with by the court having jurisdiction with regard to the subject matter in Vienna.

(2) It is explicitly agreed that this contract is governed by Austrian law with the exception of all norms serving as legal reference, whereas contractual provisions (in particular the General insurance conditions and the Final declaration) always take priority over legal regulations.

(3) In alteration of all presently valid and future legal regulations concerning the distribution of acquisition costs it is explicitly agreed that such expenses are included in the calculation of the amount insured and the surrender values (Art. 15 par. 4) right at the beginning of the contract period by ways of zillmerisation and will on no account be determined on basis of the actual duration of the insurance.

Section 2: PROVISIONS FOR LUMP-SUM RISK INSURANCES (LIFE INSURANCE = "Main insurance")

Article 14: Scope of insurance coverage

(1) Basically, insurance protection exists irrespective of what caused the insured event.

(2) The benefit in the event of death is limited to the value of the actual mathematical reserve in accordance with the given rate, if an insured event is related to the fact that

- the insured person dies as the result of warlike operations of any kind, irrespecitve of the fact whether war was declared or not, including any acts of violence initiated either by a country or by a political or terroristic organisation;
- the insured person participates in any other warlike actions;
- the insured person dies as the result of civil commotion, civil war, revolution, rebellion, riot or uprising;
- the insured person dies as a result of earthquake or flood;
- the insured person is sentenced to death due to a criminal offense and the sentence is carried out;
- the insured person is killed while committting or trying to commit a criminal offense showing the characteristics of a deliberate action;
- the insured person dies as a result of pathological alcohol or drug abuse;
- the insured person dies as a result of a past or present nuclear, chemical or bacteriological danger of an extent which is able to lead to a significant and not just temporary increase of the mortality rate in the affected region.

(3) If not otherwise agreed, the benefit in the event of death is furthermore limited to the mathematical reserve in accordance with the given rate, if death occurs as the result of

- flying as a special pilot (e.g. hang-gliding, ballooning, paragliding, parachuting), helicopter pilot or military pilot;
- dangerous sports (e.g. free climbing or deep-sea diving)
- participation in races or precompetitive training in a motor vehicle, aircraft or watercraft.
- an epidemic. An epidemic is an illness that affects many individuals in a population. Any illness that is classified as pandemic by the WHO is at any case an epidemic.
- HIV infection. If the HIV infection was caused by a medical treatment, this exclusion does not apply.

(4) If the insured person commits suicide after the expiration of five years from the date of conclusion or alteration of the contract, full insurance coverage exists.
Before expiry of this period the insurer reimburses only the value of the mathematical reserve in accordance with the given rate.
If the insurer is provided with sufficient proof that the suicide was committed in a state of mental derangement which prevented the victim from correctly perceiving the nature of his action, full insurance cover is effective.

Article 15: Termination, delay in premium payment and surrender value

(1) The insurance contract can be terminated by the policy holder at any time by the end of the current coverage year or within a coverage year by the end of the month subject to three months' notice, but at the earliest by the end of the first coverage year.
(2) The contract can be terminated wholly or partly. Termination in part can, however, only be pronounced in the form that the policy holder is committed to pay premiums to a total amount of USD 300 a year from the upheld part of the insurance contract.

(3) The policy holder can demand conversion of the insurance into a premium-free insurance for the end of the current period. If the amount insured resulting after conversion does not exceed an amount of USD 1,000, only the surrender value is granted instead of conversion.

For the calculation of the premium free value it is regarded as being agreed that the premium free value is to be determined from the actual cash value by making a deduction of five per cent of the actual cash value (= actuarial net reserve), but at least of fifteen per cent of the annual premium.

(4) For the calculation of the surrender value it is regarded as being agreed that the surrender value is to be determined from the actual cash value by making a deduction of five per cent of the actual cash value (= actuarial net reserve), but at least of fifteen per cent of the annual premium.
The surrencer value is determined according to actuarial principles, taking into account any expenses incurred, the amount of the premium reserve and the volume of insurance protection. The table of surrender values shown in the policy is an integral part of this clause.

(5) If a renewal premium is not paid within 14 days as of receiving the insurer's reminder stating the legal consequences conversion into a premium-free insurance ensues in as far as the premium-free amount insured does exceed an amount of USD 1,000.

Article 15A: **Policy loan**

(1) The policyholder may request for a policy loan of the future benefit payment on the condition that the surrender value of the policy is greater than the minimum amount required by the insurer. For this policy loan additional premiums have to be paid, which are subject to the regulations of Article 8, these additional premiums (interests) are deducted from the loan before payment to the policyholder. The amount of repayment is the full loan amount including interests.

In such cases all rights of the policy will be ceded to Medlife Insurance Ltd.

If any debit balances are owed to the insurer after the repayment period, then this will be deducted from the value of the policy.

(2) The maximum loan amount granted will be set by the insurer from time to time as a percentage of the surrender cash value.

(3) In the case of non-repayment of the loan, the policy loan will be balanced with the benefit payment in case of death, and with the surrender value in case of non-payment of your renewal premiums.

(4) There shall be no policy loan on term insurance rates.

Article 16: Provisions for the event of benefit payment

(1) The following obligations apply to any beneficiary wishing to assert a benefit claim on the insurer:

- The death of the insured person must be reported to the insurer immediately, within five days at the latest.
- Benefits from the insurance contract will only be paid if the policy is handed over.
- In the event of the insured person's death an official death certificate is to be presented.

- Upon request, the insurer must be presented with further medical or official supporting documents.

- The insurer must be truthfully and completely provided with all the information he wishes that is necessary for determining his obligation to perform.

(2) The insurer is released from his obligation to perform in as far as obligations as per par. 1 are violated deliberately or through gross negligence and thus relevant circumstances are unclarifiable.

Article 17: Special provisions relating to the payment of insurance benefits

(1) If the policy holder deliberately causes the death of the insured person by an unlawful act, the insurer is releaved from its liability for payment.

(2) If the beneficiary deliberately causes the death of the insured person by an unlawful act, his entitlement to benefit becomes void; in this case the right to receive the reimbursement from the insurer passes over to the policyholder.

(3) If in the case of an insured person´s death the insurer is liable to effect payment under several policies, the total amount of benefit from all policies covering the same life is limited as follows:

- term insurance benefit: maximum 3,000 USD per person insured
- accidental death insurance benefit: maximum 80,000 USD per person insured
- accidental permanent disability insurance benefit: maximum 80,000 USD per person insured.

Article 18: Right to pension option

Instead of capital payment, payment of a pension can be chosen. Before payment falls due the policy holder is entitled to the right to this option, thereafter the beneficiary. The right exists as long as the capital has not been paid.
The amount of the pension is calculated according to the rates that are valid at the date the capital payment falls due. The age of the recipient of the pension as at the due date of the capital payment is decisive for calculating the amount of the pension.
This right can be asserted either for part of the capital payment or for the whole capital payment. Here, pension payment due at the beginning or at the end of the relevant period can also be agreed upon.
During the period of ongoing pension payments the policyholder has no right to cancel the contract.

Article 19: Surplus participation

(1) The provisions of this article shall not apply to risk insurances.

(2) All insurance contracts with surplus participation concluded according to these provisions belong to the profit class stated in the policy. The amount of surplus to be allocated to a specific profit class is determined on basis of the business plan and profit plan. At least 85 per cent of this surplus reserve is allocated in terms of bonuses. The dividends are designated according to the business plan and profit plan and published in the insurer's business report.

(3) The dividends of the individual insurances consist of the interest surplus share and final share in surplus. Interest surplus shares are allocated at the end of each coverage year, at the end of the second coverage year at the earliest. The final share in surplus falls due if the insurance benefit is paid due to expiry of the coverage period or due to the event of death provided that at least two coverage years have expired.

(4) The interest surplus share represents the share of the insurance in the surplus that is attained via capital income from the covering funds exceeding the calculated rate of interest.
The interest surplus share is calculated in per cent of the mathematical reserves of the main insurance meant for surplus participation as per business plan and any participating additional insurance; here, the mathematical reserve as per business plan is to be determined at the beginning of the coverage year preceding the coverage year at the end of which allocation ensues.

(5) The interest surplus share to be allocated results from multiplying the calculated interest surplus share as per par. 3 by the rate of interest as per par. 7 fixed as per business plan.

(6) The final share in surplus fixed as per business plan for the event of death amounts to the sum of the interest surplus share calculated as per par. 3 for the coverage year in which death occurs. The final share in surplus fixed as per business plan for expiry of the coverage period is calculated as the sum of the interest surplus share as per par. 3 with the last coverage year being taken into account instead of the previous coverage year.

(7) The due dividends are accumulated with the rate of interest fixed as per business plan and, at the same time, paid with the insurance benefit if no other provision is made in the business plan for certain amounts insured, insurance forms etc.

(8) As future profit accumulation is not predictable, any figures related to profit participation are the result mere forecasts made on basis of the present situation. Therefore such statements are not binding.

Article 20: Incorrect declaration of age

(1) If the age of the insured person is incorrectly declared at the conclusion of the contract and thus the premium incorrectly determined, the insurer's benefit is decreased or increased according to the relation of the premium corresponding to the real age and the agreed-upon premium.

(2) The right of rescission due to misrepresentation is only due to the insurer if the real age is outside the limits for concluding contracts as set in the business plan.

Section 3: PROVISIONS FOR THE ADDITIONAL ACCIDENTAL DEATH INSURANCES

Article 21: Object of the insurance

(1) If the insured person's death occurs during the premium payment period and before attaining the age of 75 years due to an accident occurring after the begin of the additional accidental death insurance, the insurer pays the agreed-upon amount insured as per the additional accidental death insurance along with the due amount insured as per the main insurance.

(2) Liability as per the additional accidental death insurance only exists for as long as the corresponding main insurance is fully in force. Conversion of the additional accidental death insurance into a premium-free insurance and surrender hereof is ruled out. The additional accidental death insurance is without participation in surplus.

Article 22: Validity of the provisions as per section 6

The provisions as per articles 33 - 38 and 40 - 43 also apply as agreed to the additional accidental death insurance.

Article 23: Validity of the provisions as per section 1 and 2

The General Contract Terms (articles 1 - 13) and the provisions of the main insurance (articles 14 -20) apply mutatis mutandis to the additional accidental death insurance in as far as no other provisions are made in this section.

Section 4: PROVISIONS FOR THE ADDITIONAL ACCIDENT INSURANCES FOR THE EVENT OF PERMANENT DISABILITY

Article 24: Object of the insurance

(1) If the insured person has an accident during the premium payment period of the main insurance and before attaining the age of 75 years and if, furthermore, permanent disability of 30 % or more results within one year as a result of this accident, the agreed-upon amount insured of the additional accident insurance for the event of permanent disability is paid according to the degree of disability.
If the degree of the determined disability is less than 30 % no benefit is paid from this contract.

(2) Liability as per the additional accident insurance for the event of permanent disability exists only for as long as the corresponding main insurance is fully in force. Conversion of the additional accident insurance for the event of permanent disability into a premium-free insurance and surrender hereof is ruled out. The additional accident insurance for the event of permanent disability is without surplus participation.

Article 25: Validity of the provisions as per section 6

The provisions as per articles 33 - 38 and 40 - 43 also apply as agreed to the additional accident insurance for the event of permanent disability.
The provisions as per article 24 paragraph 1 are agreed as a modification of the regulations as per article 39.

Article 26: Validity of the provisions as per section 1 and 2

The General Contract Terms (articles 1 - 13) and the provisions for the main insurance (articles 14 - 20) apply *mutatis mutandis* to the additional accident insurance for the event of permanent disability if no other provisions are made in this section.

Section 5: PROVISIONS FOR THE ADDITIONAL TERM INSURANCES

Article 27: Object of the insurance

If the death of the insured person occurs during the premium payment period of the main insurance the insurer pays the agreed-upon amount insured as per the additional term insurance along with the benefit due as per the main insurance.

Article 28: Limitation of the insurance benefit

Please refer to art. 17 (3) which expressly states that in the case of multiple insurance the amount of the insurance benefit is limited.

Article 29: Inception and end of the coverage period

(1) Insurance coverage begins as of the begin of liability as per the main insurance.

(2) If the main insurance is terminated or converted into a premium-free insurance before the expiry of the scheduled premium payment period of the additional term insurance, the policy holder's obligation of premium payment and the insurer's obligation to perform also end.

Article 30: Policy holder's right to termination, surrender

(1) The insurance contract can be terminated by the policy holder at any time by the end of the current coverage year or within a coverage year by the end of the month subject to three months' notice, but at the earliest by the end of the first coverage year.

(2) No surrender value is granted for additional term insurances.

Article 31: Participation in surplus

Additional term insurances are without participation in surplus.

Article 32: Validity of the provisions as per section 1 and 2

The General Contract Terms (articles 1 - 13) and the provisions for the main insurance (articles 14 - 20) apply *mutatis mutandis* to the additional term insurance in as far as no other provisions are made in this section.

Section 6: PROVISIONS FOR THE PERSONAL ACCIDENT INSURANCE

Article 33: Object of the insurance

(1) The insurer provides insurance coverage if the insured person has an accident.

The benefits insured result from article 39 and 40 in connection with the policy.

(2) The contingency insured against is the occurrence of an accident as per article 34.

(3) The entire earth is the territorial area of applicability of the personal accident insurance.

(4) The temporal scope of application is defined in that accidents are insured that occur while the insurance coverage is in effect (article 9).
The accident insurance contract is concluded for a fixed term that is agreed upon in proposal and policy.

Article 34: Definition of the term accident

(1) Accident is an occurrence independent of the intention of the insured person that suddenly affects his body from outside mechanically or chemically causing bodily damage or death.

(2) The following occurrences, independent of the insured person's intention, are regarded as being accidents:

- Drowning;
- Burns, scalds, effects of lightning or electric current;
- Inhalation of gases or vapours, taking poisonous or corrosive substances unless these effects ensue gradually;
- Dislocation of limbs as well as pulling and tearing muscles, tendons, ligaments and capsules located on limbs and the spinal column due to a sudden deviation from the planned course of motion.

(3) Illnesses are not regarded as being accidents, contagious diseases are not regarded as being the result of an accident.

This does not apply to the effects of poliomyelitis if the disease is diagnosed serologically and breaks out at the earliest 15 days after the begin, but not later than 15 days after expiry of the insurance contract.
The begin of the disease (date of the insurance contingency occurring) is the day on which a doctor is first consulted about the disease diagnosed as poliomyelitis.

The insurer's benefit is, however, limited to USD 20,000 within the agreed-upon amount insured.

The exclusion also does not apply to tetanus and rabies as caused by an accident as per par. 1.

(4) Insurance coverage also applies to accidents of the insured person as an airline passenger in motor aircraft officially registered for use in passenger transport.

An airline passenger is someone who does not have a causal connection with the operation of the aircraft, nor is a crew member, nor is engaged in professional activity with the aid of the aircraft.

Article 35: Uninsurable persons

(1) Uninsurable and on no account insured are persons who are permanently totally incapacitated for work or who have a severe nervous condition or who are mentally ill.

Total incapacity for work is given if the insured person cannot be expected to be gainfully employed from a medical point of view due to illness or defect and if there actually is no gainful employment.

(2) No insurance contract is brought about with regard to an uninsurable person.

If the insured person has become uninsurable within the term of the insurance contract, insurance cover expires. At the same time the contract for this insured person also ends.

Article 36: Excluded from insurance cover are accidents resulting from

(1) the use of aviation devices, the performance of parachute jumps or the use of an aircraft, as far as not covered by the provisions of art. 34 par. 4;

(2) the participation in a motor sport contest (including assessment races and rallies) or precompetitive training;

(3) the participation in national or international contests in skiing, ski jumping, skeleton, bob or skibob riding, including precompetitive training;

(4) the insured person committing or attempting to commit a criminal offense which shows the characteristics of a deliberate action;

(5) warlike operations of any kind, irrespective of the fact whether war was declared or not, including any acts of violence initiated by a country, political or terroristic organisation;

(6) civil commotion, civil war, revolution, rebellion, riot or uprising;

(7) the direct or indirect influence of
- ionizing radiation
- nuclear energy
- earthquake or flood;

(8) the fact that the insured person has suffered a heart attack or stroke; a heart attack is in no case regarded as result of an accident;

(9) the fact that the insured person´s consciousness is disturbed or his mental capacity is considerably impaired by the influence of alcohol, drugs or medicine;

(10) bodily damage received in the course of therapeutic measures or surgery performed on the body of the insured person by himself or any other person, as far as not an insured event was the cause for it; if an insured event was the cause, par. 7 does not apply.

(11) It is not regarded an accident if the insured person is sentenced to death for a criminal offence and the sentence is duly carried out.

(12) It is not regarded an accident, if the insured person has been intentionally killed or intentionally injured by a third person.

Article 37: Obligations

(1) Obligations before the insurance contingency occurs

An obligation whose violation results in the insurer being released from his obligation to perform is that the insured person as a motor vehicle driver must at all accounts be in possession of the driving license required for driving the motor vehicle on public roads; this also applies where the vehicle is not driven on public roads.

(2) Obligations after the insurance contingency has occured

Obligations whose violation results in the insurer being released from his obligation to perform are:

(2.1) The insurer must be informed in writing of an accident immediately, within five days at the latest.

(2.2) The insurer must be informed in writing of a death immediately, within five days at the latest; this also applies if the accident has already been notified.
(2.3) The insurer must be granted the right to have the corpse viewed by doctors, opened up and, if necessary, exhumed.

(2.4) After the accident medical aid must be immediately made use of and medical treatment must be continued until the healing procedure has been completed; equally so, appropriate medical care must be ensured and, if possible, the results of the accident avoided and lessened.

(2.5) After receiving the form for accident notification it must be immediately filled in and returned to the insurer; furthermore, the insurer must be provided with any pertinent information he demands.

(2.6) The doctor or hospital in charge of treatment and any doctors or hospitals that have treated or examined the insured person for other reasons must be authorized and requested to provide information the insurer requires and to supply reports. If the accident has been reported to another insurance company or any other similar institution, this company or institution must also be authorized as in the above sense.

(2.7) The authorities dealing with the accident must be authorized and induced to provide the information required by the insurer.

(2.8) The insurer can demand that the insured person let himself be examined by doctors designated by the insurer.

(2.9) All the provisions made for the policy holder apply mutatis mutandis to insured persons and those persons asserting claims on pertaining to the insurance contract. Along with the policy holder, these persons are responsible for fulfilling the obligations of damage mitigation and the duty to try and salvage.

Article 38: Substantive limitation of insurance coverage

(1) Insurance benefit is only paid for the results of the accident that occurs (bodily damage, death).

(2) For assessing the degree of disability the amount of a previous disability is only deducted if a bodily or mental function is affected by the accident that was already impaired.

Previous disability is assessed as per art. 39 par. 2 and 3.

(3) If diseases or defects that existed before the accident occurred influence the results of the accident the benefit is reduced in accordance with the proportion of the disease or defect in as far as this proportion is at least 25%.

(4) A benefit is only paid for organic disorders of the nervous system if and in as far as this disorder is attributable to organic damage caused by the accident.

Psychologically abnormal behaviour (neuroses, psychoneuroses) are not regarded as being the results of an accident.

(5) Benefit is only paid for disc hernias if they arise due to direct mechanical effect on the spinal column and if what is involved is not a worsening of symptoms that existed before the accident occurred.

(6) Benefit is only paid for any kind of abdominal rupture if it was directly caused by an outside mechanical influence and is not inherent.

Article 39: Permanent disability

(1) If it results within one year as of the date of accident that permanent disability remains as the result of the accident, the appropriate amount according to the degree of disability from the amount insured for this event is paid.
(2) The following provision applies for assessing the degree of disability:

(2.1.) for the total loss or the total incapacity

of an arm 70%
of a hand .... 60 %
of a thumb .... 20 %
of an index finger .... 10 %
of another finger .... 5 %
of a leg .... 70 %
of a foot .... 50 %
of a big toe .... 5 %
of another toe .... 2 %
of sight of both eyes .... 100 %
of sight of one eye .... 35 %
in as far as the sight of one eye was lost before the insurance contingency occurred .... 65 %
of hearing of both ears .... 60 %
of hearing of one ear .... 15 %
in as far as the hearing of one ear was lost before the insurance contingency occurred .... 45 %
of the sense of smell .... 10 %
of the sense of taste .... 5 %

(2.2.) In the event of partial loss or partial incapacity of the above-mentioned parts of the body or organs, the rates as per par. 2.1. are applied pro rata.
In the event of limited capacity of the arms or legs the rate for the whole extremity is to be applied pro rata.

(3) If the degree of disability is not assessable as per paragraph 2, the degree to which the bodily or mental capacity has been impaired from a medical point of view is decisive.

(4) Multiple percentages resulting from paragraph 2 and 3 are added together. The degree of disability can, however, never amount to more than 100 %.

(5) In the first year following the accident a disability benefit is only paid if the nature and scope of the results of the accident are clearly specified from a medical point of view.

(6) If the degree of permanent disability is not clearly specified, the insured person and the insurer are entitled to have the degree of disability re-assessed every year to a maximum of four years as of the date of the accident.
If the final assessment in such a case amounts to a greater disability benefit than the insurer has already paid, the additional amount falls due within one month as of determination.
(7) If the insured person dies

(7.1.) due to accident within one year following the accident, there is no entitlement to disability benefit;

(7.2.) due to a non-accident cause within one year following the accident, payment must be made according to the degree of the permanent disability that would have had to be reckoned with on the basis of the last medical results;

(7.3.) due to accident or a non-accident cause later than one year following the accident, payment must also be made according to the degree of the permanent disability that would have had to be reckoned with on the basis of the last medical results.

Article 40: The event of death

(1) If death ensues within one year as of the date of the accident as the result of the accident, the amount insured for the event of death is paid.

(2) Only payments that have been made for permanent disability from the same occurrence are appropriated to the benefit for the event of death and are therefore deducted from any amount paid to this respect. The insurer cannot claim any amounts of benefit paid in excess for permanent disability.

(3) Only the appropriate funeral costs incurred are reimbursed for persons under 15 years of age within the scope of the amount insured.

Article 41: Termination

(1) After the insurance contingency has occurred the insurer can terminate if he has recognised the entitlement to the insurance benefit on the merits or has paid the insurance benefit or if the policy holder has fraudulently asserted a claim on insurance benefit.
(2) Termination is to be effected within a month

- following recognition on the merits;
- following payment of the insurance benefit;
- following rejection of the fraudulently asserted claim for insurance benefit.

Termination can only ensue upon one month's notice.

(3) If the policy holder has fraudulently asserted a claim, the insurer can terminate with immediate effect.

Article 42: Change of the insured person's professional activity or employment

(1) Any changes of the insured person's declared profession or declared employment as per proposal must be immediately notified. Being called up for regular military service and for short-term military exercises does not constitute a change of profession or employment.

(2) If, according to the valid rate at the date of the change, a lower premium results for the insured person's new professional activity or employment, only this premium must be paid as of the receipt of the notification.

(3) If a higher premium results, full insurance coverage is granted for the new professional activity or employment for the period of three months as of the date at which the insurer should have received the notification. If an insurance contingency attributable to the new professional activity or employment occurs after the expiry of the three months, and if no agreement has been meanwhile reached on the additional premium, the insurer's benefits are assessed in such a way as that the contract is based on amounts insured in the form of amounts that result in accordance with the premium rates necessary for the new professional activity or employment, on the basis of the actual premium calculated in the policy.

Article 43: Special provisions for the event of benefit payment

(1) If the policy holder causes the accident of the insured person deliberately by an unlawful act the insurer is released from the obligation to perform.

(2) If the beneficiary causes the accident of the insured person deliberately by an unlawful act the entitlement to benefit is regarded as not effected; the insurer's benefit is due to the policy holder.

(3) If the insured person causes the accident deliberately the insurer is released from the obligation to perform.