LIFEPLAN' EXPAT

// INFORMATION BOOKLET SERVING AS THE GENERAL TERMS & CONDITIONS

CONTENTS

1 / PRESENTATION OF ASFE AND ITS ADMINISTRATOR MSH INTERNATIONAL

You have chosen an ASFE international insurance plan from Groupama Gan Vie, managed by MSH INTERNATIONAL, and we are delighted to welcome you as a member.

ASFE, the Association of Services For Expatriates, was created in 1992 and is governed by the French law of 1901 on associations. Its purpose is to provide expatriates all over the world with solutions in the fields of healthcare coverage, life & disability, medical assistance/repatriation and third-party liability. Throughout this document ASFE will be referred to as "ASFE" or the "Contracting association".

MSH INTERNATIONAL, the designer and Administrator of ASFE plans, is a world leader in international benefits with over 400,000 globally-mobile individuals insured worldwide. MSH INTERNATIONAL provides you with the services of a dedicated team which is on hand to support and advise you day after day. MSH INTERNATIONAL, an organization mandated by the Insurer to administer the plan, will be referred to throughout this document as "MSH INTERNATIONAL", "the Administrator", "the Administrating Organization" or "the Insurer" whenever this term is used in the context of the administrative management of the plan.

The plan is insured by Groupama Gan Vie – a French "*société anonyme*" with a capital of 1,371,100,605 euros (fully paid) – registered with the Paris Trade and Companies Register under number 340 427 616 - APE 6511 Z Head office: 8-10 rue d'Astorg - 75383 PARIS Cedex 08 France - Company regulated by the French Insurance Code and subject to the French Prudential Supervision and Resolution Authority (ACPR) - 4 place de Budapest - CS 92459 - 75436 Paris Cedex France hereinafter referred to as "the Insurer".

2 / GENERAL PROVISIONS OF THE LIFE & DISABILITY BENEFITS

2.1/GENERAL INFORMATION

ARTICLE 1 – PURPOSE OF THE INSURANCE

The purpose of the group insurance plan with optional membership is:
- the payment of a lump sum to the designated Beneficiary or Beneficiaries in the event of the Member's death (Article 4),
- the payment of a lump sum to the Member him / herself in the event of permanent total disability (Article 5), and, if optional benefits have been purchased by the Member:
- the payment of an additional lump sum to the designated Beneficiary or Beneficiaries in the event of the accidental death of the Member (Article 6),
- the payment to the Member of a lump sum proportional to the degree of infirmity, in the event of his or her total or partial infirmity (Article 7),
- the provision to the Member of benefits in the event of sick leave from work following an illness or accident (Article 8).

In respect of this Sick Leave benefit, three options are available to the Member: "Standard Sick Leave benefit", "Short Term Disability benefit" and "Long-Term Disability benefit". Reference numbers specific to each particular plan, as described in Article 3 below, are assigned to these different options.

The benefits and options purchased by the Member are shown on the certificate of enrollment.

ARTICLE 2 – GEOGRAPHICAL LIMITS AND DEFINITIONS

• **GEOGRAPHICAL LIMITS**

Coverage applies in the country of destination, as well as in France and in the FODRs and FOCs.
Coverage also applies during occasional stays, for non-medical reasons, of a duration not exceeding 60 consecutive days between two stays in the country of destination during international trips outside the country of destination (in a private capacity).

However, as a result of events (civil or foreign war, insurrection, etc.) which may be taking place there and, in all circumstances, in accordance with the classification of at-risk countries published by the French Ministry of Foreign Affairs, coverage may be excluded, both at the time of enrollment and during the period of membership of the plan, for certain countries to which travel is classed by this Ministry as highly inadvisable (red zone).

During the period of membership of the plan, if a country or zone to which travel is classed as highly inadvisable (red zone) is excluded, coverage will be suspended for the duration of the red zone classification. At the time of purchasing the plan, coverage will also be subject to prior acceptance by the insurer if travel to that country is classed as inadvisable by this Ministry unless for compelling reasons (orange zone). This list of countries or zones varies and is regularly updated by the French Ministry of Foreign Affairs.

• DEFINITIONS

Accident: Any physical injury, not intended by the Member or the Beneficiary, resulting from sudden, unpredictable action with an external cause. The cause and symptoms must be medically and objectively definable, and be subject to diagnosis and treatment. In accordance with Article 1353 of the French Civil Code, it is the responsibility of the Beneficiary or Beneficiaries to provide evidence of the Accident and the direct relationship of cause and effect between the Accident and the death.

Basic social security scheme: Any Social Security scheme in force in the country of expatriation, or the Caisse des Français de l'Etranger – CFE.

Certificate of enrollment: Document issued to each Member confirming their enrollment in the plan and specifying, in particular, the benefits and level of coverage selected, the effective date and the premiums.

Certified document: A certified document is a document drawn up by a public official and signed before them by all parties to the document.

Contracting association: ASFE: Legal entity having purchased the plan for the benefit of its Members and which agrees to fulfill the corresponding obligations.

Excluded countries: Stays which are not occasional, for medical reasons or which are occasional and whose duration is greater than or equal to 60 consecutive days are not covered.

As a result of events (civil or foreign war, insurrection, etc.) which may be taking place there and, in all circumstances, in accordance with the classification of at-risk countries published by the French Ministry of Foreign Affairs, coverage may be excluded for certain countries or zones to which travel is classed by this Ministry as highly inadvisable (red zone) or inadvisable (orange zone).

FOC: French Overseas Communities (Saint Pierre and Miquelon, Wallis and Futuna, Saint-Barthelemy and Saint-Martin).

FODR: French Overseas Departments and Regions (Guadeloupe, Guyana, Martinique, Reunion and Mayotte).

Hospitalization: A medically-prescribed stay in a hospital (public or private) for medical or surgical treatment of an illness, an Accident or maternity.

Illness: Any deterioration in the state of health certified by a competent medical authority.

Interest: Payment of interest from the date of death: Without prejudice to the provisions of Article L.132-23-1 of the French Insurance Code, the death lump sum will generate interest from the date of death.

This interest, net of charges, is set for each calendar year at the regulatory minimum rate, i.e., on the date of enrollment in the plan, at a rate equal to the lower of the following two rates:

·the Average Borrowing Rate in France (*Taux Moyen des Emprunts de l'Etat français* or TME) averaged over the last twelve (12) months, calculated on November 1 of the previous year,

·the latest Average Borrowing Rate in France available on November 1 of the previous year.

The revaluation ceases on the date of receipt of the supporting documents required for payment of the claim or, where applicable, on the date on which this lump sum is deposited with the "*Caisse des Dépôts et Consignations*" under Article L.132-27-2 of the French Insurance Code.

Member: Member of the contracting association requesting enrollment in the plan and meeting the conditions set out in Article 12.

Private deed: A private deed is a freely drafted document, drawn up by one of the parties to the deed and signed by all participants in this deed. There must be as many originals as there are participants. The private deed may or may not be registered with the tax department.

Reported accident: Accident recorded by a competent authority (police, fire service, medical authorities, etc.) having issued a certificate specifying the circumstances and nature of the injury as well as the date of the accident.

Stabilization: Medically stationary state of health of a member who has had an accident or is suffering from an illness.

Waiting period: Number of days during which no sick leave benefits are paid by the insurer.

ARTICLE 3 – LANGUAGE AND CURRENCY OF THE PLAN – REFERENCE NUMBERS USED IN THE PLAN

MSH INTERNATIONAL is the organization mandated by the Insurer, particularly for the purpose of managing membership of the plan.

• **LANGUAGE OF THE PLAN**
The language of the group insurance plan is French.

However, MSH INTERNATIONAL provides Members with English versions of the information booklet serving as the general terms and conditions and the documents required for the management of plan membership such as individual enrollment forms, medical questionnaires, confidential medical certificates, etc.
However, in case of disagreement on the interpretation of the benefits provided under the plan or the terms of their implementation, only the French version of the relevant document will be taken into consideration. Translations of documents are made available to Members purely for information purposes and only the French language version is binding.

• **CURRENCY OF THE PLAN**
The currency of the plan is the euro or the American dollar, both for the premiums and the benefits.
The currency selected by the Member is shown on the certificate of enrollment.
A particular reference number, as described in the paragraph below, is assigned to the plan according to whether the membership operates in euros or American dollars.

IMPORTANT

Payments cannot be made, either directly or indirectly, to a country which is subject to sanctions such as those imposed, for example, by the United Nations, the Office of Foreign Assets Control of the US Treasury (OFAC) or the European Union.

• **REFERENCE NUMBERS USED IN THE PLAN**
The plan uses the following reference numbers:

1/ Membership in euros:
- no. 9054/863693/10000 if the Member has opted for the "Standard Sick Leave" benefit,
- no. 9054/863694/10000 if the Member has opted for the "Short-Term Disability" and/or "Long-Term Disability" benefit.

2/ Membership in dollars:
- no. 9054/863693/10010 if the Member has opted for the "Standard Sick Leave" benefit,
- no. 9054/863694/10010 if the Member has opted for the "Short-Term Disability" and/or Long-Term Disability" benefit.

2.2 / BENEFITS

PREAMBLE – INSTRUCTIONS TO MEMBERS FOR CLAIMING BENEFITS

The purpose of this section is to provide the Member with an overview of how the life & disability benefits operate should they need to make a claim:

1/ Contact: the AD&D AND SUPPORT department at MSH INTERNATIONAL:
- by telephone: + 33 (0)1 44 20 48 07,
- by email: add_support@msh-intl.com,
- by fax: + 33 (0)1 44 20 48 79.

2/ To make the payment of benefits easier and faster, all the documents to be provided (listed in the relevant article describing each type of benefit) should be sent to the AD&D AND SUPPORT department at MSH INTERNATIONAL.

ARTICLE 4 – BENEFIT IN CASE OF DEATH OF THE MEMBER

• DEFINITION AND AMOUNT OF THE BENEFIT

The purpose of this benefit is to pay a lump sum in the event of the death of the Member to the Beneficiary or Beneficiaries specified in the paragraph "Allocation of death benefits" below. This payment is subject to the provisions of the paragraph "Exclusions from coverage" below with the amount being equal to 100% of the selected lump sum.

The Member is free to choose the amount of the lump sum. The amount of the insured lump sum to be selected can be between:
- in euros: €25,000 and €1,000,000, in multiples of €25,000,
- in dollars: $30,000 and $1,200,000, in multiples of $30,000.

The amount selected by the Member is shown on the certificate of enrollment.

• EXCLUSIONS FROM COVERAGE

The benefit is not payable in the following cases:

- **Death resulting from a war involving France is not covered.**
- **Death caused by civil or foreign war, insurrection, riots, brawls, regardless of where the events take place and who the protagonists are (unless the Member does not take an active part or is called upon to carry out a servicing or surveillance assignment for the purpose of ensuring personal security) is not covered.**
- **Suicide, however it is classified, is not covered during the first year of membership of the plan.**

• ALLOCATION OF DEATH BENEFITS

Subject to any stipulation to the contrary which is valid on the day of the Member's death, the insured lump sum is paid:
- to his or her surviving spouse from whom he or she is neither divorced nor legally separated or, failing that, to his or her surviving civil partner. (A civil partnership is a contract concluded between two adult persons of the opposite sex or same sex to organize their common life together (Article 515-1 of the French Civil Code)),
- failing that, to his or her children born and unborn, living or represented for the purposes of inheritance,
- failing that, equally between them, to his or her father and mother or the entire amount to the surviving parent,
- failing that, to his or her other heirs.

If the Member does not want the insured lump sum to be allocated according to the above clause, or if, during the life of the plan, he or she wants to designate one or more other Beneficiaries, he/she should designate the Beneficiary or Beneficiaries of his/her choice and inform the insurer.

This designation may be carried out by private deed or certified document.
It should be noted that domestic partners(*) are not provided for in the standard beneficiary clause. A Member who wishes the lump sum to be allocated to his or her domestic partner must in this case fill out a special beneficiary designation form.

To avoid any risk of duplication of names and to make it easier to locate the designated Beneficiary or Beneficiaries, the Member should provide details for each Beneficiary which will allow them to be accurately identified, including their surname, first names and date and place of birth.

Any designation or change in designation which is not brought to the attention of the insurer is non-binding.

(*): Domestic partner means any person cohabiting with the member, insofar as the member and the domestic partner share the same home and are free of any other ties of the same type (i.e. they are both single, widowed or divorced and have not entered into a civil partnership).

IMPORTANT

The insurer draws the Member's attention to the need for regular updates of their special Beneficiary designation(s).

With the Member's agreement, any designation of Beneficiary may be accepted, after a period of at least 30 days following the effective date of membership of the plan, if the designation is made free of charge.

While the Member is alive, this acceptance must be formalized either by an endorsement signed by the insurer, the Member and the Beneficiary or by a private deed or certified document signed by the Member and the Beneficiary.

Acceptance is only binding on the insurer if they have been notified in writing. Proof of such notification falls upon the person claiming the benefit.

IMPORTANT

It should be noted that the designation in favor of a specific Beneficiary becomes irrevocable if it is accepted by them under the above conditions.

The entitlement of Beneficiaries to the insured lump sum is subject to them surviving for two days following the death of the Member.

- **FORMALITIES TO BE COMPLETED IN THE EVENT OF A CLAIM AND PAYMENT OF BENEFITS**

The death must be declared to the insurer as soon as possible by sending them the supporting documents required for settlement, including:

- an original extract of the death certificate,
- a medical certificate, to be sent to the insurer's medical advisor under confidential cover, showing the date of death and specifying if the death was natural or accidental or resulting from an event excluded under the plan,
- any additional documents allowing the benefits to be allocated:
  - any documents proving identity and/or family status, and in particular a full photocopy of the family record book and/or the birth certificate of the beneficiary, a certified statement and, where applicable, proof of the civil partnership,
  - the bank details required for payment,
- where applicable, any documents specifying the cause and circumstances of the Accident resulting in the death.

The insurer reserves the right to request any additional supporting documents they consider necessary for settlement of the claim.

Payment of the lump sum is made to the designated Beneficiary or Beneficiaries within one month of the date of receipt of the supporting documents by the insurer.

If there is more than one Beneficiary:
- the lump sum is allocated as specified by the Member or, in the absence of any specific instructions or designated Beneficiary or Beneficiaries, shared equally between Beneficiaries of the same class,
- the lump sum will not be distributed by the insurer but a single payment will be made subject to a receipt being signed jointly by the parties or their legal representative.

ARTICLE 5 – BENEFIT IN CASE OF PERMANENT TOTAL DISABILITY OF THE MEMBER

This benefit is payable in addition to the death benefit provided for under Article 4.

- **DEFINITION AND AMOUNT OF THE BENEFIT**

If, before claiming their old-age pension from Social Security and no later than the date of their 70th birthday, a Member, following an illness or Accident and subject to the provisions of the paragraph "Excluded risks" below, is affected by a disability which renders them totally unable to perform any professional activity whatsoever and, moreover, if they require the assistance of a third party to perform everyday tasks, the insurer will recognize them as having a permanent and total disability.

Permanent and total disability status is assessed by the insurer's medical advisor independently of the decisions made by the Social Security scheme to which the Member may belong.

The insurer then pays the Member a lump sum of the same amount as that paid under Article 4.

Payment of the permanent total disability benefit terminates the Member's entitlement to death benefits under Articles

4 and 6.

• **EXCLUDED RISKS**

- **Accidents or illnesses caused intentionally by the Member or resulting from either a suicide attempt or intentional self- inflicted injuries or the use of narcotics or psychotropic drugs without a medical prescription,**
- **Accidents or illnesses caused by civil or foreign war, insurrection, riots or brawls regardless of where the events take place and who the protagonists are unless the Member does not take an active part or is called upon to carry out a servicing or surveillance assignment for the purpose of ensuring the security of persons and goods,**
- **Accidents or illnesses caused by a war involving France.**

Furthermore, other than in application of Article L113.-8 of the French Insurance Code, and subject to the exclusions listed above, the benefit applies to the consequences of medical conditions or disabilities which occurred before the date of signature of the application for coverage under the plan if they were declared on the application form and were not subject to a specific exclusion of which the Member was notified by registered mail.

• **FORMALITIES TO BE COMPLETED IN THE EVENT OF A CLAIM AND PAYMENT OF THE LUMP SUM**

FORMALITIES TO BE COMPLETED

Responsibility for declaring the state of permanent and total disability rests with the Member who is required to provide proof of the condition to the insurer by means of the supporting documents required for settlement. These include:

- a detailed certificate from the treating doctor indicating the nature of the illness or Accident, to be sent to the insurer's medical advisor under confidential cover,
- any evidence establishing the need for third party assistance such as the notification of the award, where applicable, by Social Security of a disability allowance requiring third party assistance,
- any additional documents allowing the lump sum to be allocated:
    - any documents proving identity and/or family status, and in particular a full photocopy of the family record book and, where applicable, proof of the civil partnership,
    - the bank details required for payment,
- where applicable, any documents specifying the cause and circumstances of the Accident having caused the permanent total disability.

The insurer reserves the right to request any additional supporting documents they consider necessary for settlement of the claim.

RECOGNITION AND MONITORING BY THE INSURER OF THE STATE OF PERMANENT AND TOTAL DISABILITY

Until the date on which the benefit becomes payable, the insurer has the right to carry out any checks and submit the claimant to any medical examinations deemed useful in order to assess, recognize or monitor the state of permanent and total disability. For this purpose, the insurer's doctors, agents or representatives must be able to visit the Member, who agrees to meet with them and provide them with an honest account of his or her condition. **If the Member does not agree to the visits and/or medical examinations, the insurer is automatically authorized by law to suspend payment of the benefit.**

In the event of a disagreement between the Member's doctor and that of the insurer regarding the state of permanent and total disability, the Member and the insurer may together choose a third doctor in order to reach a majority decision and, if they cannot agree on the choice of doctor, the appointment will made by the Tribunal de Grande Instance of Paris. Arbitration fees are shared equally between the Member and the insurer. **Members agree to submit to the jurisdiction of the Paris courts and waive the right to any proceedings in any other country.**

PAYMENT OF THE LUMP SUM

The insured lump sum, payable to the Member him / herself, is paid six months after the date of recognition by the insurer of the permanent and total disability and subject to the continuation of this state.

In the event of the Member's death before the lump sum is paid, a lump sum will be paid to the designated Beneficiary or Beneficiaries as defined under Article 4 "Benefit in case of death of the member".

ARTICLE 6 – OPTIONAL BENEFIT IN CASE OF ACCIDENTAL DEATH OF THE MEMBER

This benefit, which is purchased in addition to the death benefit provided for under Article 4, is payable if it is specified on the certificate of enrollment.

• **DEFINITION AND AMOUNT OF THE BENEFIT**

The purpose of this benefit is to pay the Beneficiary or Beneficiaries specified under Article 4, if the Member dies following an Accident as defined under Article 2 and subject to the provisions of the paragraph "Exclusions from coverage" below, an additional lump sum the amount of which is equal to 100% of the death benefit provided for under Article 4.

This additional lump sum is not payable in the event of permanent total disability resulting from an accident. The benefit is payable on condition that the death occurs no later than twelve months after the Accident.

• **EXCLUSIONS FROM COVERAGE**

The benefit is not payable in the following cases:

- **illness, even if it is the result of an accident,**
- **accidents caused intentionally by the Member or resulting either from suicide or intentional self-inflicted injuries or the use of narcotics or psychotropic drugs without a medical prescription,**
- **accidents resulting from the Member being under the influence of alcohol as defined by a blood alcohol concentration equal to or above that set by the French highway code to characterize the offense of drunk driving,**
- **air navigation accidents unless the Member is aboard an aircraft with a valid certificate of airworthiness and flown by a pilot in possession of a non-expired permit and license. The pilot may be the Member him / herself.**
- **accidents caused by:**
  - **games, races, bets or sporting competitions,**
  - **motor racing,**
  - **decay of the atomic nucleus,**
- **accidents caused by the practice of:**
  1. **extreme sports: bungee jumping, caving, extreme canoeing or kayaking (in rapids greater than Class V, rivers greater than Class II, on seas and oceans more than two nautical miles from land), sailing (transoceanic and single-handed navigation more than 20 nautical miles from shelter), and base jumping;**
  2. **a sport for profit, where its remuneration is based on its practice in competitions, in any form and at any level whatsoever;**
  3. **mountain sports: mountaineering, climbing (excluding artificial holds with a safety rope), rock climbing, solo hiking above 3,000 meters, ski jumping, bobsleigh, skeleton, skiing (alpine, cross-country and snowboarding) off marked trails which are open to the public, and canyoning;**
  4. **air sports whether or not they require the use of a motorized device (shows, conventions, adventure racing, aerobatics or flying competitions, records or record attempts, and preparatory and acceptance trials): parachute jumps not carried out for safety reasons, hang-gliding, paragliding, and microlighting: aerobatics, gliding and parachuting (unless the jump was carried out for safety reasons), microlighting, hang-gliding, paragliding and skysurfing;**
  5. **water sports: scuba diving to a depth of more than 20m, competitive surfing, and hydrospeeding.**

- **accidents caused by civil or foreign war, insurrection, riots or brawls regardless of where the events take place and who the protagonists are unless the Member does not take an active part or is called upon to carry out a servicing or surveillance assignment for the purpose of ensuring the security of persons and goods,**
- **accidents caused by a war involving France.**

• **PAYMENT OF THE BENEFIT**

FORMALITIES TO BE COMPLETED IN THE EVENT OF A CLAIM

The formalities are the same as those defined under Article 4 for benefits payable in the event of the Member's death. In addition to the supporting documents listed for payment of the benefit, proof of the accident and the direct relationship of cause and effect between it and the death must be provided to the insurer by means of any suitable document.

ALLOCATION OF THE LUMP SUM

The lump sum is paid under the conditions defined under Article 4 for benefits payable in the event of the Member's death.

ARTICLE 7 – OPTIONAL BENEFIT IN CASE OF INFIRMITY OF THE MEMBER

This benefit, which is purchased in addition to the death benefit provided for under Article 4, is payable if it is specified on the certificate of enrollment.

• DEFINITION AND AMOUNT OF THE BENEFIT

The purpose of the benefit is to provide, subject to the provisions of the paragraph "Excluded risks" below, a lump sum to the Member in the event of illness or accident causing bodily injury and occurring in the exercise of their profession or in the course of their private life, resulting in the Member's physical infirmity.

The Member is free to choose the amount of the lump sum, up to the level of the death lump sum selected by them.

The amount of the insured lump sum to be selected can be between:
- in euros: €25,000 and €1,000,000, in multiples of €25,000,
- in American dollars: $30,000 and $1,200,000, in multiples of $30,000.

The amount selected by the Member is shown on the certificate of enrollment.

The amount of the lump sum due for cases of total infirmity (equal to 100%), as determined by the insurer's doctor, is set at 100% of the selected lump sum. If the infirmity is partial, the amount of the lump sum paid is proportional to the degree of infirmity.

No lump sum is due for cases of infirmity of less than 33%.

The age and profession of the member are never taken into account.

The degree of infirmity is determined by the insurer's doctor on the date on which the member's condition is deemed to be medically stationary following an accident or on which the illness is deemed to have stabilized based on the attached scale.

Determining the degree of infirmity

The degree of infirmity used in the application of the insurance contract is determined by medical expertise (joint opinion of the Member's treating doctor and the insurer's medical examiner and, if necessary, by a third doctor acting as arbitrator as described below), depending on the degree of functional incapacity of the Member.

Functional, physical or mental incapacity is assessed independently of any consideration of resources or profession, with reference to the scale of incapacity in common law published in the French medical journal, Concours Médical (see page 27).

IMPORTANT

The degree of functional incapacity used for the calculation of this benefit may not be increased by illnesses or medical conditions which existed prior to the date of signature of the application for coverage under the plan and which were subject to a specific exclusion of which the Member was notified by the insurer by registered mail.

• EXCLUDED RISKS

The benefit is not payable in the following cases:

- **accidents or illnesses caused intentionally by the Member or resulting from either a suicide attempt or intentional self- inflicted injuries or the use of narcotics or psychotropic drugs without a medical prescription,**
- **accidents or illnesses caused by civil or foreign war, insurrection, riots or brawls regardless of where the events take place and who the protagonists are unless the Member does not take an active part or is called upon to carry out a servicing or surveillance assignment for the purpose of ensuring the security of persons and goods,**
- **accidents or illnesses caused by a war involving France,**
- **the Member driving a vehicle without a valid license or under the required age,**
- **accidents or illnesses resulting from the Member being under the influence of alcohol as defined by a blood alcohol concentration equal to or above that set by the French highway code to characterize the offense of drunk driving,**
- **working underground or under water, handling explosives, and the effects of atomic radiation,**
- **hernias and lumbago,**
- **accidents caused by the practice of the sports listed under points 1, 2, 3, 4 and 5 of article 6.**

FORMALITIES TO BE COMPLETED IN THE EVENT OF A CLAIM AND PAYMENT OF BENEFITS

The Member must declare the illness or accident to the insurer as soon as possible with the declaration including details of the gravity, causes and circumstances of the illness or accident.

The Member must also:
- send the insurer's medical advisor a certificate under confidential cover from the doctor who was called to provide first aid describing the precise nature of their current condition, injuries and their consequences,
- where applicable, send any documents required to establish the fact and extent of the accident,
- agree to be examined by the insurer's doctor.

The insurer reserves the right to request any additional documents they deem necessary.

Any fraud, concealment or false declaration on the part of the Member with the purpose of misleading the insurer with respect to the circumstances or consequences of the illness or accident will lead to loss of entitlement to the benefit.

RECOGNITION BY THE INSURER OF THE STATE OF INFIRMITY

The insurer has the express right to assess, recognize or monitor the state of infirmity of the Member. For this purpose, the insurer's doctors, agents or representatives must be able to visit the Member, who agrees to meet with them and provide them with an honest account of his or her condition. They may also invite the Member to attend an appointment.

If the Member does not agree to the visits and / or medical examinations, the insurer is automatically authorized by law to suspend payment of the benefit.

In the event of a disagreement between the Member's doctor and that of the insurer regarding the state of infirmity, the Member and the insurer may together choose a third doctor in order to reach a majority decision and, if they cannot agree on the choice of doctor, the appointment will made by the Tribunal de Grande Instance of Paris. Arbitration fees are shared equally between the Member and the insurer. **Members agree to submit to the jurisdiction of the Paris courts and waive the right to any proceedings in any other country.**

PAYMENT OF THE LUMP SUM

Payment of the lump sum is made within a maximum period of one month following the agreement between the Member's doctor and that of the insurer on the causes and consequences of the illness or accident and the degree of infirmity.

ARTICLE 8 – OPTIONAL BENEFIT IN CASE OF SICK LEAVE FROM WORK BY THE MEMBER

This benefit which is purchased in addition to the death benefit provided for under Article 4, is payable if it is specified on the certificate of enrollment.

- **DEFINITION AND PURPOSE OF THE BENEFIT**

DEFINITION OF THE BENEFIT

Temporary total incapacity to work is a state of temporary incapacity following an illness or accident affecting the Member in their professional activity or in their private life and which makes it totally physically or mentally impossible for them to perform any professional activity whatsoever. This state must be medically diagnosed and recognized by the insurer.

Permanent total or partial disability is a disability following an illness or accident making it totally or partially physically or mentally impossible for the Member to carry out their normal professional activities or any professional activities providing the same level of income as before the period of sick leave following an illness or accident. This state must be medically diagnosed and recognized by the insurer.

PURPOSE OF THE BENEFIT

The purpose of this benefit is to provide an allowance in the event of a period of sick leave by the Member (a daily allowance in case of temporary total incapacity to work or an annual pension in case of permanent total or partial

disability) following an illness or accident.

Three options hereafter referred to as "Standard Sick Leave Benefit", "Short-Term Disability Benefit" and "Long-Term Disability Benefit", are available to the Member in respect of this benefit. The "Short-Term Disability" and "Long-Term Disability" options may be purchased together (see definitions below).

The option or options selected by the Member are shown on the certificate of enrollment.

Sick leave benefits are paid to the Member, provided he or she is recognized by the insurer as suffering from temporary total incapacity to work or permanent total or partial disability as defined in the paragraph "Definition of the benefit" above and subject to the provisions set out in the paragraph "Exclusions from coverage" below.

The state of temporary total incapacity to work or permanent total or partial disability is determined by the insurer's medical advisor independently of the decisions made by any Social Security scheme to which the Member may belong.

CONDITIONS GOVERNING THE AWARD OF BENEFITS

Benefits are awarded with reference to current French Social Security regulations. If, at a later date, these regulations were to be amended, resulting in a change to the obligations of the Member and the insurer, the insurer would adjust the premium payable in respect of sick leave benefits. If the Member does not respond to the proposal made by the insurer, or if they expressly reject the new premium, the insurer may terminate the membership at the end of a period of 30 days. However, the insurer reserves the right, with respect to the payment of benefits, to refer to the legislation in force at the time of enrollment in the plan.

· AMOUNT OF BENEFITS

Depending on the option selected by the Member, the insurer will pay the following benefits to a Member recognized to be in a state of temporary total incapacity to work or permanent disability:

OPTION 1: STANDARD SICK LEAVE BENEFIT (DAILY ALLOWANCE AND PENSION)

AMOUNT OF THE BENEFIT:

The Member is free to choose the amount of the daily allowance, up to a maximum of one thousandth of the selected death lump sum.

The amount of the daily allowance to be selected can be between:
- in euros: €25 and €400 per day, in multiples of €25,
- in American dollars: $30 and $480 per day, in multiples of $30,
up to a maximum of one thousandth of the selected death lump sum.

However, if the amount of the selected death lump sum is less than or equal to €250,000 or $300,000, the amount of the daily allowance selected by the Member may exceed one thousandth of the selected death lump sum and may be increased by €25 or $30 per day.

The monthly amount of the permanent total disability pension (where the degree of disability is greater than or equal to 66%) is equal to the daily allowance selected multiplied by 30 to form a monthly base.
The amount of the daily allowance selected by the Member is shown on the certificate of enrollment.

Furthermore, it should be noted that the daily allowance paid cannot, under any circumstances, exceed 70% of the average daily professional income earned by the Member during the 12 calendar months preceding the period of sick leave under consideration.

MAXIMUM AMOUNT OF BENEFITS

The maximum total amount of benefits (daily allowances + pension) paid by the insurer, per member, under the "Standard sick leave" benefit, throughout the entire duration of membership of the plan, is in all cases capped at €3,000,000 / $3,600,000.

TEMPORARY TOTAL INCAPACITY TO WORK:

When the insurer recognizes the Member to be in a state of temporary total incapacity to work, the Member is paid a daily allowance from the expiration of a period of total and continuous sick leave from work (known as the "waiting period") of 30 days, 60 days or 90 days as chosen by the Member and shown on the certificate of enrollment.

The amount of temporary total incapacity benefit paid by the insurer is set at 100% of the selected daily allowance, limited in all cases to 70% of the average daily professional income earned by the Member during the 12 calendar months preceding the period of sick leave under consideration.

1/ Terms of payment of the benefit: The daily allowance, which is acquired on a daily basis for as long as the Member is in a state of temporary total incapacity to work, is payable to the Member monthly in arrears until the date on which the Member is deemed to be medically stationary following an accident or on which the illness is deemed to have stabilized and **for a maximum period of no more than 24 months (consecutive or not) for the entire duration of membership of the plan.**

2/ Cessation of payment of the daily allowance: Payment of the daily allowance ends in all cases:

- when the Member returns to work or is found to be medically fit to return to work, even on a part-time basis,

- from the day on which the Member is recognized to be in a state of permanent disability with the provisions of the paragraph "Permanent disability" below being applicable on that date,

- on the date on which the Member receives their retirement pension from Social Security, including for reasons of unfitness for work, **and no later than the day on which the Member reaches the age of 65,**

- and no later than the end of the maximum payment period of 24 months mentioned above. On this date:

In the event of stabilization of the state of health, the provisions of the Permanent Disability benefit as set out below are applicable.

If the state of health is not stabilized, the insurer's medical advisor will review each member's case on an individual basis.

PERMANENT DISABILITY

Determining the degree of disability "n": The degree of disability "n" is determined by medical expertise (joint opinion of the Member's treating doctor and the insurer's medical examiner and, if necessary, by a third doctor acting as arbitrator as described below), and with reference to the scales of functional and occupational incapacity shown below. The degree of disability is determined by the insurer's medical advisor independently of the decisions made by the Member's Social Security scheme on the date on which the Member is deemed to be medically stationary following an accident or on which the illness is deemed to have stabilized.

Functional, physical or mental incapacity is assessed independently of any professional considerations, with reference to the scale of incapacity in common law published in the French medical journal, Concours Médical. Occupational incapacity is assessed on the basis of the degree and nature of the incapacity in relation to the insured's occupation, with consideration given to the manner in which the occupation was performed prior to the illness or accident, the normal conditions for performing the occupation and their remaining capacity to perform the occupation.

IMPORTANT

The degree of functional and occupational disability used for the calculation of this benefit may not be increased by illnesses or medical conditions which existed prior to the date of signature of the application for coverage under the plan and which were subject to a specific exclusion of which the Member was notified by the insurer by registered mail.

The following table shows the rating obtained for various degrees of functional and occupational incapacity. To qualify for a permanent disability pension, the degree "n" must be at least 40%.

DOI*	DEGREE OF FUNCTIONAL INCAPACITY								
	20	30	40	50	60	70	80	90	100
10	–	–	–	–	–	–	40.00	43.27	46.42
20	–	–	–	–	41.60	46.10	50.40	54.51	58.48
30	–	–	–	42.17	47.62	52.78	57.69	62.40	66.94
40	–	–	40.00	46.42	52.42	58.09	63.50	68.68	73.68
50	–	–	43.09	50.00	56.46	62.57	68.40	73.99	79.37
60	–	–	45.79	53.13	60.00	66.49	72.69	78.62	84.34

70	–	–	48.20	55.93	63.16	70.00	76.52	82.79	88.79
80	–	41.60	50.40	58.48	66.04	73.19	80.00	86.54	92.83
90	–	43.27	52.42	60.82	68.68	76.12	83.20	90.00	96.55
100	–	44.81	54.29	63.00	71.14	78.84	86.18	93.22	100.00

** DOI = Degree of Occupational Incapacity*

In the event of a disagreement between the Member's doctor and that of the insurer regarding the degree of permanent disability, the Member and the insurer may together choose a third doctor in order to reach a majority decision and, if they cannot agree on the choice of doctor, the appointment will made by the Tribunal de Grande Instance of Paris. Arbitration fees are shared equally between the Member and the insurer. Members agree to submit to the jurisdiction of the Paris courts and waive the right to any proceedings in any other country.

In any event, payment of the benefit may be terminated if there is an improvement in the state of health.

1 Amount of the permanent disability pension: If the degree of disability "n" determined by the insurer is greater than or equal to 66%, the disability is deemed to be total. A pension is then paid, the monthly amount of which is equal to 30 times the amount of the selected daily allowance. This amount is limited in all cases to 70% of the average daily professional income earned by the Member during the 12 calendar months preceding the period of sick leave under consideration.

If the degree of disability "n" determined by the insurer is between 40% and 66%, the disability is deemed to be partial. A reduced pension is then paid, the amount of which is based on the pension paid by the insurer in the event of total disability with the application of a coefficient of n / 66.

No benefits are due if the degree of disability "n" determined by the insurer does not reach 40%.

SPECIAL PROVISION

If the disability results from mental health, nervous or psychological disorders of any kind, the maximum duration of the payment of benefits by the Insurer is set, for the entire duration of membership of the plan, at 24 months.

2 Terms of payment of the benefit: The pension is paid from the date on which the disability is recognized by the insurer but no earlier than at the end of the maximum benefit period of 24 months in respect of the temporary total disability benefit specified above.

The amount of the pension may be reviewed if there is a change in the disability status.

The pension is payable to the Member quarterly in arrears, for the entire duration of the disability with the exception of mental health, nervous or psychological disorders of any kind.

3 Cessation of payment of the pension: Payment of the pension ceases in all cases:
- when the Member returns to work or is found to be medically fit to return to work,
- when the maximum amount of benefit shown above (€3,000,000/$3,600,000) is reached, and, at the latest, on the date on which the Member receives their retirement pension from Social Security, including for reasons of unfitness for work and, at the latest, on the day on which the Member reaches the age of 65.

OPTION 2: SHORT-TERM DISABILITY BENEFIT

If the insurer recognizes the Member to be in a state of temporary total incapacity to work, the Member will be paid a daily allowance from:

- the 7th day of total and continuous absence from work due to illness,
- the 1st day of absence from work due to hospitalization,
- the 1st day of absence from work due to an accident.

The amount of the daily allowance is set at 70% of the average daily professional income earned by the Member during the 12 calendar months preceding the period of sick leave under consideration.

1 Terms of payment of the benefit: The daily allowance, which is acquired on a daily basis for as long as the Member is in a state of temporary total incapacity to work, is payable to the Member monthly in arrears until the date on which the Member is deemed to be medically stationary following an accident or on which the illness is

deemed to have stabilized and, at the latest, for a maximum duration which the Member is free to choose and which is shown on the certificate of enrollment of 30, 60 or 180 days of sick leave, **whether continuous or not**, per 3-year period, calculated from the 1st day of the first period of sick leave for which benefits were paid.

2 Cessation of payment of the daily allowance: Payment of the daily allowance ends in all cases:
- when the Member returns to work or is found to be medically fit to return to work, even on a part-time basis,
- from the day on which the Member is recognized to be in a state of permanent disability,
- on the date on which the Member receives their retirement pension from Social Security, including for reasons of unfitness for work, and at the latest on the day on which the Member reaches the age of 70,
-and, at the latest, at the end of the maximum period during which benefits can be paid of 30, 60 or 180 days, whether continuous or not, per 3-year period, calculated from the 1st day of the first period of sick leave for which benefits were paid (unless the Member has also taken out option 3 below).

OPTION 3: LONG-TERM DISABILITY BENEFIT

If the insurer recognizes the Member to be in a state of temporary total incapacity to work, the Member is paid a daily allowance from the expiration of a period of total and continuous sick leave from work (known as the "waiting period") of 30 days, 60 days or 180 days as chosen by the Member and shown on the certificate of enrollment.

The amount of the daily allowance is set at 70% of the average daily professional income earned by the Member during the 12 calendar months preceding the period of sick leave under consideration. This allowance cannot exceed €400/$480.

1 Terms of payment of the benefit: The daily allowance, which is acquired on a daily basis for as long as the Member is in a state of temporary total incapacity to work, is payable to the Member monthly in arrears until the date on which the Member is deemed to be medically stationary following an accident or on which the illness is deemed to have stabilized and, for no more than 1,095 days of sick leave, **whether continuous or not**, per 5-year period calculated from the 1st day of the first period of sick leave for which benefits were paid.

2 Cessation of payment of the daily allowance: Payment of the daily allowance ends in all cases:

- when the Member returns to work or is found to be medically fit to return to work, even on a part-time basis,
- from the day on which the Member is recognized to be in a state of permanent disability,
- on the date on which the Member receives their retirement pension from Social Security, including for reasons of unfitness, for work and, at the latest, on the day on which the Member reaches the age of 70,
- and, at the latest, at the end of the period of 1,095 days of benefit payments, whether continuous or not, per 5-year period, calculated from the 1st day of the first period of sick leave for which benefits were paid.

• PROVISIONS COMMON TO ALL SICK LEAVE BENEFITS

RETURN TO WORK ON A PART-TIME BASIS FOLLOWING A PERIOD OF TEMPORARY TOTAL INCAPACITY TO WORK

If, after a period of temporary total incapacity to work, the Member returns to work or is found to be medically fit to return to work on a full-time or part-time basis, the daily allowance ceases to be paid by the insurer.

PROVISION SPECIFIC TO MATERNITY OR PATERNITY LEAVE

A Member who is in a state of incapacity to work does not receive the daily allowance during periods of statutory maternity or paternity leave.

RETURN TO WORK FOR LESS THAN 90 DAYS

If a Member who has been receiving the benefits specified above returns to work but, due to a relapse, requires another period of sick leave less than 90 days after resuming work, the benefits are restarted without the application of a waiting period, provided the membership of the plan is still in force on the date of the new period of sick leave.

CUMULATIVE BENEFITS

The total amount of benefits paid by any Social Security scheme to which the Member may belong (excluding the supplement for third party assistance) and those paid by the insurer may not exceed 70% of the professional income that the Member would have earned had they continued to work.

EXCLUSIONS FROM COVERAGE

Benefits are not payable in the following cases:
- **accidents or illnesses caused intentionally by the Member or resulting from either a suicide attempt or intentional self- inflicted injuries or the use of narcotics or psychotropic drugs without a medical prescription,**

- **accidents or illnesses caused by civil or foreign war, insurrection, riots or brawls regardless of where the events take place and who the protagonists are unless the Member does not take an active part or is called upon to carry out a servicing or surveillance assignment for the purpose of ensuring the security of persons and goods,**
- **accidents or illnesses caused by a war involving France,**
- **accidents resulting from the Member being under the influence of alcohol as defined by a blood alcohol concentration equal to or above that set by the French highway code to characterize the offense of drunk driving,**
- **air navigation accidents unless the Member is aboard an aircraft with a valid certificate of airworthiness and flown by a pilot in possession of a non-expired permit and license. The pilot may be the Member him / herself,**
- **accidents caused by:**
    - **games, races, bets and sporting competitions (unless the Member is participating as an amateur),**
    - **motor racing,**
    - **decay of the atomic nucleus,**
- **accidents caused by the practice of the sports listed under points 1, 2, 3, 4 and 5 of article 6.**

In addition, sick leave benefits are not paid during the period of statutory maternity or paternity leave.

FORMALITIES TO BE COMPLETED IN THE EVENT OF A CLAIM

All periods of sick leave must be reported. It is the responsibility of the Member to send a declaration to the insurer within the following timescales:
- if the duration of the waiting period is less than 90 days: within three months of the start of the period of sick leave,
- if the duration of the waiting period is equal to or greater than 90 days: within 30 days of the expiration of the waiting period.

No payments will be made for the period prior to the declaration if the sick leave is not reported within these timescales.

This declaration must be accompanied by:

- a medical certificate to be sent under confidential cover to the insurer's medical advisor stating the start date of the period of sick leave and the nature of the illness or accident, the date of the first medical diagnosis and the expected duration of absence from work,
- proof of professional income over the last 12 months prior to the period of sick leave,
- any additional documents allowing the benefits to be allocated:
    - any documents proving identity,
    - the bank details required for payment.

- and, where applicable:
    - a confidential medical certificate using the form provided by the insurer duly completed by the treating doctor,
    - if the Member is covered by a Social Security scheme: proof of payment of cash benefits from this scheme.

The insurer reserves the right to request any additional supporting documents they consider necessary for the payment of benefits.

No benefits will be paid until the required supporting documents are sent to the insurer.
If the Member returns to work, the insurer must be informed as soon as possible.

RECOGNITION AND MONITORING BY THE INSURER OF THE STATE OF INCAPACITY OR DISABILITY

The insurer has the express right to assess, recognize and monitor the state of incapacity or disability of the Member. For this purpose, the insurer's doctors, agents or representatives must be able to visit the Member, who agrees to meet with them and provide them with an honest account of his or her condition. They may also invite the Member to attend an appointment.

If the Member does not agree to the visits and/or medical examinations, the insurer is automatically authorized by law to suspend payment of the benefits.

In the event of a disagreement between the Member's doctor and that of the insurer regarding the state of temporary total incapacity or the state of permanent total disability, the Member and the insurer may together choose a third doctor in order to reach a majority decision and, if they cannot agree on the choice of doctor, the appointment will made by the Tribunal de Grande Instance of Paris. Arbitration fees are shared equally between the Member and the insurer.

Members agree to submit to the jurisdiction of the Paris courts and waive the right to any proceedings in any other country.

PROVISIONS APPLICABLE IN THE EVENT OF TERMINATION OF THE PLAN OR MEMBERSHIP OF THE PLAN

Sick leave benefits (daily allowances paid under Options 1, 2 or 3 and disability pensions paid under option 1) continue to be paid, subject to the terms of the plan, at the level reached on the date on which the plan is terminated.

ARTICLE 9 – BENEFITS SCHEDULE

<table>
<tr><th></th><th colspan="3">TYPE AND AMOUNT OF BENEFITS</th></tr>
<tr><td colspan="4">BASIC COMPULSORY BENEFITS</td></tr>
<tr><td>Death or permanent total disability of the Member (regardless of cause)
– Articles 4 and 5

Lump sum selected by the Member:</td><td colspan="3">From €25,000 to €1,000,000 in multiples of €25,000,
or from $30,000 to $1,200,000 in multiples of $30,000</td></tr>
<tr><td colspan="4">OPTIONAL BENEFITS</td></tr>
<tr><td>Accidental death of the Member – Article 6</td><td colspan="3">Double the amount of the death lump sum (all causes)</td></tr>
<tr><td>Infirmity of the Member (regardless of cause) – Article 7

Lump sum chosen by the Member for total infirmity (equal to 100%), with reference to the scale of functional incapacity under common law published in the French medical journal, Concours médical:

If the infirmity is partial, the amount of the lump sum is proportional to the degree of infirmity (benefits are payable for infirmities equal to or greater than 33%)</td><td colspan="3">From €25,000 to €1,000,000 in multiples of €25,000,
or from $30,000 to $1,200,000 in multiples of $30,000
up to the level of the selected death lump sum (all causes)</td></tr>
<tr><td>Total sick leave from work by the Member – Article 8
3 benefits options are available to the Member:</td><td>STANDARD SICK LEAVE BENEFIT
(Daily allowance and disability pension)</td><td>SHORT-TERM DISABILITY BENEFIT</td><td>LONG-TERM DISABILITY BENEFIT</td></tr>
<tr><td></td><td></td><td colspan="2">These 2 benefits options may be purchased together.</td></tr>
<tr><td>Waiting period dependent on the options selected by the Member:</td><td>As selected by the Member:
30, 60 or 90 days</td><td>6 days
(except in case of hospitalization or accident: benefit paid from the 1st day of sick leave)</td><td>As selected by the member:
30, 60 or 180 days</td></tr>
<tr><td>Amount of the Daily allowance (or pension) dependent on the option selected by the Member:</td><td>As selected by the Member:
-from €25 to €400 per day in multiples of €25,
-from $30 to $480 in multiples of $30,
limited to one thousandth of the selected death lump sum
(with the option of increasing the amount of the allowance by €25 / $30 per day if the selected death lump sum is equal to or less than €250,000 / $300,000)
Maximum amount of benefit:
70% of the Member's professional income</td><td>70% of the Member's professional income up to a maximum of €400/$480</td><td>70% of the Member's professional income up to a maximum of €400/$480</td></tr>
<tr><td>Maximum duration of benefit, dependent on the option selected by the Member:</td><td>24 months of daily allowance followed by payment of a disability pension until the date on which the retirement pension is paid and at the latest age 65 or when the total amount of benefits paid (daily allowance + pension) reaches €3,000,000 /</td><td>As selected by the Member:
30, 60 or 180 days</td><td>Until the 1,095th day of the period of sick leave</td></tr>
</table>

	$3,600,000. And a maximum of 24 months' disability for mental health disorders		

2.3 / OPERATION OF THE PLAN

ARTICLE 10 – LEGAL FRAMEWORK

This group insurance plan with optional membership is governed by French law and the French Insurance Code, in particular by Articles L141-1 and following. The plan falls within the scope of branch 2 (Healthcare) and branch 20 (Life-Death) of Article R321-1 of the French Insurance Code.

The plan consists of this information booklet serving as the general terms and conditions and the certificate of enrollment. Coverage under the plan is based on the declarations made by the Member.

The group insurance plan is in French. MSH INTERNATIONAL may make an English version available to the Member. In case of disagreement on the interpretation of the benefits provided under this plan, only the French version of this plan will be taken into consideration. Translations of the contractual documents which make up the plan are made available to Members purely for information purposes and only the French language version is binding.

• **LIMITATION PERIOD**

In accordance with Article L114-1 of the French Insurance Code, all legal actions arising from an insurance contract are barred two years from the event that gave rise to them. However, this time limit runs:

1. in the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only from the date on which the insurer became aware of it,

2. in the event of a loss, only from the date on which the relevant parties became aware of it, if they can prove they were unaware of such facts until then.

If the action taken by the member against the insurer arises from a claim made by a third party, the limitation period shall run only from the day on which this third party brings a legal action against the member or has received compensation from him or her.

The limitation period is extended to ten years for life insurance policies where the beneficiary is a separate person from the member and for personal accident insurance policies where the beneficiaries are the heirs of the deceased member.

In respect of life insurance policies, notwithstanding the provisions of paragraph 2, the action taken by the beneficiary must be brought within thirty years of the member's death.

In accordance with Article L.114-2 of the French Insurance Code, the limitation period is interrupted by one of the following ordinary causes of interruption:

- when the debtor acknowledges the right of the person against whom they were prescribing (Article 2240 of the French Civil Code),
- a legal claim, even in summary proceedings, until the end of the hearing. This also applies when the legal claim is brought before a court which has no jurisdiction or where the act of referral to the court is cancelled by the effect of a procedural irregularity (Articles 2241 and 2242 of the French Civil Code). The interruption is void if the claimant withdraws his application or allows the suit to lapse, or if he is defeated in his claim (Article 2243 of the French Civil Code),
- an act of enforcement or interim measures taken in implementation of the code of civil enforcement procedures (Article 2244 of the French Civil Code).

A summons served on one of the joint and several debtors by means of legal action or an enforcement order or the recognition by the debtor of the right of the person against whom they were prescribing interrupts the limitation period against all the others, even against their heirs.

However, a summons served on one of the heirs of a joint and several debtor or the recognition by that heir does not interrupt the limitation period with regard to the other joint heirs, even in the case of a mortgage debt, if the obligation is divisible. Such a summons or recognition interrupts the limitation period with regard to the other co-debtors only for the share of the obligation for which that heir is liable.

To interrupt the limitation period entirely, with regard to the other co-debtors, the summons needs to be served on all the heirs of the deceased debtor or the right needs to be recognized by all of these heirs (article 2245 of the French Civil Code).

A summons served on the principal debtor or their recognition of the right interrupts the limitation period for taking action against the surety (article 2246 of the French Civil Code).

The limitation period can also be interrupted by:
- the appointment of an expert following a loss;
- a registered letter with proof of delivery (sent by the insurer to the member regarding action for payment of the premium and from the member to the insurer regarding payment of the claim).

In accordance with Article L.132-27-2 of the French Insurance Code, sums payable under life insurance policies in respect of benefits and lump sums that are not claimed are deposited with the "Caisse des Dépôts et Consignations" at the end of a period of ten years from the date on which the insurer becomes aware of the member's death. Sums deposited with the "Caisse des Dépôts et Consignations" that have not been claimed by their beneficiaries are acquired by the State after a period of twenty years from the date on which they are deposited.

• **CANCELATION**

In accordance with Article L132-5-1 of the French Insurance Code, the Member may reverse their decision to enroll in the plan by registered mail with proof of delivery within a period of 30 calendar days from the date on which their certificate of enrollment is sent out. This cancelation should be worded as follows:

'I, the undersigned ..... declare my express wish to cancel my membership of the life & disability plan no. 9054/863693/10000, no. 9054/863694/10000, no. 9054/863693/10010 or no. 9054/863694/10010 and request a refund of the premium paid under the terms and conditions set out under Article L132-5-1 of the French Insurance Code."

By canceling their membership, all amounts paid by the Member are refunded within a maximum period of 30 calendar days from the date of receipt of the registered letter by the insurer.

ARTICLE 11 – EFFECTIVE DATE – DURATION AND RENEWAL OF THE PLAN

The contract concluded between the association and the insurer took effect on July 1, 2015 for an initial period ending December 31, 2015.

It is automatically renewed on January 1 of each year for successive periods of one year unless terminated by either party by registered mail sent at least two months before each renewal date.

The plan may be amended, while it is in force, with effect from the 1st day of the calendar month, by mutual agreement between the insurer and the contracting association. If any amendments are agreed between the contracting association and the insurer, the insurer will issue an endorsement to the plan.

In this case, the Member will receive prior notification, under the conditions of Article 16, of the changes made to their rights and obligations under the plan.

ARTICLE 12 – ENROLLMENT OF MEMBERS OF THE CONTRACTING ASSOCIATION

• **ENROLLMENT**

Enrollment in the plan is open to any member of the contracting association who applies for membership of the plan, provided:
- they are aged 18 or over and under the age of 66,
- they are living abroad outside their country of nationality (the country in which they usually reside), in a private or professional capacity.

• **CONDITIONS OF ENROLLMENT**

To enroll in the plan, the above-mentioned member of the contracting association must complete and sign the enrollment form provided by the insurer and a health questionnaire.

Depending on the age of the applicant and the level of coverage being taken out, a medical visit with a doctor approved by the insurer and/or additional information or medical examinations may be required further to a review of this questionnaire.

If the medical information provided does not allow the applicant to be accepted under the standard conditions of the insurance plan, the insurer reserves the right to reject the application or grant coverage subject to the exclusion of certain risks or payment of an additional premium.

Any non-disclosure or intentional misrepresentation invalidates membership in accordance with Article L113-8 of the French Insurance Code.

If the applicant is accepted subject to special conditions, they will be notified of this by registered mail.

The person who is accepted for membership of the plan is hereafter referred to as the "Member". Membership is formalized by the issuing of a certificate of enrollment in the plan which includes:
- the reference number and effective date of membership,
- the currency used,
- the benefits and level of coverage selected,
- the premium rate.

ARTICLE 13 – EFFECTIVE DATE – DURATION – RENEWAL – AMENDMENTS TO AND TERMINATION OF MEMBERSHIP – EFFECTIVE DATE OF BENEFITS

. EFFECTIVE DATE

Membership takes effect on the date shown on the certificate of enrollment and at the earliest on the date of notification of acceptance by the insurer.

. DURATION AND RENEWAL OF MEMBERSHIP

Subject to the provisions of Article 20:

- membership runs for a period of 12 months,
- **membership is automatically renewed on its anniversary date** for successive periods of one year unless terminated by registered mail at least two months prior to each renewal date in accordance with the provisions of Article L113-12 of the French Insurance Code.

. AMENDMENTS TO AND TERMINATION OF MEMBERSHIP

In addition, during the period of membership, the member's rights and obligations may be amended by means of endorsements to the insurance contract concluded between the contracting association and the insurer. In this case, the member will be informed of the amendments at least three months before the date on which they are due to come into force.

Membership comes to an end in the event of termination expressed in accordance with the provisions set out above as well as those of Article 20.

• EFFECTIVE DATE OF BENEFITS

The benefits take effect for each Member, subject to the acceptance of the risk by the insurer, on the date of enrollment in the plan as set out above.

ARTICLE 14 – MAKING CHANGES TO THE BENEFITS

At each annual renewal of membership, the Member has the option of amending their benefits under the following conditions:

• DOWNGRADE OF SELECTED BENEFITS

If the Member requests a downgrade of their benefits, the new benefits take effect on the 1st day of the calendar quarter following the request.

• UPGRADE OF SELECTED BENEFITS

If the Member wishes to upgrade their benefits, they should complete a new enrollment form and submit to the medical formalities specified in Article 12 above. The Member must also make the request no later than two months before the annual renewal date of their membership of the plan.

The insurer reserves the right to deny the upgrade of benefits or to accept it subject to restrictions or the payment of an additional premium. However, the Member remains covered under the conditions which were in place prior to their request.

If accepted by the insurer, the new upgraded benefits will take effect from the annual renewal date of membership of the plan, subject to notification of acceptance from the insurer. The Member remains covered by the previous benefits until that date.

• PURCHASING NEW OPTIONAL BENEFITS

A Member wishing to purchase new optional benefits should complete a new enrollment form and submit to the medical formalities specified in Article 12 above.

The insurer reserves the right to deny the new benefits or to accept them subject to restrictions or the payment of an additional premium. If accepted by the insurer, the new benefits will take effect from the date of notification of acceptance by the insurer and, at the latest, on expiration of a waiting period of 6 months in respect of sick leave benefits.

ARTICLE 15 – CESSATION OF MEMBERSHIP AND BENEFITS

• CESSATION OF MEMBERSHIP

Membership of the plan and the benefits cease for each member:

- on the anniversary date of the year in which they request cessation of their membership of the plan, **provided the termination is notified to the insurer by registered mail at least two months before this date,**

- on the last day of the calendar quarter in which they cease to be members of the association, ASFE. ASFE must notify the insurer of this within a period of one month,

- on the last day of the calendar quarter during which the Member returns permanently to their country of origin. The Member must notify the insurer of this at least one month before their return date. This provision is not applicable if the Member returns for a temporary stay (of up to 60 days) for the purpose of vacations, travel, leisure or temporary visits in a professional or private capacity,

- on the last day of the calendar quarter in which their premiums are not paid subject to the provisions of Article 20 below,

- on the date on which they receive their Social Security old-age pension, including for reasons of unfitness for work, and at the latest on the last day of the calendar quarter during which they reach the age of 70,

- on the date of termination of membership by the insurer. This is only possible in the first two years of membership,

- on the date of termination of the plan. However, a person who has been a member of the plan for two years or more on the date of its termination may apply for continuation of benefits until they receive their Social Security old-age pension, subject to payment of the premium set by the insurer.

Membership also comes to an end in the cases provided for under Article 20 (refusal to accept a change in pricing introduced due to the results of the plan or a change in regulations) and, where applicable, Article 8 (refusal to accept a change in pricing introduced due to changes in Social Security regulations governing sick leave from work).

It should be noted that daily allowances and pensions already in payment continue to be payable on the date of termination of membership, including if the member returns to their country of origin.

• CESSATION OF BENEFITS

The benefits provided under the plan come to an end for each Member on the date of cessation of their membership, under the conditions of paragraph 1) above and, at the latest, on the last day of the calendar quarter during which they reach the age of 70.

In addition:

- sick leave benefits cease to be paid in all cases on the date on which the Member returns to work or is found to be medically fit to return to work, regardless of the type of work involved,
- in the event of termination of the plan, sick leave benefits continue to be paid under the terms of the plan, at the level reached on the date of termination of the plan.

. FORFEITURE OF COVERAGE

The insurer may deny coverage to the member if it is discovered that they have intentionally made a false claim for coverage under the plan, or have provided false information or used fraudulent or falsified documents when making a claim.

· MISREPRESENTATION

In accordance with the provisions of Article L. 113-8 of the French Insurance Code, membership of the insurance plan is null and void in the event of intentional concealment or misrepresentation.

In accordance with the provisions of Article L. 113-9 of the French Insurance Code, any unintentional omissions or inaccuracies in the reporting of the risk will result in:

- **an increase in the premium or termination of membership of the plan if the omission or inaccurate reporting is discovered before any claims have been made;**

- **a reduction in compensation in proportion to the premium rate which would actually have been due against the premium paid, and termination of membership of the plan if the omission or inaccurate reporting is**

discovered after a claim has been made.

· **SUBROGATED CLAIMS**

This refers to the insurer's right to recover the amounts of claims they have settled from the person who was responsible for a loss.

If the member is suffering from a disease or is the victim of an accident for which compensation may be paid by a liable third party, the insurer may make a subrogated claim against the person liable to pay the compensation, or their insurer. A member who has suffered injuries caused by a third party must inform the insurer at the time of the claim for benefits.

If the member is the victim of a road traffic accident (involving a motor vehicle), they must provide the insurer of the person having caused the accident, when requested, with the name of their insurer in their capacity as third party payer.

In accordance with the French Insurance Code, the recipient of the benefits is subrogated to the insurer with respect to their rights to seek remedy from any liable third parties.

ARTICLE 16 – INFORMATION TO MEMBERS

The general terms and conditions drawn up by the insurer serve as the information booklet and are issued to the Member together with the certificate of enrollment specified under Article 12.

It is the duty of the contracting association to inform Members in writing of any proposed amendments to their rights and obligations, in accordance with Article L141-4 of the French Insurance Code, at least three months before the date of their entry into force.

ARTICLE 17 – COMPLAINTS – MEDIATION – PROTECTION OF PERSONAL DATA – PAPERLESS COMMUNICATIONS IN RESPECT OF THE INSURANCE PLAN – ANTI-MONEY LAUNDERING AND THE FINANCING OF TERRORISM

COMPLAINTS – MEDIATION

To make a complaint (disagreement or dissatisfaction) regarding the plan, the Member can contact MSH INTERNATIONAL, their usual advisor or the customer relationship department at the following address:

Groupama Gan Vie - Service des relations avec les consommateurs
Immeuble West Park 2 – 2 Boulevard de Pesaro - 92024 Nanterre
src-collectives@ggvie.fr

If the complainant is not satisfied with the initial response, the complaint may be submitted to the insurer's complaints department at the following address:

Groupama Gan Vie - Service Réclamations
TSA 91414 - 35090 Rennes Cedex 9
https://reclamations.ggvie.fr

In both these cases, the complainant will receive an acknowledgement of their complaint within a maximum of 10 working days of receipt. A final response to their complaint will be sent to the complainant within 2 months at the most. If the processing time needs to be extended due to special circumstances, the complainant will be informed.

Lastly, subject to having exhausted all the avenues of remedy set out above, the complainant may refer the matter to the Insurance Ombudsman:
Médiation de l'Assurance - TSA 50110 - 75441 Paris Cedex 09 - France - www.mediation-assurance.org.

Details of complaint processing procedures are available to the Member from the usual advisor and in the "Legal notices" section of the website www.gan-eurocourtage.fr.

If the opinion of the Insurance Ombudsman is not deemed to be satisfactory, the matter may be taken before the courts.

PROTECTION OF PERSONAL DATA

Personal data are collected by the insurer at different stages of its commercial or insurance activities with respect to members or persons involved in or affected by the insurance plans.

These personal data are processed by the insurer, in its capacity as data controller, in accordance with the regulations in force relating to the processing of such data and the protection of privacy, in particular the provisions of the French Data

Protection and Freedom of Information Act No. 78-17 of January 6, 1978 (amended) and the General Data Protection Regulation (Regulation 2016/679 of April 27, 2016).

Personal data are stored for the duration required for the implementation of the insurance plan and then archived until the expiration of the applicable statutory limitation periods.

RIGHTS OF THE INDIVIDUAL

The above-mentioned persons, subject to providing proof of identity, have the right to:

- read the information held by the insurer and request additions or corrections (rights of access and rectification);
- request the erasure of their data or the restriction of their use (right to erasure or restriction of data);
- object to the use of their data, in particular with regard to direct marketing (right to object);
- retrieve data which they have personally provided to the insurer for the implementation of their insurance plan or for which they have given their consent (right to data portability);
- set guidelines for the storage, erasure and disclosure of their data after their death.

These rights may be exercised by mail, email or via the Internet. The relevant departments and websites are as follows:

Groupama Gan Vie
Délégué Relais à la Protection des Données
Immeuble West Park 2 – 2 boulevard de Pesaro – 92024 Nanterre – France
contact.dpo@ggvie.fr.

With regard to health data, these rights can be exercised by sending a letter to the insurer's Medical Advisor at:

Groupama Gan Vie: Monsieur le Médecin-conseil - Service Médical Collectives
Immeuble West Park 2 – 2 Boulevard de Pesaro – 92024 Nanterre – France.

Data subjects may also file a complaint with the French Data Protection Authority, Commission Nationale de l'Informatique et Libertés (CNIL) if they feel the insurer has failed to meet its obligations with respect to their data.

As part of its obligations, the insurer is required to regularly check that personal data are accurate, complete and up-to-date. To this end, the insurer may be required to contact the aforementioned persons to check or complete this information.

WHY DOES THE INSURER COLLECT PERSONAL DATA?

The processing of personal data is required for the execution, administration and implementation of the insurance plan and the benefits, the management of commercial and contractual relations, the management of the risk of fraud or the implementation of the legal, regulatory or administrative provisions in force, for the purposes listed below.

Execution, administration and implementation of the insurance plans and the commercial management of clients and prospects

The data collected by the insurer at various stages of the application for or management of insurance plans are required for the following purposes:

- the analysis of insurance needs in order to recommend plans to suit individual circumstances;
- the assessment, acceptance, control and monitoring of the risk;
- the administration of the plans (from the pre-contractual phase to termination of the plan), and the implementation of the benefits provided under the plan;
- client management;
- the exercise of remedies and the management of complaints and disputes;
- the production of statistics and actuarial studies;
- the introduction of preventive measures;
- compliance with legal or regulatory obligations;
- research and development activities during the life of the plan.

The recipients of this information are, within the limits of their respective remits, MSH INTERNATIONAL, the usual advisor or point of contact, the insurer's departments in charge of the commercial management or the execution, administration and implementation of the plans, and its delegated administrators, intermediaries, partners, agents, processors, or other entities of the Groupama Group in the exercise of their duties.

This information may also be passed on, where appropriate, to the insurance organizations of the data subjects or those providing supplementary benefits, to co-insurers, reinsurers, professional bodies and guarantee funds, as well as to all persons directly or indirectly involved in the plan and its implementation, and to all persons accredited as Authorized Third Parties (courts, arbitrators, mediators, relevant government ministries, guardianship and supervisory authorities and all public bodies authorized to receive it, as well as to supervisory services such as statutory auditors, internal auditors and internal control departments).

Health data may be processed if they are required for the execution, administration and implementation of insurance plans. This information is processed in compliance with medical confidentiality and with the data subject's consent. In the case of employee benefits, data subjects expressly agree to this data being collected and the required processing being carried out.

This information is intended exclusively for the insurer's medical advisors or the medical advisors of entities of the Groupama Group responsible for the administration of the benefits, its medical department or specially authorized internal or external persons (including its delegated administrators or medical specialists). This information may also be used by authorized persons in matters of fraud prevention.
When an insurance contract has been entered into, the data are stored for the duration of the plan, extended by the duration of the management of any ongoing claims or disputes, and until the expiration of the statutory limitation periods.

If no insurance contract has been entered into (prospect-related data):

- health data are stored for a maximum of five (5) years for evidentiary purposes;
- other data may be stored for a maximum of three (3) years.

Marketing

The insurer and the companies of the Groupama Group (Insurance, Banking and Services) have a legitimate interest in canvassing their clients or prospects, and carry out the required data processing for the purposes of:

- performing operations with regard to prospect management;
- acquiring data on clients or prospects in compliance with the rights of individuals;
- carrying out research and development activities in the context of client management and marketing activities.

The use of certain methods of carrying out marketing activities is subject to obtaining the agreement of the prospects. These are:

- using their email address or telephone number for electronic marketing purposes;
- using browsing data to recommend personalized offerings (see cookies notice on the website for further information);
- passing on data to partners.

Any person may opt out of advertising by mail, email or telephone at any time by contacting the insurer (see above Rights of the individual).

With respect to telephone or electronic marketing (by email or SMS/MMS), the above-mentioned persons may also opt out by changing their preferences in their personal online area or by using the unsubscribe link provided in the insurer's messages.

With respect to telephone marketing, they may also opt out by registering free of charge with the BLOCTEL opt-out directory (www.bloctel.gouv.fr), which prohibits professionals with whom they do not have a current contractual relationship from contacting them by telephone for marketing purposes.

Combating insurance fraud

The above-mentioned persons are also informed that the insurer operates a system for the purpose of combating insurance fraud, which may lead to their inclusion on a list of persons presenting a risk of fraud. This may result in longer processing times in respect of applications for insurance or claims, or even the reduction or denial of a right, benefit, plan or service provided by entities of the Groupama Group.

In this context, the personal data of the above-mentioned persons may be processed by all authorized persons working within the entities of the Groupama Group as part of its anti-fraud measures.

These data may also be passed on to authorized personnel of organizations directly affected by fraud (other insurance organizations or intermediaries; social or professional bodies; legal authorities, mediators, arbitrators, court officials, ministry officials; third party organizations authorized by a legal provision and, where applicable, victims of acts of fraud or their representatives).

Data for this purpose may be passed on to the French Insurance Fraud Prevention Agency (Agence pour la Lutte contre la Fraude à l'Assurance or ALFA).

These persons are also informed that ALFA operates a system whereby data from insurance plans and claims made to insurers are shared for the purpose of combating fraud. Rights in respect of these data may be exercised at any time by writing to ALFA, 1, rue Jules Lefebvre - 75431 Paris Cedex 09 France.

Data processed for the purpose of combating fraud are stored for a maximum of five (5) years from the closure of the fraud file. In the event of legal proceedings, the data will be stored until the end of the proceedings and the expiration of the applicable limitation periods.

Individuals added to a list of suspected fraudsters will be de-registered after five (5) years from the date of registration on this list.

ANTI-MONEY LAUNDERING AND THE FINANCING OF TERRORISM

In order to meet its legal obligations and enable the application of financial sanctions, the insurer implements monitoring systems designed to combat money laundering and the financing of terrorism.

Data used for this purpose are stored for 5 years from the closure of the account or the end of the relationship with the insurer. Data relating to transactions carried out by individuals are kept for 5 years from their execution, including if the account is closed or if the relationship with the insurer comes to an end.

This information is intended for the insurer's departments responsible for dealing with measures to combat money laundering and the financing of terrorism.

TRACFIN may also receive information for this purpose. In accordance with the French Monetary and Financial code, the right of access to these data is exercised by applying to the French Data Protection Authority, Commission Nationale de l'Informatique et Libertés (www.cnil.fr).
As an insurance company, Groupama Gan Vie is subject to the legal and regulatory provisions relating to measures to combat money laundering and the financing of terrorism under the provisions of Articles L. 561-1 and following of the French Monetary and Financial Code. Groupama Gan Vie is therefore under obligations to identify and know its clients and exercise constant vigilance which justify the collection of information from its Clients.

Satisfaction/Quality of services

In its own interest and that of its clients, the insurer measures and seeks to continuously improve the quality of its services and products. This may include the carrying out of satisfaction surveys.

In this context, communications by mail, email or telephone between the insurer and the above-mentioned persons may be recorded and analyzed.

Telephone recordings are kept for a maximum period of six (6) months and the other elements required for the purpose of improving quality of service are kept for a maximum period of three (3) years.

Research and statistics

The insurer and the entities of the Groupama Group (or their subcontractors) may also use and process personal data involving the above-mentioned persons for statistical or research purposes, particularly with a view to developing their product and service offerings and personalizing their relationship with the data subject.

These data may be linked, combined or include personal data in respect of the above-mentioned persons and collected automatically or provided by the person themselves.

They may also be combined with statistical or aggregated data from various internal or external sources.

TRANSFER OF INFORMATION OUTSIDE THE EUROPEAN UNION

Personal data are processed within the European Union. However, data may be transferred to countries outside the European Union in compliance with data protection rules and subject to the appropriate safeguards (e.g. standard European Commission contractual clauses, countries with a level of data protection recognized as adequate, etc.).

These transfers may be carried out for the implementation of insurance contracts, anti-fraud measures, compliance with legal or regulatory obligations, the management of actions or disputes enabling the insurer to ensure the establishment, exercise or defense of its rights in law or for the needs of the defense of the data subjects. Certain types of data, which are strictly necessary for the provision of assistance services, may also be transferred outside the European Union in the interest of the data subject or the protection of human life.

PAPERLESS COMMUNICATIONS IN RESPECT OF THE INSURANCE PLAN

Paperless communications with the member

With regard to information and documentation relating to their insurance plan, the member should be aware that the insurer may exchange information and documents in a paperless manner and in particular provide or make this information and documentation available to them using a durable medium other than paper, including email.

By providing their email address at the time of enrollment or during the life of the plan, the member accepts that paperless communications are appropriate to their circumstances.

The member may at any time opt out of paperless communications and ask the insurer, by any means, to use paper-based communications, at no cost to them.

To do this, the member may send a letter or email to the insurer or call them.

Contact details for the relevant departments and the websites are provided above.

The member agrees to inform the insurer without delay if there are any changes to their email address and, more generally, if there are any changes in their situation that may have any impact on the administration of their plan.

Agreement on evidence

This agreement on evidence applies to the provision by the insurer of information or documents sent to the member by email;

The member and the insurer jointly accept and acknowledge that, in general, the data held in the insurer's information system are binding on the member and will have evidentiary value in terms of the application of the provisions of their insurance contract.

ARTICLE 18 - MISREPRESENTATION

Irrespective of the ordinary causes of nullity and subject to the provisions of Article L132-26 of the French Insurance Code, the insurance plan is null and void in the event of concealment or intentional misrepresentation on the part of the Member, when such concealment or misrepresentation changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the Member concealed or distorted has no impact on the claim. The insurer is then entitled to retain the premiums paid and to payment of all due premiums by way of damages.

2.4 / ARBITRATION AND PREMIUMS

ARTICLE 19 – ARBITRATION

All disputes regarding this plan will be resolved by arbitration. Each party appoints an arbitrator and the two arbitrators together appoint a third. If one of the parties fails to appoint their arbitrator within one month of notification by either party of the implementation of the arbitration clause, or if both arbitrators fail to agree on the appointment within the same timescale, the appointment will be made by the president of the Tribunal de Grande Instance, in summary proceedings, as instructed by the first party to act.

Arbitrators are not required to follow usual procedure and their decision will be final: the arbitration ruling is final and binding and must be delivered within a period of six months from the setting up of the arbitration tribunal. The parties also submit to the decision of the arbitrators with respect to arbitration costs.

This exclusion cannot impede, where applicable, the payment of benefits acquired in return for premiums or contributions previously paid by the insured.

ARTICLE 20 – PREMIUMS

- **SETTING AND PAYING THE PREMIUM**

Benefits provided under the plan are subject to the payment of a premium expressed in euros or dollars, set according to the Member's age, the benefits selected and their amount.

The amount of the premium is shown on the certificate of enrollment.

Premiums are adjusted by the insurer on January 1 of each year, based on the claims experience recorded over the previous year.

Any taxes or charges which may become applicable to the plan, the recovery of which is not prohibited, are charged to the Member and payable at the same time as the premium.

- **PAYMENT**

PAYMENT OF THE PREMIUM BY THE MEMBER

Premiums are payable to the contracting association monthly, quarterly, bi-annually or annually in advance, in euros and dollars. The payment frequency is shown on the certificate of enrollment.

If membership is terminated, the membership and benefits are maintained until the end of the period covered by the last premium to be paid.

NON-PAYMENT OF PREMIUM

In accordance with the provisions of Article L113-3 of the French Insurance Code, any premium due remains payable and may be recovered by any legal means.

In accordance with the provisions of Article L141-3 of the French Insurance Code, the contracting association must, at the earliest, ten days after the due date of the unpaid premium, send the Member a registered letter of formal notice. By mutual agreement between the insurer and the contracting association, it is agreed that the contracting association authorizes the insurer to prepare and send out this letter.

The letter will state that, at the end of a period of 40 days of dispatch of this letter, the Member is barred from the insurance plan due to non-payment of the premium. The Member remains liable for the full premium until the date of their removal from the plan.

ARTICLE 21 - WAIVER OF PREMIUM PAYMENTS – CONTINUATION OF COVERAGE IN THE EVENT OF SICK LEAVE

If the member is on total sick leave from work following an illness or accident occurring before the date of their 70th birthday, the Member will continue to benefit from the coverage purchased as per the plan's terms and conditions, without having to pay the corresponding premium, as of the date of payment of the benefits provided under the Sick leave coverage and for the entire duration of the payment.

These provisions only apply in the event of sick leave resulting from an illness or accident occurring after the effective date of enrollment of the Member in question.

- **DETERMINING THE BENEFIT**

Your sick leave is deemed to be total and continuous if we have recognized you as being in a state of temporary total incapacity to work or permanent total disability as defined in Article 8 above.

- **DECLARING AND PROVIDING PROOF OF SICK LEAVE**

You are responsible for providing proof of sick leave from work and you must declare the sick leave under the conditions set out under article 8 above. Periods of sick leave declared after the set deadline will result in the premium being payable for the period prior to the declaration. This declaration must be supported by the documentation specified in article 8 above. The insurer reserves the right to request any additional supporting documents required for application of the coverage. If the Member has purchased the "standard" sick leave benefit, no documents other than those provided for this coverage are needed. If the Member returns to work or if their total sick leave from work ends, they must inform the insurer without delay.

- **RECOGNITION AND MONITORING OF THE STATE OF INCAPACITY OR DISABILITY**

The insurer reserves the express right to assess, recognize and monitor the Member's state of incapacity or disability. To this end, the provisions of article 8 above apply to this coverage.

- **EXCLUDED RISKS**

The risks excluded under the "Waiver of premium payments – Continuation of coverage in the event of sick leave" benefit are the same as those listed in article 8 above.

- **DURATION AND CESSATION OF CONTINUATION OF COVERAGE**

Continuation of coverage is granted for the duration of the period of sick leave qualifying for the premium waiver. It will end as soon as the Member returns to work or if a medical authority certifies that they can resume a professional activity, regardless of the nature of this activity. Furthermore, continuation of coverage will cease at the latest on the date on which the Member starts receiving a basic old-age pension (including due to unfitness for work) and, in all cases, on the day they reach the age of 70. It will also end in the event of termination of the plan.

Appendix: Disability scale for physical infirmity benefit

I - PERMANENT TOTAL DISABILITY

Total and incurable insanity resulting directly and wholly from an accident	100%
Total loss of sight in both eyes	100%
Complete paralysis resulting directly and wholly from an accident	100%
Total loss of use of two limbs	100%

II - PERMANENT PARTIAL DISABILITY

Head and spine

Total loss of sight in one eye	25%
Total and incurable deafness resulting directly and wholly from an accident	40%
Total and incurable deafness in one ear	10%
Fracture of the odontoid process of the axis with displacement: maximum based on level of stiffness	30%
Pronounced fracture or dislocation of the spinal column with significant spinal stiffness, evidence of radiculomedullary irritation and pronounced clinical deviation of traumatic origin	25%
Loss of teeth with no possibility of dentures:	
. Incisors - canines	per tooth: 0.60%
. Premolars	per tooth: 0.80%
. Molars	per tooth: 1.00%
Head injury with loss of consciousness and post-concussive phenomena with no objective neurological signs: maximum	5%

Upper limbs

	Right	Left
Amputation or total paralysis of an upper limb	60%	50%
Amputation of the forearm at the elbow joint	55%	45%
Total loss of hand or use of hand	50%	40%
Unhealed fracture of the humerus (hanging arm)	25%	20%
Unhealed fracture of the forearm (loose pseudoarthrosis in both bones)	25%	20%
Total loss of movement:		
- of the shoulder	25%	20%
- of the elbow	20%* to 25**%	15%* to 20**%
- of the wrist	15%* to 25**%	15%* to 20**%
Total loss of thumb	20%	15%
Total loss of index finger	12%	8%
Total loss of middle finger	8%	6%
Total loss of 2 fingers other than thumb or index finger	15%	10%

Lower limbs

Amputation of the thigh at the hip joint or total paralysis of a lower limb	60%
Amputation of the leg at the knee joint	45%
Total amputation of a foot, tibio-tarsal disarticulation (Syme)	35%
Unhealed fracture of the thigh (pseudoarthrosis of the femur): maximum	35%
Unhealed leg fracture (pseudoarthrosis in both bones): maximum	35%
Unhealed fracture of the fibula only (pseudoarthrosis)	2%
Total loss of movement:	
. of the hip	30%* to 40**%
. of the knee	20%* to 30**%
. of the instep	10%* to 15**%
Amputation of the big toe	5%
Amputation of another toe	1%

If the Member is left-handed, and provided they have notified the insurer of this, the rates provided for the various disabilities of the right upper limbs will apply to the left and vice versa.

* In a favorable position.
** In a very unfavorable position.

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MSH INTERNATIONAL
SIACI SAINT HONORE GROUP

MSH International, a French insurance broker and simplified joint stock company (société par actions simplifiées) with a capital of €2,500,000 whose registered office is located at 39 rue Mstislav Rostropovitch 75815 Paris Cedex 17 France. It is registered with the Paris Trade and Companies Register under number 352 807 549 and with ORIAS under number 07 002 751 - intra-Community VAT identification number FR 78 352 807 549. MSH INTERNATIONAL is regulated by the French Prudential Supervision and Resolution Authority.

Groupama Gan Vie, a French public limited company (société anonyme) with a capital of 1,371,100,605 euros - registered with the Paris Trade and Companies Register under number 340 427 616 - APE 6511 Z Head office: 8-10 rue d'Astorg - 75383 Paris Cedex 08 France - Company regulated by the French Insurance Code and subject to the French Prudential Supervision and Resolution Authority (ACPR) - 4 place de Budapest - CS 92459 - 75436 Paris Cedex 09 France.
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