General Provisions for Unit-linked Life Insurance
MEDLIFE Insurance Limited
LV 90700/04

Policyholder is the term used for the person who takes out an insurance contract with **MEDLIFE Insurance Ltd.**

Insured person specifies the person whose life is insured under the contract.

The term **Beneficiary** is used for the person designated to receive the benefit proceeds.

Insurer stands for the insurance company **MEDLIFE Insurance Limited.**

§ 1. Definition of Unit-linked Life Insurance

(1) Unit-linked Life Insurance provides both life insurance protection and a savings component. It is called “Unit-linked”, because the money is invested in a portfolio of securities, and the value of the units you own in this portfolio (fund) represents the mathematical reserve of your policy. The value of your policy increases in case of a good investment performance of the underlying assets, but may also decrease in case of a declining performance. In the case of an additional relation to foreign currency rates, this may lead to even higher fluctuations in value. Bonuses are credited to the policy by converting them into units of the portfolio.

(2) In case, if the insured person dies during the policy term, the designated beneficiary receives the guaranteed death benefit stated in the policy. The policy furthermore contains information on how the indemnity payment increases, if the cash value of the mathematical reserve exceeds the death benefit.

(3) In the case of survivance you receive the value of the units you own in the portfolio.

§ 2. How to submit your application

(1) To apply for Unit-linked life insurance you need to submit a written proposal for the conclusion of a life insurance contract. In this proposal you are to state all facts which are important for the insurer´s decision whether to accept or reject a risk.

(2) You are bound to your application for the period of six weeks starting from the day of the medical examination. If no medical examination is performed, the binding period begins on the day you submit your application.

(3) Basis of the contract are the insurance proposal, the insurance policy itself, the chosen rate and the relevant Insurance Provisions.

§ 3. When does insurance coverage commence?

On condition that the initial premium has been paid in time according to § 5 (2), insurance coverage commences on the date the proposal has been accepted by the insurer. Acceptance occurs by written notice from the insurer or delivery of the insurance policy. No insurance cover is provided before the inception date stated in the policy.

§ 4. How your premium is distributed

(1) All parts of the premium that are not used to cover specific costs are put into a portfolio of securities (investment fund), where they are converted into units of the given fund.

(2) The premium to cover the death risk, as well as administration costs, are deducted from your policy´s mathematical reserve once a month in advance. In case of a decreasing investment performance or if the contract is free of premium, this may lead to a complete consumption of the mathematical reserve before the end of the agreed term of insurance. In this case the contract becomes void.

(3) The cost of the risk premium depends on the chosen rate and the insured person´s age. The age is determined by deducting the year of birth from the actual calendar year. In the case of a substandard risk, additional premiums or special provisions may be agreed.

§ 5. Some important facts concerning the premium payment

(1) Premiums may be current premiums or single premiums and are to be paid free of charge for the insurer. Current premiums are paid annually.

(2) The payment of the initial premium or single premium is precondition for the printing and delivery of the insurance policy.

(3) Renewal premiums become due for payment at the beginning of each insurance year and must be paid on or before the annual due date.

(4) A reduction of premium is possible at the earliest by the end of the third year of insurance.

§ 6. What happens if a premium is not paid on time?

(1) Initial or single premium:

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.

(2) Renewal premium:

If a renewal premium is not paid on time, you will receive from us a premium reminder. If the due premium is not paid within the two-week grace period, as stated in the reminder, we have the right to cancel the contract by expiry of the grace period, unless the delay of payment occured without your fault. Insurance cover will be suspended or reduced (see paragraph 3). This fact will be expressly stated in the reminder.

(3) If two full annual premiums have already been paid and a surrender value has been formed according to § 7 (4), the insurance contract is converted by the insurer into a premium free status at the end of the term specified in Section 2. If two full annual premiums have not yet been paid, the contract ends without payment at the end of the term specified in Section 2 (i.e. all premiums paid remain with the insurer in full)

(4) If the insurer converts the policy to premium free status, the policy holder is obliged to pay the insurance fee as well as the fee for converting the policy to non-premium status. If the policy is converted to non-premium status before the end of the third insurance year, the fee is 20% of the annual premium. The fee for converting the policy to non-premium status is 10% of the annual premium.

§ 7. When do you have the right to cancel your contract and when do you have the right to terminate or convert your insurance contract to non-premium status?

(1) You are entitled to cancel your contract partly or totally in writing

- as per any periodic transaction day (valuation date according to §14 par. by giving 42 days notice,
- but at the earliest by the end of the second year of insurance if two full annual premiums have been paid.

(2) As soon as the policy has a surrender value, you have the right to convert it into a policy free of premium according to par. (1)

(3) If the policy is converted to premium free status, we charge insurance fees as well as fees for conversion to premium free status. The insurance fees until the end of the third policy year are 20% of the annual premium and the fees for conversion to non-premium status are 10% of the annual premium. If the actuarial reserve determined at the time the policy is converted to premium free status is not less than €500.00, the contract will be surrended. This 10% fee is applied pro rata in the event of a decrease in the annual premium.

After a premium free status, the risk premiums and the administrative costs are withdrawn from the actuarial reserve on a monthly basis. In the event of falling rates, this can lead to the actuarial reserve being depleted before the end of the agreed insurance period. In this case, the contract ends without benefits.

(4) If your insurance contract is terminated totally, you will be paid the surrender value of the contract. The surrender value of the contract corresponds to the value of the actuarial reserve as of the valuation date according to § 14 para. 2, reduced by the deductible.

The total deductible consists of an insurance fee of 20% of the annual premium and a deductible of 5% of the actuarial reserve. In case of cancellation of a single premium, the insurance fee is 20% of the single premium, but not more than 3,000 euros.

(5) In the case of partial surrender of your contract, you will receive the requested partial surrender value. The partial surrender value corresponds to 95% of the actuarial reserve withdrawn during the partial surrender and must amount to at least EUR 1,000. During the entire insurance term, a maximum of three partial surrenders are permitted and the remaining actuarial reserve after the respective partial surrender must not be less than the minimum amount of EUR 1,000.

§ 8. What is the importance of the statements you made in your application?

(1) The insurer provides insurance protection relying upon the fact that you have responded truthfully and thouroughly to the questions on the application form.

(2) If the life of a person other than the policyholder is to be insured under the policy, this person can also be held responsible for false statements in the application.

(3) If deliberately false or unexact statements were made, the insurer has the right to withdraw from the contract.

(4 The acceptance of your application and the premium calculation base on the state of your health at the time of contract conclusion. You expressly agree that any abuse of nicotine, alcohol, medicine or other narcotics is regarded an increase of risk.

Such an increase of risk must be immediately reported to the insurer. It entitles us to cancel the contract, or it may release us from our contractual obligations in case if an insured event occurs.

(5) If the insurer disputes the contract or declares his withdrawal, only the surrender value will be returned.

§ 8A. How can you apply for change of policy holder?

(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.

§ 9. What is covered by your policy?

If not otherwise agreed, the following applies:

(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, irrespective of the fact whether war was declared or not, including any acts of violence initiated either by a country or by a political or terrorist 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 offence and the sentence is carried out;
- the insured person is killed while committing or trying to commit a criminal offence 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 policy holder deliberately causes the death of the insured person by an unlawful act, the insurer is relieved from its liability for payment.

(5) 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.

§ 10. Is suicide covered under this policy?

If the insured person commits suicide after the expiration of five years from the date of conclusion, alteration or reactivation 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 relevant 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.

§ 11. What is required to receive a benefit payment?

(1) Benefits due for payment will be effected only at return of the original policy.

(2) In the event of death, the insurer is to be supplied with an official death certificate. If additional documents are needed to settle the claim, the insurer has the right to demand them.

§ 12. When and where is benefit payment effected?

(1) Insurance benefits become payable as soon as the insurer has completed all surveys necessary to assess the case and to determine the scope of benefit. Place of payment is the administration office of MEDLIFE Insurance Ltd. in Graz, Austria.

(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 §16A, plus submission of probable further evidence.

The place of payment is the insurer's headquarters.

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

(3) If there are any doubts concerning the insurance holder, the insured person or the beneficiary in regard of their entitlement to receive payment, the insurer is entitled to defer the payment of benefits until sufficient evidence is provided. If in connection with the given insured event official proceedings or a criminal prosecution have been instituted against one of the above stated persons, the insurer may defer the benefit payment until their closure.

§ 13. In what amount will you receive your insurance benefit?

(1) In the event of death the insurance benefit includes

- the cash value of the mathematical reserve plus

- the difference in EUR between the death benefit effective on the date of death and the cash value of the mathematical reserve.

(2) In the case of survivance the benefit equals the cash value of the mathematical reserve.

§ 14. How is the cash value of the mathematical reserve determined?

(1) The cash value of the mathematical reserve is determined by multiplying the number of units in the portfolio by the value of one such unit on the valuation day, whereas the value of foreign currency units will be converted into EUR. The valuation day is the official monthly transaction date, which is usually the first calendar day of each month, on which the value of the portfolio is regularly reassessed.

(2) If your insurance contract ends by expiry or surrender, the cash value of the mathematical reserve is determined by the valuation date previous to termination. In the event of the insured person´s death, the same applies to the valuation date previous to the date of death. Money transfer to the beneficiary´s bank account is effected at the recipient´s expenses. Value fluctuations which take place before payment of the proceeds will be credited or debited to the beneficiary´s account.

(3) Regulations mentioned above are also valid if the beneficiary is recipient of payments according to par. (2) and (3).

§ 15. What formalities have to be complied with when making statements concerning the insurance contract?

(1) Statements by the policyholder need to be made in writing and take effect on the date of their delivery to the administration office of **MEDLIFE Insurance Ltd.** in Graz, Austria.

(2) All relevant papers and documents must be submitted in English or German, otherwise the insurance holder will be obliged to reimburse any translation costs.

(3) Statements from our side are only valid if made in writing and if they bear the signature of two authorized representatives of our company. They take effect at the supposed time of delivery to the address you have reported to us last.

If you change your address you are obliged to inform us in writing. If you miss to do so, statements from our side will be regarded as effective at delivery to your old place of living.

(4) If an event insured has occurred, the insurer has the right to send statements such like a refusal, withdrawal or rescission to the policyholder´s old place of living. They take effect at the supposed time of delivery to the address you have reported last.

§ 16. Who receives the insurance benefit?

(1) As the owner of the policy you have the right to name the person who is entitled to receive the proceeds under your policy. You may change the beneficiary at any time before occurrence of an insured event.

(2) Beneficiaries can also be designated as irrevocable. In this case they obtain the right to the proceeds immediately and cannot be replaced without their approval.

§ 16A. 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.

§ 16B. 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 § 7. The provisions as per par. 1 and 2 are also applicable to the persons insured in this contract.

§ 17. What regulations apply in the case of pledging the policy or assigning insurance claims?

(1) If not otherwise agreed, you have the right of disposal over your contract. You are free to pledge your policy or assign insurance claims to a third party.

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

§ 18. What happens in case you lose your policy?

If you notify us in writing about the loss of your policy, we will provide you with a replacement policy.

§ 19. Which fees will we charge you?

We will charge you only such fees, postal charges and costs for additional expenditures caused by you, which are legally justified.

§ 20. During which period of time must an insurance claim be raised?

(1) Claims are to be raised within a three-year limitation period. If a person other than the policyholder is entitled to receive the proceeds, the limitation period starts by the day this person has gained knowledge of this fact.

(2) The insurer shall be relieved of its liability for payment, if a claim is not asserted through legal proceedings within one year. This limitation period starts, after the insurer has rejected the beneficiary´s claim in writing, by notifying him of the legal consequences connected with the expiry of the time limit and by stating the reason of the refusal with reference to the relevant legal or contractual clause.

§ 21. Which of the above provisions may be altered and under which conditions?

(1) We are entitled to adjust the amount of the insurance premium and to alter the provisions concerning the surrender value, surplus participation and paid-up policy value even for existing contracts in the case of

- an increase of risk in regard of the insured person or
- a (partial) conversion of the policy into a premium-free contract.

(2) Furthermore we reserve for ourselves the right to modify individual provisions of the contract even for existing contracts in case, if

- this becomes necessary due to a change of the law or by final jurisdiction,

provisions become ineffective,

or

- an objection by the supervisory authorities requires an alteration.

(3) In order to eliminate diversities of interpretation, we are entitled to change the wording of individual provisions, if this fits into the meaning and the context of the previous terms and complies in good faith with the actual or supposed intention of both parties to the contract.

§ 22. Annuity option

The insurer and the policyholder or respectively the beneficiary may agree that insurance proceeds shall be paid in form of an annuity instead of a lump sum. Annuities are calculated according to the relevant rates valid on the due-date of the benefit payment and depend on the annuitant´s age on this date. The annuity option may also be applied to part of the benefit payment.

Annuities are paid in advance installments.

The insurer reserves the right to reject an annuity application without giving reasons or to change the modalities of the annuity option.

§ 23. 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. 7 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.