GLOBALITY HEALTH
premium health insurance worldwide

Corporate Travel

General Terms and Conditions of Insurance

Contents

I. Fundamentals

The Insurer underwriting the Insurance Policy is Foyer Global Health S.A., a health insurance company established in Luxembourg under the form of a public limited liability company (société anonyme) having its registered office at 12, Rue Léon Laval L-3372 Leudelange, registered under no. B134.471 in the Luxembourg Trade and Companies Register, supervised by the Commissariat aux Assurances (11, rue Robert Stumper, L-2557 Luxembourg; +352226911-1; caa@caa.lu).

The provisions of the following General Terms and Conditions of Insurance for corporate travel and the Glossary (together the "GTCs") apply to the corporate travel insurance offered by the Insurer.

These GTCs apply to insurance for Business trips.

The mutual rights and obligations of the Insurer, the Policyholder and the Insured Person under the Insurance Policy are governed by the following documents, as amended from time to time, which, together, constitute the Insurance Policy:

- the present GTCs;
- the Glossary included at the end of the present GTCs;
- the Group Contract;
- the Insurance Certificate (where applicable);
- any subsequent written agreements concluded between the Insurer, the Policyholder and, where relevant, the Insured Person;
- any relevant applicable statutory rules and regulations.

In case of any discrepancy between these GTCs and the Group Contract, the provisions set out in the Group Contract shall prevail.

1. **Who is eligible for insurance?**
   All employees of a Policyholder travelling on Business trips are eligible as Insured Persons. The marital or non-marital partner and children accompanying the Insured Person (as defined under II. 1. below) may also be insured as an Insured Person. Insurance cover is conditional upon the Policyholder's main place of business and the Insured Person's place of work. Persons normally residing in countries other than the ones where the policy is administered may be included in the insurance cover upon request.

2. **How do you join the group insurance contract?**
   The application for insurance is made by the Policyholder. Details are set out in the Group Contract. Subsidiaries can be included under the same policy. The Insured Person is informed of the essential provisions of the Group Contract by the Policyholder.

3. **What is the maximum Business trip duration allowed?**
   The permissible maximum continuous duration of a journey for each Insured Person shall be up to 180 days on a per trip basis unless otherwise explicitly specified in the Group Contract.

4. **What is the permissible maximum total number of travel days by company staff per year?**
   The permissible maximum total number of travel days by company staff per year is agreed between the Insurer and the Policyholder and it is specified in the Group Contract.

5. **What is the area of coverage?**
   The insurance cover provided under the Insurance Policy applies worldwide.

II. Insurance cover

1. Who is the Insured Person?
The Insured Person is an individual in whose favor the Policyholder has concluded the Group Contract. Insured Persons are either named in the Insurance Policy or belong to the group of persons described in such policy. Insured Persons have the insurance cover.

2. Who is the Policyholder?
The Policyholder is the company with whom the Insurer has concluded the Group Contract. The Policyholder is named in the Group Contract.

3. Which Business trips are covered?
The Insured Person has insurance cover for any number of Business trips taken during the term of the Insurance Policy provided that the maximum trip duration and maximum total number of travel days by company employees, as specified under sections I. 3 and 4 above are complied with. The maximum term of insurance per Business trip is defined in the GTC to be read in conjunction with the Group Contract. The amount of insurance Benefit per Insured Event shall be limited to the amount of damage arising as a result of the Insured Event and to the sum insured.

4. When does the Insurance Policy enter into force and when does the insurance cover begin and end?

4.1 The Insurance Policy is deemed to have been concluded as of the date of the signature of the Group Contract by the Insurer and the Policyholder.

4.2 The insurance cover under the Travel Cancellation and Curtailment Insurance (section e.) begins on the Effective Date, however not prior to booking a covered Business trip and ends when the Business trip commences, however at the latest upon the agreed end of the Group Contract.

4.3 Under the other insurance types, the insurance cover begins on the Effective Date, at the earliest however when the Business trip commences. The insurance cover ends when the Insured Person has finished its Business trip, at the latest however upon the agreed end of the Group Contract.

4.4 In case the Insured Person was not able to finish its Business trip as scheduled for reasons beyond its control, then in that case, the insurance cover is extended up to 30 calendar days beyond the date that was originally agreed with the Insurer.

4.5 The Insurance cover ends upon termination of the employment contract, which the Insured Person has concluded with the Policyholder.

5. Are Holidays (Incidental Private Travel) during a Business trip insured?
Incidental Private Travel Insurance coverage will be granted up to 6 days to Insured Persons that qualify as members of the senior management (director and above), provided the senior management is covered under this Group Contract.

6. What is the Insurance Period and how can the Insurance Policy be terminated?

6.1 Insurance Period shall mean the period specified in the Group Contract, during which the Insurance Policy applies. The Insurance Period may not be shorter than the duration of the Business trip, unless otherwise agreed. The Insurance Policy extends automatically for a maximum additional period of one year, if neither of the parties opposes such renewal in accordance with the formalities and notice periods provided for below.

6.2 The Insurance Policy may be terminated by the Insurer if an Insured Event has occurred, provided that the Insured Event does not fall under the sickness-related coverage of the Insurance Policy.
The termination shall be notified to the Policyholder within one month of the first payment of Benefits by the Insurer. In case the Insurer exercises such termination right, the Policyholder may terminate any other contracts concluded with the Insurer, provided it notifies such termination no later than one month after receiving the Insurer's notification mentioned in the second sentence of this paragraph.

6.3 The Insurance Policy shall terminate automatically if the insurance cover has been suspended continuously for 2 (two) years.

6.4 The Insurance Policy shall also automatically end in the following cases:

a. When the Group Contract is ended by the Policyholder or by the Insurer,
b. If the Insured Person leaves the group of eligible persons to be covered under the Insurance Policy in accordance with the Group Contract,
c. If the Insurance Policy is declared null and void.

If the Insurance Policy covers more than one Insured Person and the conditions for termination of the Insurance Policy are met only for particular Insured Persons, the exercise of the aforementioned termination rights may be limited to the relevant Insured Persons.

6.5 The Policyholder may terminate the Insurance Policy in its entirety or terminate the Insurance Policy for certain Insured Persons at each renewal of the Insurance Policy upon receipt of the payment notice from the Insurer advising the Policyholder of the renewal of the Insurance Policy, of the due date of the next premium and of the Policyholder's right to terminate. The relevant termination letter must be sent by the Policyholder to the Insurer no later than 30 (thirty) calendar days after the date on which the aforementioned payment notice is postmarked. The termination shall take effect on the second business day following the date on which the termination letter is postmarked, but no earlier than the date of renewal of the Insurance Policy. Notwithstanding the above, in regards to sickness-related insurance coverage, the Policyholder shall be required to send the relevant termination letter mentioned in this paragraph no later than 90 (ninety) calendar days after the date on which the aforementioned payment notice is postmarked.

6.6 If the present GTCs are amended according to the terms of the present GTCs, the Policyholder may terminate the Insurance Policy within 1 (one) month of the dispatch of the notification letter from the Insurer informing the Policyholder of the relevant amendment. The termination shall take effect after 1 (one) month following the date of the bailiff notification of the termination letter, the date indicated on the receipt for the termination letter or the day following the delivery of the termination letter to the postal services, as the case may be.

6.7 If the premiums are increased in accordance with the provisions of the GTCs, the Policyholder is entitled to terminate the Insurance Policy within 60 (sixty) days of the postmarked date of the Insurer's dispatch of the notification letter informing the Policyholder of the relevant premium increase. The termination shall take effect on the second business day following the postmarked date of dispatch of the termination letter, but no earlier than the date of renewal of the Insurance Policy.

6.8 If the Policyholder terminates the entire Insurance Policy or terminates it for one or more of the Insured Persons individually, the Insured Person may renew the Insurance Policy by appointing a new Policyholder, provided that such appointment is declared to the Insurer within 2 (two) months of the relevant termination. The termination shall only take effect if the Policyholder proves to the Insurer that the relevant Insured Persons have been informed about the Policyholder's notice of termination.

6.9 Except for sickness-related insurance, the Insurer may terminate the Insurance Policy in its entirety or terminate the Insurance Policy for certain Insured Persons at each renewal of the Insurance Policy. The relevant termination letter must be sent by the Insurer to the Policyholder no later than 60 (sixty) calendar days before the renewal of the Insurance Policy. The termination shall take effect on the second business day following the date on which the termination letter is postmarked, but no earlier than the date of renewal of the Insurance Policy.

6.10 Without prejudice to any other causes for termination provided for in the Insurance Policy, the Insurer may terminate the Insurance Policy with immediate effect if the Policyholder or an Insured Person has obtained or attempted to obtain insurance Benefits fraudulently. This right to terminate shall be forfeited if it has not been used within 1 month from the date on which the Insurer was informed of the facts prompting the termination.

If the Insurance Policy covers more than one Insured Person and the conditions for termination of the Insurance Policy are met only for Insured Persons, the exercise of the aforementioned termination rights may be limited to the relevant Insured Persons.

6.11 Any termination of the Insurance Policy must be made by registered letter ("lettre recommandée"), by bailiff notification ("exploit d'huissier") or by delivery of the termination letter against receipt ("remise de la lettre de résiliation contre récépissé"). Unless otherwise provided for herein, the termination shall take effect after a period of 1 (one) month following the date of the bailiff notification of the termination letter, the date indicated on the receipt for the termination letter or the day following the delivery of the termination letter to the postal services, as the case may be.

6.12 Notwithstanding the cause of termination, the premiums that have been paid by the Policyholder in relation to the Insurance Period that runs after the date on which the termination becomes effective shall be refunded within 30 (thirty) days of the date on which the relevant termination becomes effective. Once this 30 (thirty) day period has expired, statutory interest accrues by operation of law.

6.13 If, in bad faith, a given risk is insured under one or more insurance policies, including the Insurance Policy, with a premium that is too high, the Insurance Policy shall be null and void. In this case, the Insurer acting in good faith may keep the premiums collected as a means to indemnify any loss suffered.

7. What must the Insured Person consider in the event of Increased risk?

7.1 The Policyholder and/or the Insured Person is required to declare any circumstances that may result in a perceptible and lasting increase in the insured risk.

7.2 Where, during the performance of the Insurance Policy, the risk of the occurrence of a Claim is aggravated in such a way that, if the aggravating circumstance had existed at the time of underwriting the Insurance Policy, the Insurer would have concluded the Insurance Policy only on different terms, the Insurer shall, within 1 month of the date on which the Insurer became aware of the relevant aggravating circumstance, propose an amendment to the Insurance Policy with retroactive effect to the date of the aggravation.

7.3 If the Insurer proves that it would never have insured the aggravated risk, it may terminate the Insurance Policy within the same period of time.

7.4 If the Policyholder refuses the proposal to amend the Insurance Policy submitted by the Insurer or if, after a period of 1 month from receipt of the relevant proposal, the proposal has not been accepted, the Insurer may terminate the Insurance Policy within 15 calendar days.

7.5 If a Claim occurs before either the amendment of the Insurance Policy or the termination of the Insurance Policy has taken effect, and if the Policyholder has fulfilled the obligation referred to in section II. 7.1 above, the Insurer shall be obliged pay the agreed Benefit.

7.6 If a Claim arises and the Policyholder has not fulfilled the obligation referred to in section II. 7.1 above:

a) the Insurer shall be obliged to pay the agreed Benefit, if the failure to declare is not the fault of the Policyholder;
b) the Insurer shall only be obliged to pay compensation in accordance with the proportion of the premium actually paid by the Policyholder to the premium that the Policyholder would have been required to pay if the aggravation had been taken into account, if the failure to declare is not the fault of the Policyholder. However, if the Insurer proves that it would never have insured the aggravated risk, its liability in the event of a Claim shall be limited to the reimbursement of the premiums paid in respect of the period following the occurrence of the relevant aggravation;
c) if the Policyholder has acted with fraudulent intent, the Insurer may refuse all Benefits. Premiums due up to the time when the Insurer became aware of the fraud shall be due to the Insurer as damages.

7.7 The provisions in this section II. 7 shall not apply in respect of a subsequent change in an Insured Person's state of health.

8. What is the contract language? What requirements apply to the provision of information? What needs to be considered to submit a Declaration of Intent?

8.1 The Policyholder and the Insured Person expressly require that these GTCs and, more generally, the Insurance Policy and all supporting documents and information be submitted to the Policyholder and the Insured Person in English or German, unless otherwise specified in the Group Contract.
The Policyholder and the Insured Person expressly acknowledge that they fully understand the language(s) chosen in the Group Contract.

8.2 Correspondence and, more generally, all other types of communications between the Insurer, the Policyholder and the Insured Person shall be in English or German, unless otherwise specified in the Group Contract.

8.4 Notices and Declarations of Intent must be made by e-mail or ordinary mail, unless otherwise explicitly specified, provided that they are readable, and that the transmission quality of the documents is high enough for processing them. This applies to the Policyholder, the Insured Person, and the Insurer.

8.5 Any information provided by the Insurer to the Policyholder pursuant to the Insurance Policy shall be deemed to remain valid unless otherwise stated to the contrary.

9. Do any waiting periods apply?

9.1 No waiting periods apply to the Insurance Policy.

10. Does the Policyholder benefit from any right of withdrawal?

10.1 If the Insurance Policy is entered into remotely and qualifies as a "distance contract" within the meaning of the applicable rules and regulations, the Policyholder shall have a period of 14 calendar days to withdraw from it, without penalty and without providing an explanation or reason.

10.2 The period during which this right of withdrawal may be exercised begins to run:
- from the date on which the Insurance Policy is entered into remotely; or
- from the date on which the Policyholder receives the Insurance Policy if this date is subsequent to the date referred to in the first indent.

10.3 If the Policyholder exercises his/her right of withdrawal, such exercise shall be notified before the expiry of the 14-day withdrawal period by registered letter to the registered office of the Insurer indicated in these GTCs. This deadline is deemed to have been met if the notification is postmarked before the expiry of the withdrawal period.

10.4 The withdrawal shall have the effect of releasing the Policyholder for the future from any obligation under the Insurance Policy.

10.5 Where the Policyholder exercises his/her right of withdrawal, he/she may only be required to pay, as soon as possible, for the insurance cover actually provided by the Insurer under the Insurance Policy, and provided that the amount due has been duly communicated to the Policyholder. The execution of the Insurance Policy may only begin after the Policyholder has given his/her consent. The amount to be paid:
- shall not exceed an amount proportionate to the insurance services already provided in relation to the entirety of the services provided for under the Insurance Policy;
- shall in no case be such as to be construed as a penalty.

10.6 The Insurer shall not be entitled to request any payment if, before the expiry of the withdrawal period, it began execution of the Insurance Policy without previously being requested to do so by the Policyholder.

10.7 The Insurer shall be obliged to reimburse to the Policyholder, as soon as possible and at the latest within 30 calendar days, all sums received from the Policyholder in accordance with the Insurance Policy, with the exception of the amount due by the Policyholder for the insurance cover actually provided

referred to in the previous paragraphs. Such 30-day period shall begin to run on the date on which the Insurer receives notification of the withdrawal. If reimbursement is not made within 30 calendar days, the amount due shall be increased by operation of law at the statutory interest rate applicable from the first day after expiry of the relevant payment period.

10.8 The Policyholder shall return to the Insurer, as soon as possible and at the latest within 30 calendar days, any sums and/or property received from the Insurer, with the exception of insurance Benefits due for the Insurance Period if such cover has already commenced at the request of the Policyholder. Such 30-day period shall begin to run on the date on which the Policyholder's notification of withdrawal is postmarked. If the reimbursement is not made within 30 calendar days, the sum due shall be increased by operation of law, at the legal interest rate in force, from the first day after the expiry of the payment period.

III. Coverage

i. General information concerning coverage and Scope of Benefits

There are 5 Plans. These Plans have different Benefits and limits for the insured sums, as provided for in the table included in section ii. below. Which Plan is applicable to the Insurance Policy and the covered Insured Persons is governed by the Group Contract. Any deviation to these Plans is agreed between the Insurer and the Policyholder and reflected in the Group Contract. In accordance with the agreed Plan, the Insurer will reimburse the eligible expenses as specified in the scope of Benefits under the selected Plan.

ii. Overview of Scope of Benefits

Section	Essential	Classic	Care	Plus	Premium
A. Medical Travel Insurance Including Emergency Medical Assistance, Evacuation and/or Repatriation/Burial, Emergency dental treatment, Travel expenses of a relative in the event of an inpatient stay, Childcare, Hospital daily allowance.	✓ Unlimited	✓ Unlimited	✓ Unlimited	✓ Unlimited	✓ Unlimited
B. Domestic Travel Insurance Travel within the country of residence. 50 km restriction applies.	✓	✓	✓	✓	✓
C. Travel Delay Insurance	✗	✓ € 1,500	✓ € 1,500	✓ € 1,500	✓ € 1,750
D. Personal Liability Insurance Including Legal protection in the event of criminal prosecution, fees and court fees, legal fees in the event of imprisonment / imminent imprisonment, refundable deposit payment, assumption of costs for rental car deductible and cash advance in the event of lost or stolen means of payment.	✗	✓ € 1,000,000	✓ € 1,500,000	✓ € 2,000,000	✓ € 2,500,000
E. Travel Cancellation and Curtailment Insurance Including travel delays, additional travel costs, non-use of booked services including accommodation, failure of means of transport and extended stay and substitute employee.	✗	✓ € 2,500	✓ € 5,000	✓ € 7,500	✓ € 10,000
F. Replacement employee Insurance	✗	✓ € 1,000	✓ € 1,000	✓ € 1,500	✓ € 1,500
G. Travel Accident (Death and Disability) Insurance Including Disappearance and search and Rescue and property damage to the Insured Persons.	✗	✓ € 50,000 Death € 100,000 Disability	✓ € 100,000 Death € 200,000 Disability	✓ € 150,000 Death € 300,000 Disability	✓ € 200,000 Death € 400,000 Disability
H. Luggage Loss and Delay Insurance Including damage or loss of portable business equipment and document theft (travel documents and money including credit card fraud).	✗	✓ € 2,500	✓ € 5,000	✓ € 7,500	✓ € 10,000

✗ not covered ✓ covered/paid in full

All figures are in Euros.

Note: The Overview of Scope pf Benefits above sets out the maximum amounts the Insurer will pay each Insured Person for each Trip under the applicable plan. Sub-limits and cover restrictions may apply.

iii. Timeline for the reporting of Claims and obligations and formalities to be completed when making a Claim

The Policyholder and/or the Insured Person shall report any Claim to the Insurer Immediately.

With regard to insuring health care-related costs (as mentioned under points 1 and 2 in the overview in section III. ii. above) and unless otherwise provided in the Insurance Policy, each hospital medical treatment must be reported within 30 calendar days as of the start of treatment.

With regard to the reimbursement of Claims pursuant to other travel-related Insured Events (as mentioned under points 3 to 14 in the overview in section III. ii. above) and unless otherwise provided in the Insurance Policy, each such Claim must be reported within 30 calendar days following the occurrence of the Insured Event.

Claims shall be reported by using the „Online Claim Portal". The Policyholder and Insured Person are further required to consult the "How to claim guide (Appendix 2, claim procedure)" appended at the end of this GTC and to comply with the practical modalities for any Claims reporting provided for therein.

The Insured Person must take all the necessary measures to avoid or limit the consequences of any Claims.

The Policyholder and/or the Insured Person must without delay provide all relevant information and documents to the Insurer and/or its agent, where relevant, and respond to all of the latter's inquiries, in order to enable the Insurer to determine the circumstances and the extent of the Claim.

At the request of the Insurer, the Insured Person is required to be examined by a Doctor appointed by the Insurer.

iv. Deductibles

Does the Insured Person have to pay a deductible?
If the Policyholder has chosen coverage with a deductible, the Insured Person will have to pay part of the expenses equivalent to the applicable deductible. Please refer to the deductibles outlined in Appendix 1, Scope of Benefits attached at the end of this GTC.

Any deviations to the deductible amount outlined in Appendix 1, will be captured in the Group Contract.

v. Detailed Scope of Benefits

A. MEDICAL TRAVEL INSURANCE

1. What is covered?

1.1 In case the Insured Person becomes ill during a covered Business trip or has an Accident, then the Insurer will pay the costs for:
- A) Medical treatment Abroad.
- B) Return transport of the patient and luggage from Abroad.
- C) Burial Abroad or repatriation.

1.2 In case the Insured Person has a medical emergency during a covered Business trip, then the Insurer will provide assistance with its 24-hour Emergency Hotline.

1.3 Notwithstanding section IV.1 below, the Insurance Policy also covers Pandemics.

2. What medical treatment does the Insurer pay for Abroad?

2.1 Medically necessary treatment, which is performed or prescribed by Doctors, is covered.
Medically necessary treatment must be recognized by conventional medicine. Alternative treatments are covered if no conventional methods or medicines are available.

2.2 The Insurer will pay the costs for:
- A) In-patient treatment in the hospital including surgery.
- B) Outpatient treatment:
- C) Drugs, medicines, and bandages.
- D) Pain-relieving dental treatment including basic dental fillings: The Insurer will reimburse a combined limit for D) and E) up to € 1,000 for each Insured Event.

E) Repair of existing dentures and existing dental-prostheses: The Insurer will reimburse a combined limit for D) and E) up to € 1,000 for each Insured Event.
F) Temporary dentures or temporary dental prostheses after an Accident.
G) Pacemakers and prostheses: If they become necessary for the first time during the trip and are required to ensure that the Insured Person can be transported.
H) Aids, which become necessary for the first time during the trip, e.g., Zimmer frames, rental of a wheelchair.
I) Costs of treatment by a chiropractor or alternative therapist for up to 10 visits. The Insurer assumes up to € 1,500 per Insured Person and insurance year.

2.3 If a treatment or another measure exceeds what is Medically necessary then the Insurer can reduce the payment to a reasonable amount. The fees and charges invoiced may not exceed the amount, which is generally deemed to be customary and reasonable in the relevant country. Otherwise, the Insurer can reduce the reimbursement to the standard rates applicable in the country.

2.4 Telephone costs: In case the Insured Person has to contact the Emergency Hotline, then, the Insurer will reimburse the telephone costs up to € 25 for each Insured Event.

3. What does the Insurer pay for pregnancy Abroad?

3.1 The Insurer will pay for the costs incurred Abroad for:
A) Medical treatment of complications related to pregnancy if they arise during the insured trip.
B) Termination of pregnancy on medical grounds.
C) Premature births up to and including the 36th week of pregnancy.
D) Miscarriages up to and including the 36th week of pregnancy.
E) Medical treatment for the Insured Person's newborn child in the event of a premature birth up to and including the 36th week of pregnancy.

3.2 In case the Insured Person becomes pregnant during the Business trip, then the Insurer will pay for the costs incurred Abroad for:
A) Maximum five medical Check-ups.
B) Two ultrasound scans. The Insurer will pay the costs for additional scans if they are Medically necessary due to special circumstances.
C) Medical treatment of pregnancy complications.
D) In-patient or outpatient delivery of the baby. The Insurer will pay for the additional costs of a caesarean if it is medically necessary.
E) Termination of pregnancy on medical grounds.
F) Obstetricians and midwives.
G) Postnatal care for mothers and the newborn baby.

4. In case the Insured Person experiences a psychological trauma triggered by an event that occurs during the Business trip, then:

4.1 The Insurer will reimburse the costs of psychological treatment. Treatment must be provided by a psychologist or psychiatrist authorized to practice in the country in which the Insured Person is staying.

4.2 The Insurer will reimburse the costs for a maximum of 10 sessions per Insured Event, limited to a maximum of € 1,500. The Insured Person must commence treatment within six months of the event causing the trauma.

5. When does the Insurer pay the hospital daily Benefit?

In case the Insured Person does not want the Insurer to pay the in-patient medical treatment costs, then the Insurer will offer a hospital daily Benefit of € 100 per day. The Insurer will pay this amount for a maximum of 30 days from the start of the in-patient treatment. The Insured Person has to inform the Insurer of its choice at the beginning of the treatment.

6. A child has to be treated as an in-patient?

In case an under-age child travelling on the trip has to be treated as an in-patient, then the Insurer will pay the costs for the accommodation of a person to accompany the child while he/she is in the hospital.

7. Is the Insured Person not able to be transported at the end of the trip?

In case the Insured Person is not able to be transported at the end of a trip then the Insurer will pay the costs of treatment until the day on which the Insured Person can be transported, for a maximum of up to a year from the date of the incident.

8. What does the Insurer pay for the return transport of the patient and ambulance service?

8.1 The Insurer will organize return transport for the Insured Person with medically adequate means of transport if it is medically reasonable and justifiable. The Insurer will pay the costs for repatriation to the Insured Person's place of residence or to a suitable hospital nearest to its place of residence.

8.2 The Insurer will bring the Insured Person's luggage back to their place of residence if a return transport was organized for the Insured Person.

8.3 The Insurer will refund the costs for the Insured Person's medically required ambulance service in a suitable hospital Abroad:

A) For in-patient treatment.
B) For initial outpatient treatment.

9. What does the Insurer reimburse in the case of death?

9.1 At the request of the Insured Person's Relatives, the Insurer will organize the repatriation. Repatriation will be to the Insured Person's last place of residence prior to the Start of the Business trip. The Insurer will pay these costs.

9.2 Alternatively, the Insurer will organize the burial Abroad. The Insurer will pay the burial costs up to the amount of the repatriation costs.

9.3 The Insurer will bring the Insured Person's luggage back to their last place of residence prior to the Start of the Business trip.

10. The Insured Person would like advice on medical care or medicines?

10.1 In case the Insured Person has questions before or during the Business trip about medical care Abroad, then the Insurer will inform the Insured Person about the options available for medical care. If it is possible, the Insurer will give the Insured Person the name and the contact details of a Doctor in accordance with the Insured Person's needs.

10.2 The Insurer will give the Insured Person advice on:

A) Medicines and vaccinations which are necessary during the Business trip.
B) Substitute medicinal products if medicines, which the Insured Person requires during the Business trip, are lost.

11. How does the Insurer help in the case of hospitalization?

11.1 A Doctor, who has been appointed by the Insurer, will establish contact with the hospital Doctors giving treatment. If it is necessary, the Insurer will consult the Insured Person's Doctor. The Insurer ensures that information is passed on between the Doctors involved, subject to the applicable professional secrecy obligations. If the Insured Person wishes, the Insurer will inform the Insured Person's Relatives.

11.2 In case the Insured Person is expected to stay in hospital for more than five days, then the Insurer will organize the journey of a person close to the Insured Person to the hospital and then back to its place of residence. The Insurer will pay the costs for the journey there and back (first class rail travel or economy class air ticket).

11.3 The Insurer will give the hospital in which the Insured Person is being treated a guarantee to pay costs up to € 15,000. The Insurer will settle the charges with the hospital. If the costs are not covered by the insurance, any costs borne by the Insurer must be paid back within one month after invoicing. If the costs are covered by the insurance, the Insurer will increase the cost payment guarantee if required.

12. Can children or persons in need of care who are accompanying the Insured Person no longer be cared for?

In case the Insured Person can no longer care for under-age children or persons in need of care during the Business trip due to illness, injury resulting from an Accident or death; then the Insurer will organize the return journey for the children or the persons in need of care and will pay the additional costs for this. Alternatively, the Insurer will organize the journey of a person close to the Insured Person to the Travel location and back to the Insured Person's permanent place of residence. The Insurer will pay the costs for the journey there and back.

13. Are search, rescue and recovery costs insured?

In case the Insured Person has an Accident and therefore there is a need for a search, rescue, or recovery operation, then the Insurer will pay the costs for this up to € 25,000.

14. What is not covered?

The following is not insured:

A) Medical treatment, where the Insured Person was already aware before the Start of the Business trip that it would have to be carried out during the Insured Person's Business trip, e.g., dialysis.
B) Purchase and repair of visual and hearing aids.
C) Illnesses and injuries, which occur as a result of a deliberate act, and their consequences.
D) Treatment of alcoholism, drug-related diseases and other addictions including withdrawal treatments and cures.
E) Fango, massages and hypnosis.
F) Need for care or safekeeping.
G) Treatments by spouses or civil partners, parents, or children. Documented material costs will be paid in accordance with the tariff.

15. What obligations does the Insured Person have after the Insured Event has occurred?

15.1 The Insured Person must comply with the obligations of the General Terms and Conditions.

15.2 The Insured Person or in the event of death, the Insured Persons' legal successor must contact the Emergency Hotline Immediately:

A) Before the start of in-patient treatment.
B) Before carrying out the return transport of the patient.
C) Before burial Abroad or before repatriation in the event of death.
D) If children or persons in need of care, who are accompanying the Insured Person, can no longer be cared for.

15.3 The Insured Persons are obliged to submit to the Insurer the original invoices or copies with proof that another Insurer has reimbursed the costs. Any Claim must be submitted in compliance with the timeline set out in section III. iii. above.

B. DOMESTIC TRAVEL INSURANCE

1. What is covered?

The Insurer provides insurance cover for Domestic Business trips beyond 50km from the usual place of residence of the Insured Person's.

2. What does the Insurer reimburse in the case of Domestic Business trips?

The Insurer provides the following Benefits in the case of Domestic Business trips:

A) Return transport of the patient and luggage in case of medical treatments.
B) The Insurer will pay a hospital daily Benefit amounting to € 100 per day. The Insurer will pay this amount for a maximum of 30 days from the start of the in-patient treatment.
C) At the request of the Insured Person's Relatives, the Insurer will organize the return of mortal remains and the transfer of luggage to the last place of residence prior to the Start of the Business trip.

3. What does the Insurer pay for the return transport of the patient and ambulance service?

3.1 The Insurer will organize the Insured Person's return transport with medically adequate means of transport if it is medically reasonable and justifiable. The Insurer will pay the costs for repatriation to the Insured

Person's place of residence or to a suitable hospital nearest to its place of residence.

3.2 The Insurer will bring the Insured Person's luggage back to its place of residence if a return transport was organized for the Insured Person.

4. What does the Insurer reimburse in the case of death?

4.1 At the request of the Insured Person's Relatives, Insurer will organize the return of mortal remains to the Insured Person's last place of residence.

4.2 The Insurer will bring the Insured Person's luggage back to its last place of residence if the return of mortal remains was organized for the Insured Person.

5. What is not covered?

All items which are not explicitly listed in section b. 2. and 3. are not insured under the Domestic travel coverage.

6. What obligations does the Insured Person have after the Insured Event has occurred?

6.1 The Insured Person must comply with the obligations set out in the General Terms and Conditions.

6.2 The Insured Person or in the event of death, its legal successor must contact the Emergency Hotline Immediately:

A) Before the start of in-patient treatment.
B) Before carrying out the return transport of the patient.
C) Before return of moral remains.

6.3 The Insured Person is obliged to submit to the Insurer the original invoices or copies with proof that another Insurer has reimbursed the costs. Any Claim must be submitted in compliance with the timeline set out in section III. 3. above.

C. TRAVEL DELAY INSURANCE

1. What is covered?

The Insurer will reimburse the Insured Person for costs incurred due to the delay of Public transportation.

2. What expenses are covered if Public transportation is delayed?

2.1 If a delay in Public transportation causes the Insured Person to miss a connection and must continue their Business trip after a delay, the Insurer will reimburse additional travel costs up to €1,500 per person and per Insured Event. Reimbursement will be made in accordance with the type and standard of the originally booked mode of transportation.

2.2 If the Insured Person's onward travel is delayed due to a delay in Public transportation, the Insurer will reimburse verified expenses for necessary and reasonable expenses (such as meals and accommodation) up to a maximum of €150 per person and per Insured Event.

3. What obligations does the Insured Person have after the Insured Event has occurred?

3.1 The Insured Person must comply with the obligations of the General Terms and Conditions.

3.2 The Insured Person is required to obtain confirmation of the Public transportation delay from the relevant transport company. This confirmation, along with proof of insurance and booking documents, must be submitted to the Insurer. Any Claim must be submitted in compliance with the timeline set out in section III. iii. above.

D. PERSONAL LIABILITY INSURANCE

1. What is covered?

1.1 The Insurer will protect the Insured Person against personal liability risks during their Business trip, excluding liabilities related to professional activities. In cases where a third party makes a complaint against the Insured Person for personal injury or property damage, the Insurer will assess the extent of the Insured Person's liability under statutory liability provisions in private law.

1.2 The Insured Event refers to the incident resulting in a complaint and causing direct harm to a third party. The timing of the damage leading to the complaint is not relevant.

1.3 The insurance covers the Insured Person's legal liability as a private individual arising from everyday life risks, except for exclusions specified in section d. 2.

1.4 If the Insurer deems complaints against the Insured Person unjustified, it will challenge them.

1.5 Upon determination of the Insured Person's obligation to compensate with binding effect, the Insurer will promptly indemnify the Insured Person against valid complaints.

1.6 Obligations to pay compensation are justified if the Insured Person is obliged to pay compensation by virtue of a law, final judgement, admission, or settlement agreement. Any admission made by the Insured Person without the Insurer's consent is binding only if the complaint would have arisen regardless. The same principle applies to settlement agreements made without the Insurer's consent.

1.7 Compensation for each Insured Event is limited to the specified sum according to the selected Plan, even if multiple individuals are liable for compensation. Multiple events leading to a complaint are considered one Insured Event if they stem from the same cause.

1.8 The Insurer is authorized to make declarations on behalf of the Insured Person as deemed necessary to process or contest complaints. In legal disputes related to complaints for compensation, the Insurer has the right, but no obligation to undertake legal proceedings instead of the Insured Person.

1.9 If a justified complaint for compensation exceeds the sum insured, the Insurer will cover the Insured Person's expenses for judicial and extrajudicial defense against third-party complaints, including lawyer's fees, expert's fees, witness fees, and court fees, in proportion to the insured sum compared to the total complaint's amount.

2. What is not covered?

The Insurer will not pay for:

2.1 Damage or loss deliberately and unlawfully caused by the Insured Person.

2.2 Risks directly associated with criminal offenses committed deliberately and unlawfully by the Insured Person.

2.3 Damage or loss incurred by the Insured Person itself (referred to as "own damage").

2.4 Damage or loss caused by the Insured Person to individuals covered by the same policy.

2.5 Damage or loss caused by the Insured Person to its Relatives.

2.6 Complaints pertaining to salary, pension, wages, or other fixed earnings, as well as subsistence, medical treatment in cases of incapacity to work, and welfare complaints.

2.7 Complaints made against the Insured Person as a result of its official function, professional activity, office, or honorary position.

2.8 Damage or loss resulting from the Insured Person's engagement in a dangerous occupation.

2.9 Damage or loss caused by the use of motor vehicles, aircraft, or motorized water vehicles, irrespective of whether the Insured Person is the owner, possessor, holder, or driver of the vehicle.

2.10 Damage or loss caused by the transmission of diseases through Gross negligence by the Insured Person.

2.11 Damage or loss incurred through the care or keeping of animals.

2.12 Complaints arising from contract fulfillment or under public law.

2.13 Damage or loss due to property loss.

2.14 Damage or loss to items hired, rented, leased, or borrowed by the Insured Person, with the exception of rented accommodation. Additionally, damage to furniture in hotels, Holiday flats, Holiday homes, ship cabins, and similar accommodations is covered. Loss of keys for such accommodation is also insured, with

the Insurer covering up to €5,000 for lock replacement. Complaints resulting from consequential damage due to lost keys are excluded.

2.15 Complaints arising from financial losses asserted against the Insured Person based on any advice or recommendation.

2.16 Damage or loss caused by the Insured Person while hunting.

2.17 Damage or loss associated with the Insured Person's participation in Extreme sports and high-risk activities.

2.18 Damage or loss resulting from the Insured Person's participation in horse races, cycle races, races with motorized vehicles, or during training for such events.

2.19 Complaints related to training or participation in boxing, wrestling matches, or martial arts performances.

3. What obligations does the Insured Person have after the Insured Event has occurred?

3.1 The Insured Person must comply with the obligations of the General Terms and Conditions.

3.2 The Insured Person must inform the Insurer of any Insured Event within one week after becoming aware of it.

3.3 The Insured Person must:

A) As far as possible avoid or reduce the complaint and reasonably comply with the directives provided by the Insurer.

B) Provide the Insurer with detailed and true reports on the complaint and to support in the assessment and settlement of the complaint.

C) Inform the Insurer of all circumstances which in the Insurer's opinion are significant for processing the complaint and send all requested documents to the Insurer.

3.4 In addition, the Insured Person must notify the Insurer Immediately if a third party asserts any liability complaints against the Insured Person. This also applies if legal proceedings are initiated by a public prosecutor or the court. Or default summon is issued to the Insured Person or a third-party notice be served.

3.5 If the Insured Person receives a default summons from a person claiming compensation for damage, the Insured Person must contest it in due time and in due form. Also, in the case of an order issued by the administrative authorities, the Insured Person must lodge an appeal in due time and in due form. The Insured Person should not wait for instructions from the Insurer.

E. TRAVEL CANCELLATION AND CURTAILMENT INSURANCE

Travel Cancellation

1. What is covered?

1.1 A Doctor from the Medical Cancellation Advisory Team of the Insurer, specialized in travel medicine will advise the Insured Person.

1.2 The Insurer will pay compensation to the Insured Person up to the specified limit applicable to the selected plan in the following cases:

A) The Insured Person cancels its Business trip.

B) The Insured Person delays starting its Business trip.

1.3 Reimbursement up to the specified limit applicable to the selected Plan only applies if no different amount is mentioned below.

2. What services are offered by the Medical Cancellation Advisory Team?

2.1 In the following cases, the Insurer will provide advice to the Insured Person through its Medical Cancellation Advisory Team:

A) The Insured Person falls ill after having booked its Business trip.

B) The Insured Person has had an Accident.

C) The Insured Person becomes pregnant.

D) The Insured Person's Doctor establishes that the Insured Person has immunization intolerance.

2.2 The Insurer will help the Insured Person to decide whether and when it should cancel its Business trip.

2.3 If, in contrast to the assessment conducted by the Insurer's Medical Cancellation Advisory Team, it transpires that the Insured Person is unable to begin their Business trip, the Insured Person must promptly cancel their trip upon confirmation of their inability to travel. Consequently, the cancellation by the Insured Person is deemed to have been Immediately executed.

2.4 If the Insured Person fails to cancel their trip despite advice from the Medical Cancellation Advisory Team, the Insured Person will personally bear the risk of any additional cancellation costs incurred.

3. What is covered if the Insured Person has to cancel its Business trip?

3.1 If the Insured Person has to cancel its Business trip, the Insurer will refund the contractually agreed cancellation costs. These are the costs which the Insured Person owes to the service provider (e.g., airline, hotel) if the Insured Person cancels its booked Business trip.

3.2 To get the Benefits listed in section 3.1, the Insured Person must satisfy all the following requirements:

A) The Insured Event affects the Insured Person or a Related Person.
B) This event was not expected at the time the insurance was taken out.
C) The Insured Person cancelled the Business trip because this event occurred.
D) Due to the event, the Insured Person cannot be expected to carry out its Business trip as scheduled.

4. What events are covered?

The following events are covered as Insured Events if they cause the cancellation of a Business trip:

4.1 Coverage includes unexpected serious illnesses. An illness is deemed unexpected if it manifests for the first time after the booking of the Business trip.

4.2 The unexpected deterioration of an illness, which already existed on the date the Insured Person booked the Business trip. The prerequisite is: There was no treatment in the last six months before booking the Business trip. Check-ups are not considered treatment.

4.3 Illnesses can also be mental illnesses. A mental illness is deemed to be severe if:

A) The statutory or private health insurance company approves outpatient psychotherapy.
B) It is verified by a medical certificate from a specialist.
C) The Insured Person has in-patient treatment.
D) The Insured Person is under prolonged medication for mental illnesses.

4.4 In addition, Insured Events are:

A) Death.
B) A serious injury resulting from an Accident.
C) A date to donate or receive organs and tissue as specified in the local law on transplantations.
D) Pregnancy.
E) Adoption of a minor child.
F) Immunization intolerance.
G) Breakage of prostheses excluding dental prostheses.
H) Loosening of implanted joints.
I) Significant property damage resulting from fire, burst pipes, natural disasters, or criminal activity by a third party. The condition is that either the Insured Person or a designated individual traveling with them must be present for the assessment of the loss.
J) Receipt of a court summons. This exception does not apply if attending the court date is considered a regular part of the Insured Person's professional responsibilities.
K) Theft of the passport or identity card before the Business trip, and if a replacement document cannot be acquired promptly. The requirement is that the stolen document is essential for the Business trip.

5. Who are considered Related Persons for the Insured Person?

Related Persons for the Insured Person include:

5.1 The Insured Person's Relatives and the Relatives of their partner.

5.2 Caregivers responsible for looking after the Insured Person's accompanying or non-accompanying Relatives who are underage or require care.

5.3 A co-worker who typically acts as a substitute for the Insured Person or for whom the Insured Person usually substitutes.

5.4 The owner of the company and members of the company's management.

6. What is covered if the Insured Person delays the Start of the Business trip?

6.1 In case the Insured Person has to delay the start of its Business trip because the Insured Person or a Related Person has been affected by an Insured Event then the Insurer will pay:

A) Insured Person's verified additional costs of the outward journey. The additional costs corresponding to the type and standard of the originally booked and insured outward journey are insured.

B) Insured Person's unused Travel services less the costs of the outward journey.

6.2 The Insurer will reimburse up to a maximum of the cancellation costs, which would have been due if the Business trip had been cancelled Immediately.

7. What will the Insurer pay for in the case of a car break-down or Accident?

7.1 If the Insured Person's vehicle becomes inoperable due to an Accident or breakdown, causing a delay in the start of their Business trip, the Insurer will reimburse documented costs for unused Travel services or additional travel expenses, up to a maximum of €500 per person and per Insured Event. Additionally, the Insurer will cover the expenses for a rental car in a comparable vehicle category, up to €1,000.

7.2 The motor vehicle will be considered the Insured Person's vehicle if:

A) It is registered under the Insured Person's name.

B) The Insured Person is authorized to use a company car or leased vehicle.

8. Are travel agency fees covered?

8.1 A contractually agreed travel agency fee up to € 100 per person is insured. The prerequisite is: The agency stipulated the agency fee already at the time the Business trip was booked, and it is included in the sum insured.

8.2 The Insurer will reimburse the travel agency fee only if the Insured Person is entitled to a reimbursement of the cancellation costs.

9. Are Rebooking fees covered?

9.1 If the Insured Person prefers to reschedule rather than cancel their Business trip, the Insurer will cover the Rebooking fees. The Insurer will reimburse up to the maximum amount of cancellation costs that would have been incurred if the Business trip had been canceled Immediately. The condition is that the Insured Person is entitled to reimbursement of the cancellation costs.

9.2 If the Insured Person's local business partner, with whom a meeting was scheduled, becomes unavailable resulting in a necessary delay of the business appointment, the Insurer will reimburse the Insured Person for contractually obligated Rebooking fees as well as verified additional costs for the Business trip, up to a maximum of €1,500.

10. Are fees for the issuance of a visa covered?

If the Insured Person is unable to start its Business trip for insured reasons, the Insurer will then reimburse the Insured Persons' verified fees incurred for the issuance of a visa. This is only the case if the visa was applied for the Business trip concerned.

11. What is not covered?

The Insurer will not pay:

11.1 In the case of a psychological reaction

A) to an act of war, civil unrest, act of terrorism, an aviation Accident.

B) to the fear of acts of war, civil unrest, acts of terrorism.

11.2 In the case of addictive disorders.

11.3 For cancellation fees, e.g., processing fees for the cancellation of the trip or service fees, which are charged by the Insured Person's travel agency because the Insured Person cancels the Business trip.

11.4 For other processing fees, e.g., processing fees of the airline, which are not stated and insured at the time of the booking.

12. What obligations does the Insured Person have after the Insured Event has occurred?

12.1 The Insured Person must comply with the obligations of the General Terms and Conditions.

12.2 The Insured Person is obliged to keep the cancellation costs as low as possible. If an Insured Event has occurred, the Insured Person must therefore cancel their Business trip Immediately, at the latest however, before the cancellation costs are increased. The amount of the cancellation costs owed if an Insured Event occurs and when they will be increased can be found in the General Terms and Conditions of the Insured Person's service provider (e.g., airline, hotel) or in provisions agreed individually.

12.3 If the Insured Person seeks advice from the Medical Cancellation Advisory Team and:

A) The team advises canceling the Business trip, the Insured Person must promptly cancel it.
B) If, contrary to the Medical Cancellation Advisory Team's assessment, the Insured Person is unable to commence the trip, they must cancel it once it's confirmed they cannot travel, ensuring timely cancellation.

12.4 To process the Insured Person's Insured Event, they or, in the case of death, their legal successor must provide the following documents to the Insurer:

A) Proof of insurance, booking documents, completed Claims form, evidence of loss (e.g., cancellation fee invoice), and travel agency fees.
B) For unexpected serious illnesses, severe injuries from Accidents, pregnancy, immunization intolerance, prosthetic breakage (excluding dental prostheses), or joint implant loosening: A medical certificate with diagnosis and treatment details.
C) For theft and traffic Accidents: A copy of the police report.
D) All other Insured Events require appropriate supporting documents.

12.5 In certain cases, the Insurer may request confirmation of the Insured Person's inability to work, their medical history (medical record), or a medical certificate from a specialist. Additionally, the Insurer may require the Insured Person to undergo a medical evaluation to confirm their inability to travel, supported by a specialist medical report.

12.6 Any Claim must be submitted in compliance with the timeline set out in section III. iii. above.

F. REPLACEMENT EMPLOYEE INSURANCE

1. What is covered?

1.1 In case the Insured Person cannot start its Business trip due to an Insured Event or must curtail or interrupt travel and its employers is required to send a replacement employee for business reasons, then the Insurer will pay:

A) Verified additional costs resulting from rebooking the Insured Person's unused ticket.
B) Additional costs for an additional ticket for outbound and/or return travel if the Insured Person's ticket cannot be used by the replacement employee and an additional ticket must therefore be purchased.
C) Additional lodging costs for the replacement employee.
D) The costs corresponding to the type and standard of the originally booked services are insured. Reimbursement will be provided up to the specified limit applicable to the selected Plan.

2. What events are covered?

The following events are covered as Insured Events if they cause the cancellation of a Business trip:

2.1 An unexpected serious illness is insured. The illness is unexpected if it occurs for the first time after booking the Business trip.

2.2 The unexpected deterioration of an illness, which already existed on the date the Insured Person booked the Business trip. The prerequisite is: There was no treatment in the last six months before booking the Business trip. Check-ups are not considered treatment.

2.3 Illnesses can also be mental illnesses. A mental illness is deemed to be severe if:

A) The statutory or private health insurance company approves outpatient psychotherapy.

B) It is verified by a medical certificate from a specialist.
C) The Insured Person has in-patient treatment.
D) The Insured Person is under prolonged medication for mental illnesses.

2.4 In addition, Insured Events are:
A) Death.
B) A serious injury resulting from an Accident.
C) A date to donate or receive organs and tissue as specified in the local law on transplantations.
D) Pregnancy.
E) Adoption of a minor child.
F) Immunization intolerance.
G) Breakage of prostheses (Excluding dental protheses).
H) Loosening of implanted joints.
I) Considerable damage to property due to fire, burst pipes, Natural events, criminal action by a third party. The prerequisite is: the Insured Person's presence is necessary for loss assessment.
J) A court summons. The foregoing does not apply if appearance at the court hearing is part of the Insured Person's typical professional duties.
K) If the passport or identity card is stolen before the Business trip and a replacement document cannot be obtained in time. The prerequisite is: The stolen document is necessary for the Business trip.

3. What is not covered?

The Insurer will not pay:

3.1 In the case of a psychological reaction
A) to an act of war, civil unrest, act of terrorism, an aviation Accident.
B) to the fear of acts of war, civil unrest, acts of terrorism.

3.2 In the case of addictive disorders.

3.3 For cancellation fees, e. g. processing fees for the cancellation of the trip or service fees, which are charged by the Insured Person's travel agency because the Insured Person cancels the trip.

4. What obligations does the Insured Person have after the Insured Event has occurred?

4.1 The Insured Person must comply with the obligations of the General Terms and Conditions.

4.2 To process the Insured Person's Insured Event, the Insured Person or in the event of death, the Insured Person's legal successor must submit the following documents to us:
A) Proof of insurance, booking document, proof of loss (e.g. invoice for a completed rebooking).
B) In the case of unexpected serious illness, serious injury resulting from an Accident, pregnancy, immunization intolerance, breakage of prostheses, loosening of implanted joints: A medical certificate with diagnosis and treatment details.
C) All other Insured Events must be proved by submitting the appropriate documents.

4.3 In individual cases, the Insurer could request the Insured Person to submit confirmation that the Insured Person is unable to work, its medical history (medical record) or a medical certificate from a specialist. The Insurer could also request the Insured Person to have its inability to travel checked by providing a specialist medical report.

4.3 Any Claim must be submitted in compliance with the timeline set out in section III. iii. above.

G. TRAVEL ACCIDENT (DEATH AND DISABILITY) INSURANCE

1. What is covered?

1.1 If the Insured Person has an Accident during a Business trip, which leads to its death or permanent disability, the Insurer will support the Insured Person or its legal successor in providing the agreed assistance and payments.

1.2 An Accident is deemed to have occurred if the Insured Person suffers a sudden, single, unforeseen, and unexpected external physical event happening by chance that could not have been expected and which results in the Insured Person suffering death, disablement, or Injury.

An Accident must occur during the Insurance Period cover and after the Effective Date of cover for the Insured Person.

1.3 An Accident is also deemed to have occurred if, as a result of increased physical exertion:
A) One of the Insured Person's joints is dislocated.
B) The Insured Person's muscles, ligaments, tendons, or joint capsules are strained or torn.

1.4 It is also deemed to be an Accident:
A) If the Insured Person suffers sudden damage to its health in the course of lawful defense or during efforts to rescue human life, animals or property.
B) Damage to Insured Person's health typical to scuba diving.
C) Infections resulting from tick bites.
D) Rabies.
E) Tetanus.
F) Dengue (DHF)
G) Zika

2. When and to what extent does the Insurer pay Benefits if the Accident leads to permanent disability?

2.1 When does a disability exist?
Disability exists if the Insured Person's physical and mental capacity is impaired permanently as a result of the Accident. An impairment is permanent if it is likely to exist for more than three years. Furthermore, no change to the condition can be expected.

2.2 The following requirements must be met with regard to the Insured Person's disability within 15 months after the Accident:
A) The disability occurs.
B) Has been diagnosed in writing by a Doctor.
C) The Insured Person submits a Claim to the Insurer.
All these requirements for its Claim must be satisfied.

2.3 To the extent not otherwise agreed, the Insurer determine the scope of the disability as follows:
A) If the Insured Person losses its sense organs or parts of its body or their function is completely impaired, the following degrees of disability apply:

Loss of life	100%
Permanent Total Disablement	100%
Loss of or the Permanent total Loss of use of two limbs	100%
Loss of or the Permanent total Loss of use of one limb	75%
Permanent total Loss of Sight of both Eyes	100%
Permanent total loss of the following and not both as a result of the same Injury (a) Permanent total Loss of sight of one eye (b) Permanent total Loss of the lens of one eye	 75% 50%
Loss of or the Permanent total Loss of Use of one limb and Loss of Sight of an eye	100%
Permanent and incurable insanity	100%
Permanent total Loss of Hearing (a) Both ears (b) one ear	 100% 30%
Loss of speech	75%
Loss of or the Permanent total Loss of use of four fingers and thumb of (a) right hand (b) left hand	 85% 65%
Loss of or the Permanent total Loss of use of four fingers of (a) right hand (b) left hand	 55% 45%
Loss of or the Permanent total Loss of use of one thumb (a) Both right phalanges (b) One right phalanx (c) Both left phalanges (d) One left phalanx	 40% 25% 30% 20%
Loss of or the Permanent total Loss of use of fingers (a) Three right phalanges (b)Two right phalanges (c) One right phalanx (d) Three left phalanges (e) Two left phalanges (f) One left phalanx	 20% 15% 10% 15% 10% 5%
Loss of or the Permanent total Loss of use of toes (a) all one-toe (b) Great toe - two phalanges (c) Great toe - one phalanx (d) Other than great toe - each toe	 25% 10% 10% 2%
Fractured leg or patella with established non-union	20%
Shortening of leg by at least 5 cm	10%

B) In case the Insured Person loses its sense organs or parts of the body partially or their function is partially impaired, then the corresponding portion of the percentage mentioned in 2.3 A) will apply.

C) In case a part of the body or a sense organ not listed in 2.3 A), the degree of disability is measured by the extent of the overall impairment to normal physical or mental capacity. This assessment will be decided solely on medical grounds.

D) In case the affected parts of the body or sense organs are already permanently impaired prior to the Insured Person's Accident, then in this case, the Insurer will reduce the degree of disability by the disability prior to the Accident. This is assessed in accordance with the above-mentioned criteria.

E) If several sense organs or body parts are affected permanently by the Accident, the degrees of disability will be added together up to a maximum of 100%.

3. When can the Insured Person claim payment of Benefits for disability?

3.1 If the Insured Person's treatment is not yet completed, it can request payment due to disability at the earliest one year after the Accident.

3.2 The Insured Person sends all the documents to the Insurer which are required to assess the degree of disability. Within three months, the Insurer will then state whether and for what amount it will accept the Insured Person's Claim.

3.3 If the Insured Person dies within one year after the Accident as a result of the Accident, the Insured Person will not be entitled to disability Benefits. In such cases, the Insured Person is entitled to a death Benefit.

3.4 If the Insured Person dies within one year after the Accident for another reason, the Insured Person's heirs are entitled to disability Benefits. The degree of disability is measured according to the last results of the medical examination. The same applies if death occurs after more than one year, no matter what the reason is.

3.5 Once the Insurer has accepted the Claim, the Insurer will pay a lump-sum Benefit Immediately. In the case of permanent disability, the Insurer will pay the complete sum insured. In the case of partial disability, the Insurer will pay the corresponding portion of the sum insured.

4. What does the Insurer pay if the Insured Person dies as a result of the Accident within one year?

In this case, the Insurer will pay the agreed sum insured to the Insured Person's heirs or its beneficiaries.

5. When can the Insured Person's heirs or its beneficiaries claim payment for death Benefit?

5.1 The Insurer receives all the documents which it requires as proof of the Insured Event. Within one month, the Insurer will then state whether and for what amount it will accept the Claim.

5.2 Once the Insurer has accepted the Claim, the Insurer will pay Immediately.

6. Can the degree of disability be reassessed?

6.1 The Insured Person and the Insurer can have the degree of the Insured Person's disability reassessed every year. This applies for a maximum of three years after the Accident event.

6.2 The Insured Person must do this within one month of receiving the statement regarding the Insurer's liability in accordance with section 3.2.

6.3 The Insurer must exercise its rights by means of the statement specified in section 3.2.

6.4 In case the final assessment shows a higher disability Benefit than that already paid, the Insurer will then pay 5 % annual interest on the additional amount.

7. When and what amount will the Insured Person receive a transitional Benefit?

7.1 The Insured Person will receive a transitional Benefit if all the following criteria are satisfied:

- The Insured Person's physical or mental ability is reduced by at least 50% in their work or daily life due to an accident.

- This impairment continues for an uninterrupted period of three months calculated from the date of the Accident.
- Illness and infirmity have not contributed to the impairment.
- The Insured Person has submitted its Claim to the Insurer four months following the date of the Accident at the latest. And the Insured Person have likewise submitted a medical certificate to the Insurer.

7.2 In case the Insured Person satisfies all the criteria set out in section 7.1, it will receive a transitional Benefit from the Insurer. The amount of the transitional Benefit equals 10 % of the sum insured in accordance with the degree of impairment applicable to disability.

8. When does the Insurer pay a coma allowance?

In case the Insured Person falls into a coma as a result of an Accident, then the Insurer will pay an allowance of € 30 for each day the Insured Person remains in the coma. The Insurer pays this Benefit for a maximum of 365 days.

9. When and what amount does the Insurer reimburse the Insured Person's costs for cosmetic surgery?

The Insurer reimburses costs for Accident-related cosmetic operations up to € 20,000. The Insurer will pay for:

A) Doctor's fees.
B) Medications, bandages, and other aids prescribed by the Doctor.
C) Accommodations and meals in the clinic.
D) Dental treatment and dental prostheses. The prerequisite is that the Insured Person have lost its incisors and / or cuspids as a result of an Accident or they were damaged in the course of an Accident.

10. When and to what amount will the Insurer reimburse the costs of renovation?

In case the Insured Person is permanently not able to engage in its professional activity without impairment as a result of an Accident then the Insurer will reimburse costs for the renovation of the Insured Person's workplace up to € 15,000. The Insured Person's workplace is the location at which it is engaged in its professional activity for most of the time prior to the Accident. The prerequisite is that the Insured Person may resume its professional activity in whole or in part following the renovation. The Insurer will pay for renovations to:

A) Office furnishings.
B) Office.
C) Buildings.
D) Toilettes.
E) Machines.
F) Passenger vehicles or trucks.
G) Other facilities.

If the renovation is more expensive than new acquisition, then the Insurer will reimburse the costs of the new acquisition.

11. What is not covered?

11.1 The following is not covered:

A) Accidents due to mental disorders or unconsciousness, strokes, or convulsive seizures.
B) Accidents due to drunkenness with a blood alcohol level of at least 1.1 per mile or the consumption of narcotics.
C) Accidents as a pilot of a plane.
D) Accidents as a driver, passenger, or occupant of a motor vehicle at race events, where the aim is to attain top speeds. The associated test drives are likewise excluded.
E) Accidents, which occur if the Insured Person carries out Extreme sports, train for or participate in any type of boxing or wrestling matches, martial arts competitions, horse racing or cycle racing.
F) Accidents, which occur if the Insured Person deliberately carries out or attempts to carry out a criminal offence.
G) Accidents due to attempted suicide and the consequences arising from it.

11.2 No insurance cover is available for damage to the Insured Person's health caused by:

A) Therapeutic measures.
B) Surgery on the Insured Person's body.
C) Radiation.

Insurance cover remains in place in the event damage to the Insured Person's health is the result of an Accident.

11.3 No insurance cover is available for damage to the Insured Person's health caused by an infection. The foregoing does not apply in the event the pathogenic germs entered the body through an Accident. Infections where the pathogenic germs entered the body as a result of minor skin / mucous membrane injuries or as a result of insect bites remain excluded. The foregoing notwithstanding, infections resulting from tick bites, mosquito bites, rabies and tetanus are insured.

12. What obligations does the Insured Person have in the event of the Insured Event?

12.1 The Insured Person must comply with the obligations of the General Terms and Conditions.

12.2 The Insured Person must inform the Insurer of the Accident Immediately and let itself be examined by Doctors appointed by the Insurer. The Insurer will pay these costs.

12.3 The Insured Person must authorize Doctors providing treatment or examining it, to supply any information required by the Insurer. This also applies to other insurers, insurance companies and authorities.

13. What are the consequences for the Insured Person if several Insured Persons are affected by a common Accident?

13.1 The Policyholder has agreed to accumulation limits with the Insurer. This means that Benefit payments to several Insured Persons may only be made up to the agreed specific maximum amount.
Several Insured Persons insured by this Group Contract can be injured by one loss event. In this case the Insurer's liability is limited to EUR 5,000,000 in case of death and 10,000,000 in the event of disability per loss event and applies as a joint maximum Benefit for all injured Insured Persons and insured Benefit types (accumulation limit).

13.2 In case other Insured Persons are affected by the same Insured Event, then the Insurer will pay the amount of compensation agreed to the Insured Person. This applies to the other Insured Persons as well. In the event the aggregate compensation should exceed the above accumulation limits, it will be apportioned among the Insured Persons, but the sum will not be greater than the maximum sum insured of each Insured Person.

H. LUGGAGE LOSS AND DELAY INSURANCE

1. What is covered?

1.1 All accompanying luggage on the Insured Person's Business trip is insured, including all rented or borrowed items for the Business trip. This applies up to the specified limit applicable to the selected Plan.

1.2 Luggage includes:

A) The Insured Person's personal travel requisites for the respective Business trip. Laptop Computers (including accessories or attachments that come as standard equipment with the laptop), mobile phones and tablets.
B) Presents.
C) Souvenirs.
D) Sports equipment.

2. When is there insurance cover?

2.1 The Insurer will pay compensation to the Insured Person if accompanied luggage is lost, damaged, or delayed during the Business trip due to:

A) Criminal action by a third party.
B) Accident involving the means of transport.
C) An Accident the Insured Person suffers.
D) Fire or Natural events.

2.2 The Insurer will pay compensation to the Insured Person if the Insured Person's checked luggage is lost, damaged, or delayed. The prerequisite is: The luggage is in the custody of:

A) A transport company.
B) A company providing accommodation.
C) A luggage deposit service.

3. How are cash and tickets covered?

3.1. The Insured Person's cash is insured if it is stolen, stolen by extortion, or taken as a result of a break-in. The Insurer will reimburse up to € 500.

3.2. If the Insured Person's tickets are stolen, the Insurer will reimburse the Insured Person for the unused portion of the ticket up to the specified limit applicable to the selected Plan.

4. How is the Insured Person's luggage covered in a vehicle?

The Insurer covers the Insured Person's luggage in a parked and locked vehicle during the day between 6:00 am and 10:00 pm in the same manner as accompanied luggage. The Insurer likewise covers this at night between 10:00 pm and 6:00 am if the Insured Person interrupt its journey for a maximum of two hours. The motor vehicle also includes any luggage boxes, which are attached to it and locked.

5. How much compensation does the Insurer pay?

If an Insured Event occurs, the Insurer will reimburse the Insured Person up to a maximum of the specified limit applicable to the selected Plan:

A) In the case of lost or destroyed articles that are less than two years old, the Insurer will reimburse the Insured Person equivalent to the new value of the article, up to a maximum of the specified limit applicable to the selected Plan. This does not apply to electronic devices.

B) In the case of lost or destroyed articles that are more than two years old and in the case of electronic devices, the Insurer will reimburse the Insured Person equivalent to the Current value of the article, up to a maximum of the specified limit applicable to the selected Plan.

C) For damaged articles: Necessary costs of repair and, if applicable, any remaining decrease in value. The Insured Person's maximum Benefit is limited to the new value or the Current value, as applicable, in accordance with A) and B).

D) For films, video, audio, and data media, the reimbursement is limited to material value.

E) In the case of official identity documents and visas, the reimbursement is limited to official charges to obtain new documents.

F) In case the Insured Person's checked luggage was transported with delay and reaches the destination at least four hours after the Insured Person's arrival, then the Insurer will reimburse the Insured Person for the expenses of replacement purchases up to € 1.000 per person and Insured Event. Only replacement purchases, which are required to continue the Business trip, are covered.

6. What is not covered or covered only with restrictions?

6.1 The following is not covered:

A) Loss due to items that are forgotten, left behind, abandoned, lost.

B) Spectacles, contact lenses, hearing aids and prostheses.

C) Money, securities, tickets, and documents of any type except for official identity documents and visas.

D) Money and tickets subject to the exceptions provided in section 3.

E) Consequential pecuniary loss.

F) Sample collections and merchandise.

G) Damage that arises from deliberately bringing about the Insured Event. If the Insured Person brought about the Insured Event through Gross negligence, the Insurer can reduce its payment of Benefits in proportion to the severity of the Insured Person's fault. Unless the Insured Person can prove that the Insured Person did not bring about the Insured Event with Gross negligence.

6.2 The following is covered with restrictions:

A) Video and photographic equipment, mobile phones, smartphones, IT equipment and software including accessories. They are insured as accompanied luggage up to a total of 50 % of the specified limit applicable to the selected Plan. If they have been checked in as luggage, there is no insurance cover.

B) Jewelry and valuables. They are only insured if they are locked in a fixed, closed container (e.g., safe). Or if they are carried around personally by the Insured Person and kept secure. The Insurer will pay compensation for up to a total of 50 % of the specified limit applicable to the selected Plan.

C) Sports equipment including accessories. They are not insured if they are being used for the intended purpose. In all other cases, they are insured up to a total of 50% of the specified limit applicable to the selected Plan.

D) Presents and souvenirs are insured up to a total of 10 % of the specified limit applicable to the selected Plan.

7. What obligations does the Insured Person have after the Insured Event has occurred?

7.1 The Insured Person must comply with the obligations of the General Terms and Conditions.

7.2 The Insured Person is obliged to submit proof of insurance and booking documents for the trip to the Insurer.

7.3 The Insured Person must report damage caused by criminal acts to the local police Immediately. If this is not possible, the Insured Person must file a report with the next available police station. A list of all lost articles must be attached to the police report. Have this confirmed. The Insured Person must provide Insurer with certification of this.

7.4 The Insured Person are obliged to report damage to checked luggage Immediately to one of the following:
A) The transport company.
B) The company providing accommodation.
C) The luggage deposit service.
Furthermore, any damage that is not apparent from the outside must be notified in writing as soon as the Insured Person has discovered it. The Insured Person must do this within the respective deadline for complaints, at the latest, within seven days after handing out the item of luggage. The Insured Person have to supply the Insurer with the appropriate confirmations.

7.5 The Insured Person is obliged to have the delay in the Insured Person's luggage confirmed by the respective transport company.
The Insured Person must submit to Insurer the foregoing confirmation as well as proof of insurance and the booking documents. The Insured Person must document replacement purchases by submitting receipts to Insurer. Any Claim must be submitted in compliance with the timeline set out in section III. iii. above.

IV. Limited obligation to pay Benefits

The following rules apply unless otherwise agreed with the Policyholder:

1. The Insured Person is not covered by insurance for damages resulting from strikes, industrial actions, Pandemics, nuclear energy, ionizing radiation, seizures, or other Actions of higher authority. Additionally, insurance does not cover Accidents or illnesses caused by the use of Chemical, Biological, Radiological, and Nuclear (CBRN) weapons.

2. Insurance does not cover damage caused by war, civil war, war-like events, or civil unrest. By derogation to the preceding sentence, the Insured Person is covered for the first 14 days following the unexpected occurrence of such events in the country where they are located, provided they do not actively participate in these events.

3. If the Insured Person is traveling in an area where a travel warning has been issued by the Foreign Office of the country where the Policyholder is registered or where the Insured Person resides at the time of entry, they are not covered by insurance. If the Insured Person is already in an area with a travel warning, their insurance coverage ends 14 days after the travel warning was issued.

4. The Insurer will comply with international sanctions regulations. The Insurer will not provide coverage or pay any Claims that would expose them to sanctions under United Nations resolutions, economic sanctions, laws or regulations of the European Union or the United Kingdom, or sanctions of the United States of America.

5. These exclusions apply in addition to the exclusions named in the respective sections.

6. The Insurer shall not be liable for any action taken, or for failure to take any action required to be taken, in fulfilment of its obligations or in exercise of its rights under the Insurance Policy in the event and to the extent that the such action or such failure arises out of or is caused by events beyond the Insurer's reasonable control (Force Majeure), including, without limitation, civil or labour disturbances, war, insurrection, riots, civil or military conflict, sabotage, labour unrest, strike, lock-out, fire, flood or water damage, acts of God, act of any governmental authority or threat of any authority (de jure or de facto), legal constraint, fraud or forgery, accident, explosion, mechanical breakdown, computer or systems failure, failure of equipment, failure or malfunction of communications media or interruption of power supplies, local or foreign law, judicial process, decree, regulation, order or other action of any local or foreign government, authority, court, self-regulatory organisation, government agency or instrumentality of government.

7. In the absence of Gross negligence (faute lourde) or wilful misconduct (dol) on its part, the Insurer shall not be liable to the Policyholder or the Insured Person for any loss, Claim, liability, expense or damage arising from any action taken or omitted by the Insurer in connection with the provision of services or with the taking of any action contemplated under the Insurance Policy.

V. Points to note when an Insured Event occurs

1. How are Benefits claimed?

The Insurer requires the Policyholder's confirmation of insurance, specifying the Insured Person's name and period of travel. The "Claim Form" should be used where possible. The form is already available to the Policyholder or can be downloaded from the Insurer's website. The Insured Person can either hand in their documents and invoices to the Policyholder in a sealed envelope which will then be forwarded to the Insurer together with the required confirmation of insurance, or they can send the documents and invoices to the Insurer directly, together with the confirmation of insurance.

2. What must be done in the event of an Accident/ emergency?

The Insured Person has the option to reach out to the Insurer at any time, day or night. The addresses, telephone numbers, and email address are provided in all the documents provided to the Policyholder. If an Insured Person contacts the Emergency Hotline after experiencing a significant Insured Event, especially in the event of an Accident, emergency, or during inpatient treatment, the Emergency Hotline will promptly offer a callback service.

3. When will the Insured Person receive payment?

3.1 Once the Insurer has determined the liability, the Insured Person will receive the payment Immediately.

3.2 Any costs which the Insured Person has incurred in a foreign currency, will be reimbursed in Euro. The exchange rate will be based on the rate applicable on the day on which the Insured Person paid these costs.

VI. What are the Policyholder's and the Insured Persons' general obligations?

1. What obligations does the Policyholder and respectively the Insured Person upon entering into the Insurance Policy and during the term of the Insurance Policy?

1.1 The Policyholder undertakes to answer truthfully and exhaustively all the questions that the Insurer asks and to cause, where relevant, the Insured Person to do the same.

1.2 The Policyholder furthermore undertakes to declare accurately, at the time of conclusion of the Insurance Policy, all circumstances known to him/her and which he/she may reasonably consider as constituting elements that are relevant for the Insurer's assessment of the insured risk and to cause, where relevant, the Insured Person to do the same.

1.3 The insurance premium applicable to the Insurance Policy shall be set accordingly.

1.4 Notwithstanding other statutory grounds for nullity, the Insurance Policy shall be void in case of any intentional omission or inaccuracy affecting the aforementioned responses and declarations, which have misled the Insurer in its risk assessment. In such circumstances, the Insurer shall remain entitled to premiums already paid.

1.5 If the omission or inaccuracy is unintentional, the Insurance Policy is not void. In such case, the Insurer may, however, within 1 month from the date on which the Insurer becomes aware of the relevant omission or inaccuracy, propose an amendment to the Insurance Policy that would take effect at the date on which Insurer became aware of such omission or inaccuracy.

1.6 If the Insurer proves, in such circumstances, that the Insurer would never have insured the relevant risk if it had received the required full and accurate information when underwriting the Insurance Policy, the Insurer may terminate the Insurance Policy within 1 month from the date on which it became aware of the relevant omission or inaccuracy.

1.7 If the Policyholder refuses the proposed amendment of the Insurance Policy or if such proposal is not accepted within 1 month from the date on which the relevant proposal was received, the Insurer may terminate the Insurance Policy within 15 calendar days. If the omission or inaccuracy is the fault of the Policyholder and if a Claim arises before the amendment or termination of the Insurance Policy referred to in the preceding paragraphs becomes effective, the Insurer is only required to grant Benefits in accordance with the proportion of the premium actually paid by the Policyholder to the premium that the Policyholder would have been required to pay if the risk had been fully and accurately declared. However, if the Insurer proves that it would never have insured the relevant risk whose real nature was revealed by the Claim, the Benefits to be paid by the Insurer shall then be limited to the reimbursement of all premiums paid.

1.8 The Policyholder and/or the Insured Person or Insured Persons is/are required to declare any circumstances that may result in a perceptible and lasting increase in the insured risk in accordance with section II. 7 above. The Policyholder is obliged to provide to the Insurer, the risk information listed in the Group Contract for the preceding insurance year; at the latest upon the Insurer's request.

1.9 If, by negligence, the Insured Person does not appear, or does not comply with investigative measures ordered in Court proceedings initiated against the insured Person in the context of a liability complaint covered under the Insurance Policy, the Insured Person shall repair the loss suffered by the Insurer.

2. What obligations does the Insured Person have after the Insured Event has occurred?

2.1 The Insured Person must:

A) Avoid anything, which could result in unnecessary costs (obligation to mitigate loss).
B) Notify the Claim to the Insurer Immediately.
C) Describe the events leading to the Claim and the consequences truthfully.
D) Allow the Insurer to carry out any reasonable investigations into the cause and amount of the damage and the extent of its liability.

E) The Insured Person is obliged to provide all the information requested by the Insurer in order to establish its obligation to pay Benefits and the amounts of Benefit due. In addition, the Insured Person must allow the Insurer to obtain all further information required in this context (above all by releasing medical professionals from their duty of confidentiality).

F) Give to the Insurer any relevant information truthfully.

2.2 The Insured Person must provide the Insurer with original documents as proof and, where appropriate, release the Doctor's providing treatment from their obligation to maintain confidentiality. The release from the obligation to maintain confidentiality is only binding for the Insured Person if knowledge of the data is required to assess the Insurer's liability obligations or the scope of its liability.

2.3 The Insured Person must comply with the obligations of the General Terms and Conditions including the specific obligations named under the respective scope of Benefits.

3. What applies if there are Claims against third parties?

3.1 The Insurer shall be subrogated in any rights and actions that the Policyholder or Insured Person may have against any third party in relation to a Claim, for the amount of Benefits paid by the Insurer under the Insurance Policy in this respect.

3.2 If, due to any actions or omissions of the Policyholder or Insured Person, the aforementioned subrogation may no longer produce its effects to the benefit of the Insurer, the Insurer may claim repayment of the Benefits paid out under the Insurance Policy in proportion to the loss suffered.

3.3 The subrogation shall not have the adverse effect on the Insured Person of resulting in the Insured Person only being partially compensated by the payment of Benefits under the Insurance Policy. In this case, the Insured Person may exercise its rights, for the amounts that remain owed to the Insured Person, in priority to the Insurer.

3.4 Except in the event of malice on the part of the Insured Person, the Insurer shall have no legal recourse against the Insured Person's descendants, ascendants, spouse and in-laws in direct line, nor against those living in the Insured Person's home, his/her hosts or his/her household employees. However, the Insurer may take legal action against the aforementioned persons to the extent that their liability is effectively covered under an insurance policy.

4. What statute of limitations applies?

4.1 The statute of limitation period for any legal actions arising out of or in connection with the Insurance Policy is 3 years.

4.2 Such limitation period starts running as of the day on which the event that gives rise to the relevant legal action occurs. If the person who is entitled to take action can prove that he or she became aware of the actionable event only at a later date, the limitation period shall start running only at such later date, without, however, exceeding 5 years from the date of the occurrence of the actionable event, except in case of fraud. The statute of limitations runs also against minors or other persons deemed incapable under law. The statute of limitations does not run against the Insured Person that is unable to act within the prescribed time limit due to force majeure.

4.3 If the Claim has been reported in due time, the statute of limitation is interrupted until the Insurer has informed the Policyholder or Insured Person in writing of its decision pertaining to the Claim.

5. How must premiums be paid?

5.1 Unless otherwise stipulated, the legally authorised premiums, fees and taxes must be paid in advance to the head office of the Insurer and/or the agent designated by the Insurer for this purpose. Payment is required from the Policyholder.

5.2 Where the Insurance Policy covers several insured risks, the total amount of premiums due under the Insurance Policy is considered to constitute one single indivisible premium.

5.3 The premium is an annual premium. The first premium payment is due as of the date of the signature of the Group Contract by the Policyholder. Subsequent premiums are due at the renewal date of the Insurance Policy.

5.4 The payment terms for the premiums are specified in the Group Contract. Any amendment to the payment terms requires the express written agreement of the Insurer.

6. What are the consequences of late payment of premiums?

6.1 In the event of non-payment of premiums or of a fraction of a premium within 10 calendar days of the due date, the Benefits of the Insurance Policy shall be suspended after a grace period of 30 calendar days subsequent to the sending, by the Insurer, of a registered letter to the Policyholder at his/her last known place of domicile. The Insurer shall also send the relevant registered letter to the last known email address of the Policyholder.

6.2 The registered letter contains a formal notice from the Insurer for the attention of the Policyholder to pay all premiums that are due. In addition, the letter specifies the due date and the total amount of the unpaid premiums, as well as the consequences of non-payment at the end of the aforementioned 30-day grace period.

6.3 Claims occurring during the suspension period following the grace period shall not give rise to the granting of any Benefits from the Insurer.

6.4 The Insurer has the right to cancel the Insurance Policy 10 calendar days after the expiry of the aforementioned 30-day grace period.

6.5 If it is not cancelled, the Insurance Policy shall resume its effects for future Claims only as of the first hour of day following the date on which the Insurer or the agent appointed by the Insurer for this purpose receives the payment of the premiums that are due or, where the total amount of the annual premium is fractioned, the payment of the relevant fractions that have been notified as unpaid to the Policyholder, as well as the premiums that have expired during the suspension period and, where applicable, any legal and recovery costs.

6.6 The suspension of the Benefits does not affect the right of the Insurer to claim the premiums that become subsequently due, provided that the Policyholder has been sent formal notice notifying the Policyholder of the fact that the premiums have become due and that the Insurance Policy and the Benefits granted thereunder remain suspended. However, this right is limited to premiums pertaining to 2 consecutive years.

6.7 If the Insurance Policy is suspended due to the non-payment of premiums or fractions of premiums for an uninterrupted suspension period of 2 years, it shall terminate automatically upon expiry of that period.

VII. General information

1. When can the GTCs be amended?

1.1 The Insurer may amend or supplement the GTCs in the following exceptional cases, while simultaneously safeguarding the Insured Person's interests, if:

a) conditions in the healthcare sector change not just temporarily, and particularly in the following cases:

aa) changes in legal regulations underlying individual provisions of the contract,

ab) changes in supreme court rulings underlying individual provisions of the contract.

b) The GTCs contain an invalid provision and must be supplemented in order to continue the contract. This may be the case in particular if

ba) individual provisions have been declared invalid by a court of law without the right of appeal,

bb) a cartel authority, an insurance supervisory authority or a comparable authority has issued an administrative act objecting to a provision as being incompatible with the law, and the statutory regulations do not include any ruling which could replace such a provision.

1.2 The amended GTCs shall be reported and explained to the Policyholder in writing. They will come into effect at the beginning of the second month following the date on which the Policyholder was notified. The Insured Person will be informed of amendments to the GTCs by the Policyholder.
The amended GTCs are considered to have been tacitly approved by the Policyholder if the Policyholder does not, within one month of receiving notification, terminate the Group Contract and the insurance relationship for the Insured Person concerned by written notice addressed via registered letter to the Insurer with effect from the date on which the amendment comes into force.

1.3 Any change, by the Insurer, of the tariff of the premium shall occur in accordance with the provisions of the law of 27 July 1997 on the insurance policy as amended from time to time, and the terms of the Group Contract.

2. Notifications, dispute resolution, Solvency and Financial Condition Report and Guarantee Fund?

2.1 All notifications from the Insurer to the Policyholder are deemed validly made if mailed by post to the Policyholder's last known address as reflected in the Insurer's records.
Notifications from the Insurer to the Policyholder are deemed to have been received by the Policyholder 10 (ten) calendar days after the postmarked date of their dispatch by the Insurer.
Notifications made to the Insurer must be sent to the Insurer's registered office, the address of which is stated in these GTCs.

2.2 In the event of a dispute regarding the Insurance Policy, the Policyholder is required to submit a written complaint to one of the following entities:

a) The senior management of the Insurer,
Foyer Global Health S.A.
12, rue Léon Laval
L-3372 Leudelange
Luxembourg
Telephone : +352 270 444 3501
Fax : +352 270 444 3599
E-mail: feedback@globality-health.com
Internet: www.globality-health.com

b) or to the Insurance Ombudsman, in care of the Association des Compagnies d'Assurances et de Réassurances du Grand-Duché de Luxembourg (Luxembourg Insurance and Reinsurance Association), 12 rue Erasme, L-1468 Luxembourg,

c) or to the Consumer Ombudsman, Union Luxembourgeoise des Consommateurs (Luxembourg Consumer Protection Association), 55 rue des Bruyères, L-1274 Howald,

d) or to the National Consumer Ombudsman Service, Service National du Médiateur de la Consommation, 6 rue du Palais de Justice L-1841 Luxembourg,

e) or to the Luxembourg Insurance Commission, Commissariat aux Assurances, 11 Rue Robert Stumper, L-2557 Gasperich Luxembourg. The opening of the complaint procedure with the Commissariat aux Assurances is subject to the condition that the complaint has been previously dealt with by the Insurer.

This is in addition to the Policyholder's right to pursue legal action in court. For further details on the out-of-court complaint resolution procedure, please refer to the "My Globality" procedure available on the Insurer's website at www.globality-health.com.

2.3 The Solvency and Financial Condition Report of the Insurer is available on the Insurer's website under the following address: www.globality-health.com/imprint/

2.4 Under Luxembourg law, the Benefits granted under the Insurance Policy are not subject to a specific statutory guarantee fund. Any Claims to the payment of Benefits occurring under the Insurance Policy are, however, protected under the triangle of security (triangle de sécurité) constituted by the mandatory Luxembourg law provisions governing the deposit of the technical provisions underlying the Insurance Policy, the related supervision by the Commissariat aux Assurances and the applicable statutory liens (privilèges).

3. Which is the applicable law?

Unless otherwise provided by applicable national or European laws or regulations, or applicable treaties, the Insurance Policy shall be exclusively governed by and construed in accordance with Luxembourg law.

4. Which area of jurisdiction applies?

Contrary to expectations, agreement sometimes cannot be reached when handling Claims for insurance Benefits. In such a case, Claims can be asserted against the Insurer in a court of law.

Unless otherwise provided by applicable national or European laws or regulations, or applicable treaties, all disputes arising from the insurance contract shall be brought before a court of law in Luxembourg City, Grand Duchy of Luxembourg.

Glossary

Abroad:
Abroad is to be understood as a country in which the Insured Person do not have its permanent place of residence.

Actions of higher authority:
Actions of higher authority are measures taken by the authorities, examples of this are: Confiscation of exotic souvenirs by the customs authority or refusal of entry if the required entry documents are missing.

Accident:
Accident means a sudden, single, unforeseen, and unexpected external physical event happening by chance that could not have been expected and which results in the Insured Persons suffering death, disablement, or Injury. An Accident must occur during the Insurance Period and after the Effective Date of cover for the Insured Person.

Benefit:
The reimbursement of costs and expenses by the Insurer to the Insured Person subsequent to a Claim covered by the Insurance Policy.

Business trip:
A Business trip consists in the Insured Person's temporary professional absence, arranged by the Insured Person's employer, away from its permanent place of residence or regular place of work. Journeys to the permanent residence or the regular place of work and between these places are not deemed to be Business trips. Journeys to work at primarily different locations (change in place of work), as well as work in the field, are likewise not deemed to be Business trips.

Corporate travel:
Corporate travel consists in the Insured Person's temporary professional absence away from its permanent place of residence or regular place of work to the extent the Insured Person are an independent professional, a managing director, board member or other person not subject to instructions from a Policyholder. Journeys to the permanent place of residence or the regular place of work and between these places are not deemed to be corporate travel. Journeys to work at primarily different locations (change in place of work), as well as work in the field, are likewise not deemed to be corporate travel. The term "Business trip" is deemed to include corporate travel for purposes of these terms and conditions for insurance.

Carer:
Carers are people who care for the Insured Person's accompanying or non-accompanying Relatives, who are underage or are in need of care, e.g. au pair.

Check-up:
Check-ups are regular medical examinations carried out to determine the state of health of the patient. E. g. measuring the blood sugar level in case of diabetes. They are not carried out for a specific purpose or for treatment.

Claim:
Request for the payment of Benefits that is addressed to the Insurer following the occurrence of an Insured Event.

Commencement / Start of the Business trip:
For the purpose of the Travel Cancellation Insurance and the Curtailment Insurance, the Business trip is deemed to have commenced once the first booked travel service begins.
A Business trip is deemed to commence under the Travel Cancellation Insurance in particular:

- For a flight: With check-in, if the traveler checks in on the previous evening, when he / she goes through the security check on the day of travel.
- For a journey by sea: With check-in on the ship.
- For a bus trip: When the traveler enters the bus.
- For a rail trip: When the traveler enters the train.
- For a trip by rental car: With acceptance of a rental car.
- When travelling with one's own car: When the first booked travel service commences, e.g., Hotel check-in. Is a transfer service a fixed element of the entire trip? The trip then begins when the transfer commences (entering the transfer vehicle).
  For the purpose of all other types of travel insurances, the Business trip commences when the Insured Person leaves its home or regular place of employment.

Current value:
The Current value is the sum generally required to purchase new items of the same kind and quality. The Insurer will deduct an amount representing the condition of the item (age, wear, usage, etc.). from this sum.

Declaration of Intent:
Any unilateral act carried out by a concerned party with a view to producing legal effects, such as, but not limited to, a proposal to conclude a contract, the acceptance of such proposal, or a notification of termination of the contract.

Doctor:
A Doctor is a medical professional (general practitioner or specialist) or holder of a medical diploma who has statutory approbation and is licensed to practice medicine in the country in which treatment is provided.
The Insured Person is free to choose any Doctor meeting these criteria.

Domestic:
Domestic is to be understood as a country in which the Insured Person has their permanent place of residence.

Effective Date:
Date on which the Insurance Policy and the cover ("garantie") and Benefits provided for therein enter into effect, i.e. the date and time indicated in the Insurance Certificate or the date of the payment of the first insurance premium, whichever is later, without prejudice to any applicable waiting periods.

Extreme sports:
Extreme sports and high-risk sporting activities encompass any form of sport or athletic pursuit characterized by a heightened level of inherent danger. This includes activities demanding advanced expertise, extraordinary physical exertion, specialized equipment, performance of daring stunts and activities in which the Insured Person has signed a liability waiver. Includes, but is not limited to:

- Abseiling, mountaineering (apart from indoor climbing and low mountain areas) and racing of any kind
- Bobsleigh, luge, skeleton, off-piste skiing, and off-piste snowboarding.
- Bungee and cliff jumping.
- Combative sports.
- Downhill mountain biking and cross-country cycling
- Extreme tourism (e.g. tours to Antarctica)
- Horseback hunting, horse jumping, polo, steeple chasing, or any form of horse racing.
- Motorcycle sports, including motorcycle riding and quad biking.
- Microlight flying, ballooning, hang gliding, paragliding, parascending, and parachute jumping.
- Solo caving (potholing) or cave diving, scuba diving beyond 10 meters, high diving, white water rafting, and canyoning.
- Ultra marathons or activities similar in nature.

Foreign Office:
Public office that publishes extensive travel information on all countries in the world (e.g., travel and safety information, travel warnings).

Group Contract:
The group contract for the Corporate Travel insurance plan concluded between the Insurer and the Policyholder.

Gross negligence:
The willful or reckless disregard for the duty of care and complete disregard for the safety and well-being of others (faute lourde).

Glossary:
The present glossary of defined terms, which forms an integral part of the GTCs.

GTCs:
The current General Terms and Conditions of Insurance for corporate travel.

Holiday:
Personal vacation taken by an Insured Person before, during and/or Immediately after a Business trip.

Immediately:
Without culpable delay.

Incidental Private Travel:
Travel which is private and taken either side of or during an authorized Business trip.

Insurance Certificate:
The insurance certificate issued (on a case-to-case basis and on demand) to the attention of the Policyholder and the Insured Person and confirming the scope and the Effective Date of the insurance cover provided under the Insurance Policy.

Insurance Period:
The period specified in the Group Contract, during which the insurance cover granted under the Insurance Policy applies.
Insured Person:
The person designated and registered in accordance with the Group Contract as the person who is insured under the Insurance Policy.

Insurance Policy:
The contractual framework for corporate travel insurance constituted by the GTCs, together with the present Glossary, the Group Contract, the Insurance Certificate, and any subsequent written agreements between the Insurer, the Policyholder and, where relevant, the Insured Person.

Insurer:
Foyer Global Health S.A., a health insurance company established in Luxembourg under the form of a public limited liability company (société anonyme) having its registered office at 12, Rue Léon Laval L-3372 Leudelange, registered under no. B134.471 in the Luxembourg Trade and Companies Register, supervised by the Commissariat aux Assurances (11, rue Robert Stumper, L-2557 Luxembourg; +352226911-1; caa@caa.lu).

Increased risk:
A perceptible and lasting increase in the risk insured under the Insurance Policy.

Insured Event:
An Insured Event is an occurrence that causes an accident, sickness, financial loss, expense, or liability for the Insured Person and is described in the Insured Person's Group Contract as being covered and as giving rise to a Claim under the Insurance Policy. For medical treatments, the Insured Event commences with the treatment and ends when medical findings indicate that treatment is no longer required.

Medically necessary / Medically necessary treatment:
Medically necessary are all appropriate medical measures and medicines, based on internationally approved medical standards at the respective time and location, which are used to diagnose, treat, heal, or relieve the disease condition, illness or injury and are recognized as appropriate by the Insurer.

These measures must be:
a) carried out in a health care facility authorized and licensed by the authorities in the country of treatment.
b) the most appropriate considering both patient safety and cost effectiveness.
c) Consistent with the diagnosis, symptoms, or treatment of the underlying condition.
d) Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease.
e) Not required purely for comfort or convenience of the patient, medical providers, therapists, or Doctors.
f) Not for clinical trial, experimental, investigational, or cosmetic purposes (see No 6).
g) Not for screening and preventive care purposes.

Medical Cancellation Advisory Team:
The Insurer's Medical Cancellation Advisory Team, that evaluates the medical condition and assists the Insured Person in determining if and when to cancel their Business trip.

Natural events:
Natural events are explosions, storms, hail, lightning, high water levels, flooding, avalanches, volcanic eruptions, earthquakes, and landslides.

Plan:
The insurance plan agreed with the Policyholder and Insured Person, which defines the extent of the cover provided under the Insurance Policy.

Policyholder:
The person who enters into the Insurance Policy with the Insurer.

Pandemic:
A Pandemic exists if an infectious disease breaks out on large parts of a continent or on several continents. This must be established by the World Health Organization.

Public transportation:
Public transportation relates to all vehicles licensed for public conveyance of passengers by air, land, and sea. Vehicles used for tours / air tours, hire cars, taxis and cruise ships are not deemed Public transport.

Rebooking fees:
Rebooking fees are fees charged by the Insured Person's tour operator / contract partner for changes made to the destination or travel dates of its trip.

Related Person:
Related Persons include:
a) The Insured Person's Relatives and the Relatives of the Insured Person's partner.
b) Caregivers responsible for looking after the Insured Person's accompanying or non-accompanying Relatives who are underage or require care.
c) A co-worker who typically acts as a substitute for the Insured Person or for whom the Insured Person usually substitutes.
d) The owner of the Policyholder and members of the Policyholder's management.

Relatives:
Relatives are:
A) The Insured Person's spouse or civil partner, its partner living in cohabitation.
B) The Insured Person's children, parents, adopted children, adoptive parents, foster children, foster parents, stepchildren, stepparents, grandparents, siblings, grandchildren, aunts, uncles, nieces, nephews, parents-in-law, children- in-law, brothers-in-law, and sisters-in-law.

Sports equipment:
Sports equipment refers to all items required to do a sport including accessories.

Start / Commencement of the Business trip:
See "Commencement / Start of the Business trip".

Travel location:
Travel locations are deemed to include all locations the Insured Person visits in the course of a Business trip. In addition, all connecting routes between Travel locations and back to its permanent place of residence or its regular place of employment are included.

Travel services:
Travel services are deemed to be, for example, booked hotel rooms, a flight, a journey by sea, a bus or rail trip.

Appendix 1. Detailed Scope of Benefits

The deductibles/co-payments, maximum amounts, durations, or lump sums specified below for each respective benefit, or any other applicable limits will apply.

Section	Limit
A. Medical Travel Insurance	
Deductible / Co-Payment	EUR 100 for each insured event
Inpatient treatment	Paid in full
Outpatient treatment	Paid in full
Drugs, medicines and bandages	Combined limit up to EUR 1,000*
Pain-relieving dental treatments including basic dental fillings	
Repair of existing dentures and existing dental-prosthesis	Paid in full
Pacemakers and prosthesis if they become necessary for the first time during the trip	Paid in full, if they are required to ensure that you can be transported
Aids which become necessary for the first time during the stay	Paid in full
Chiropractor or alternative therapist	up to 10 visits and EUR 1,500 per person and per insurance year*
Telephone costs to call our Emergency Hotline	up to EUR 25*
Medical treatments for complications of existing pregnancy	L
Premature births up to and including the 36th week of pregnancy including medical treatment for newborn child	L
Pregnancy during business trip	L
Psychological treatment due to trauma	Up to 10 sessions per insured event, up to a maximum of EUR 1,500*
Hospital daily benefit	EUR 100 per day, maximum 30 days from the start of the inpatient treatment*
Accommodation to accompany a child during an inpatient treatment	Paid in full
Return transport (including luggage) and ambulance service for in- and outpatient treatments	Paid in full
Repatriation or burial in case of death	burial up to the amount of the repatriation costs
Advice on medical care and medicines	Paid in full
Help in case of hospitalization	Paid in full
Longer care for under-age children or persons in need	Paid in full
Search, rescue and recovery	up to EUR 25,000*

L: Caution: Limited benefits! Our benefits are limited to the maximum sums, periods or lump sums specified in the respective benefit or to other limits specified or require prior written approval.
*The specified maximum sums, maximum periods and lump sums apply per insured person and per insured event.

Section	Limit
B. Domestic Travel Insurance	
Deductible / Co-Payment	N.A.
Return transport of the patient and luggage	Paid in full
Hospital daily benefit	EUR 100 per day for a maximum of 30 days*
Return of mortal remains and transfer of luggage	Paid in full
C. Travel Delay Insurance	
Deductible / Co-Payment	20% of the refundable amount, at least EUR 25 per person
Public transport is delayed. Additional cost for outbound and return travel	Up to EUR 1,500*
Continued travel delay caused by public transport for appropriate expenses (meals and accommodation)	Up to EUR 150*
D. Personal Liability Insurance	
Deductible / Co-payment	EUR 150 per event in case of damage to property
Compensation personal liability	Max. benefit limit of plan applies
E. Travel Cancellation and Curtailment Insurance	
Deductible / Co-Payment	20% of the refundable amount, at least EUR 25 per person
Travel Cancellation	
Medical Cancellation Advisory Team Service	Covered
Cancellation of business trip	Max. benefit limit of plan applies
Delay of starting the business trip	Max. benefit limit of plan applies
Car breakdown or accident for unused services or additional cost	Up to EUR 500*/**
Car breakdown or accident for a hire car	Up to EUR 1,000*/**
Travel agency fees	Up to EUR 100*/**
Rebooking fees instead of cancellation	Up to the maximum of cancellation*/**
Rebooking fees when local business partner is unavailable	Up to EUR 1,500*/**
Fees for issuance of visa	Max. benefit limit of plan applies
Travel Curtailment	
Pro rata travel price for unused services	Max. benefit limit of plan applies
Additional costs for return trip	Max. benefit limit of plan applies
Car breakdown or accident for unused services or additional cost	Up to EUR 500*/**
Car breakdown or accident for hire car	Up to EUR 1,000*/**
Additional accommodation due to inpatient treatment	Up to EUR 1,500*/**
Additional accommodation due to outpatient treatment	Up to EUR 1,500*/**

* The specified maximum sums, maximum periods and lump sums apply per insured person and per insured event.
**Maximum benefit limit of the plan applies

Section	Limit
E. Travel Cancellation and Curtailment Insurance (cont.)	
Unused travel services in case of inpatient services	Pro rata travel prices which have not been used*/**
Cost to reach the next destination	Up to the value of travel services not used yet*/**
Unscheduled return trip due to fire or natural events	Max. benefit limit of plan applies
Extension of stay due to fire or natural event	Max. benefit limit of plan applies
Delay by more than 12 hours due to strike or accident involving a means of transport	Up to EUR 1,500*/**
F. Replacement Employee Insurance	
Deductible / Co-Payment	20% of the refundable amount, at least EUR 25 per person
Verified additional cost for rebooking unused ticket	Max. benefit limit of plan applies
Additional costs for ticket for outbound and/or return travel if the ticket cannot be used	Max. benefit limit of plan applies
Additional lodging costs for the replacement employee	Max. benefit limit of plan applies
Costs corresponding to the type and standard of the originally booked services	Max. benefit limit of plan applies
G. Travel Accident (Death and Disability) Insurance	
Deductible / Co-Payment	N.A.
Degrees of disability	Reference to table and insured sum*/**
Death	Max. benefit limit of plan applies*/**
Transitional benefit	10% of the sum insured in accordance with the degree of impairment applicable to disability*/**
Coma allowance	EUR 30 for each day for a maximum of 365 days*/**
Cosmetic surgery	Up to EUR 20, 000*/**
Costs of renovation of the workplace	Up to EUR 15,000*/**
H. Luggage Loss and Delay Insurance	
Deductible / Co-Payment	EUR 100 for each insured event
Cash stolen	up to EUR 500*/**
Tickets stolen	Unused portion of the ticket**
Lost or destroyed article less than two years old	new value**
Lost or destroyed article more than two years old	current value**
Damaged article less than two years old for repair or decrease in value	new value**
Damaged article more than two years old for repair or decrease in value	current value**
Films, video, audio and data media	material value**
Official identity documents and visas	Official charges to obtain new documents**
Luggage lost and delay (replacement purchase)	Up to EUR 1,000*/**

* The specified maximum sums, maximum periods and lump sums apply per insured person and per insured event.
**Maximum benefit limit of the plan applies

Appendix 2. Corporate Travel Claims Procedure

What to do in the event of a claim

1. Report all claims to the Insurer within 30 days of the event or as soon as possible.
2. Provide all necessary documents, such as medical reports, police reports, receipts, and other evidence needed by the Insurer to resolve the claim quickly. Please see the table below for the required documents for each type of claim.
3. For liability claims, the Insured Person must inform the Insurer of any Insured Event within one week after becoming aware of it and not admit fault or make any offers. Please ensure that any claims against the Insured Person be put in writing.
4. Report all losses related to luggage and travel documents to local authorities and/or the Transport Provider and obtain a written acknowledgment.
5. Immediately report any luggage loss or damage to the airline or carrier involved and file a claim with them first. They may be responsible for the damage or loss.
6. Call the Emergency Hotline on +352 2704441014 for help with any travel emergencies while overseas.
7. Please submit your claim online along with the required documents.

Tip:

For faster claims processing, scan all the evidence and upload it to the claim form

- You can upload your documents in the following formats: PDF, JPG or PNG.
- Please scan receipts in the correct direction if possible.
- The size is limited to 5 MB per document.
- Do not upload any documents protected with your password!
- Missing receipts or evidence will delay the processing of the claim and will be requested by us.

Before submitting the claim online, please have the following documents ready:

Section	Type of Claim	Supporting docuemts required
	ALL CLAIMS	Below information is mandatory for all types of claims:
		1. Insurance number: This is the group policy number for your organization. You can also ask your HR about this information.
		2. Your bank details.
		3. Your travel booking confirmation (proof of travel).
A	OVERSEAS MEDICAL TRAVEL	1. Doctor / hospital bill
		2. Other medical bills, e.g., for medication
		3. In case of a medical emergency or hospitalization please call the Emergency Hotline for assistance.
B	DOMESTIC TRAVEL	1. Doctor / hospital bill for the entire duration of hospitalization.
		2. Return Transport invoices.
C	TRAVEL DELAY	1. Confirmation from the carrier about the delay.
		2. Evidence of the cost of expenses (food and accommodation).
		3. Delay of a public transport during the outward journey
		4. Confirmation from the transport company about the delay in public transport.
		5. Evidence of the additional costs of the outward journey, e.g., a new flight ticket.

Section	Type of Claim	Supporting docuemts required
D	PERSONAL LIABILITY	1. Information on additional existing travel insurance (e.g., via credit card or automobile club)
		Only if applicable, we also need the following documents or proof:
		1. Evidence of a claim for damages from a third party due to a damaging event. A damaging event occurs if it results in the death, injury, or damage to health of people (personal injury) or the damage or destruction of property (property damage).
		2. Police report (e.g., accident report), witness statements etc.
		3. A detailed description of how the accident happened.
		4. Receipts of the material damage incurred (cost estimate/repair invoice)
		Additionally in the case of third-party debt:
		1. Notification of the person who caused the accident (name, address) and their liability insurer.
E	TRAVEL CANCELLATION AND CURTAILMENT	**Cancellation**
		1. Cancellation cost invoice(s): You will receive this from your tour operator or travel agency. If you have booked individual travel modules (flight, hotel, rental car, etc.) and have received a separate confirmation for each, we need a cancellation invoice for each module.
		Cancellation due to illness, pregnancy, intolerance to vaccinations
		1. Medical certificate form completed by the attending physician. (Please only use this form and have it filled out by your doctor before reporting your claim.)
		Cancellation due to a death
		1. Death certificate
		Cancellation of a flight
		1. Air tickets, e-tickets
		2. Evidence that the flight was not taken. You will receive this directly from the airline.
		Curtailment
		1. Evidence / invoices for additional costs incurred.
		Cancellation of travel due to illness, pregnancy, intolerance to vaccinations
		1. Certificate from the doctor treating you at the holiday destination.
		Cancellation of travel due to damage to property
		1. Proof of damage to property.
		Trip cut short due to death
		1. Death certificate.
		Rebooking flight
		1. Proof from the airline of the rebooking.
		2. Booking confirmation of the new flights.
		3. Proof of the reason for the rebooking.
		For all reasons for cancellation not listed here, we will contact you and request the relevant documents.

Section	Type of Claim	Supporting docuemts required
F	REPLACEMENT EMPLOYEES	1. Evidence / invoices for additional costs incurred
		2. Replacement of travel due to illness, pregnancy, intolerance to vaccinations of the initial employee.
		3. Certificate from the doctor treating you at the holiday destination
		4. Cancellation of travel due to damage to property of the initial employee
		5. Proof of damage to property
		6. Trip cut short due to death of the initial employee
		7. Death certificate
G	TRAVEL ACCIDENT (DEATH AND DISABILITY)	Only if applicable, we need the following documents or proof (examples):
		1. Proof that a joint has been dislocated or muscles, tendons, ligaments, or capsules have been strained or torn as a result of increased physical exertion (e.g., medical certificate).
		2. Evidence that damage to health has occurred during lawful defense or during efforts to save human life, animals, or property (e.g., police report, witness statements, confirmation from rescue workers, etc.).
		Additionally in the event of death:
		1. Death certificate
		2. Certificate of inheritance
		3. Specification of the responsible tax office
		4. Tax number
		Other obligations:
		The treating or assessing doctors, other insurers and authorities must be authorized to provide Foyer Global Health S.A. and the doctors commissioned by it with all the necessary information.
		Obligation to be examined by doctors commissioned by Foyer Global Health S.A.
		The contractual reporting deadlines must be observed!
H	LUGGAGE LOSS OR DELAY	1. Receipts for replacement purchases made.
		With luggage carried
		1. Police report on criminal acts.
		2. Detailed description of the course of the damage with all the accompanying circumstances and notification of where and when the damage was first detected.
		With checked baggage
		1. Damage report from the transport company for checked baggage (in the event of damage, total loss, and delayed delivery).
		2. Original receipts for replacement purchases if the delivery time has been exceeded.
		3. Final confirmation of loss from the carrier.
		4. The ticket with the carrier's baggage tags.
	ALL OTHER CLAIMS	If your claim does not fit any of the travel claim scenarios listed above, please select ‚Others' when completing the claim form.

Data Protection:

You can find all the information about the processing of your personal data on the privacy policy of Foyer Global Health S.A. available on the website (www.foyerglobalhealth.com/privacy/).

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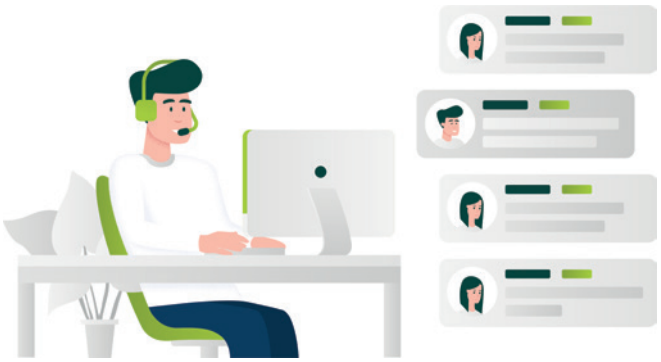

Get in touch with us

Please feel free to contact us in case of any questions on our General Terms and Conditions of Insurance or products:

Lines are open
Monday to Friday: 8am to 5pm (CET)

Phone +352 270 444 35 01
Fax +352 270 444 35 99

Or contact us anytime at:
service-travel@globality-health.com

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