DR.WALTER

Consumer information about the product PROTRIP-WORLD-PLUS

Table of contents

Fact sheet

With the following information, we want to provide you with a first overview of our product PROTRIP-WORLD-PLUS, a combination of legally independent insurance contracts developed by the LAC Living Abroad Community e. V. and concluded for its members. The following insurance conditions apply for this contract.

Please note, however, that this information is not exhaustive. The full binding content of the contract consists of

- the following insurance conditions:
  - Insurance Conditions PROTRIP-WORLD-PLUS International Health Insurance of Allianz Worldwide Care SA (hereinafter: AVB-14PW)
  - General Liability Insurance Conditions AHB 2008 of Generali Versicherung AG (hereinafter: AHB 2008)
  - General Accident Insurance Conditions including Additional Conditions of Generali Versicherung AG (AUB 2008)
  - Expansions of the General Accident Insurance Conditions (AUB) 88 Version 2008 of Generali Versicherung AG
  - General Insurance Conditions for the Insurance of Assistance Services (PROTRIP-WORLD-PLUS Additional Assistance 2014) of EuropAssistance Versicherung-AG
  - Special Conditions for Personal Liability and Accident Insurance of Generali Versicherung AG PROTRIP-WORLD-PLUS 2014 (hereinafter: Special Conditions PROTRIP-WORLD-PLUS)
- certificate of enrollment (considered as insurance certificate)
- other written agreements (where applicable)
- your membership application form

1. Type of insurance contracts

PROTRIP-WORLD-PLUS consists of a combination of travel health, travel liability, travel accident, and assistance insurance for international students and doctoral students, language and exchange students, and other persons, participating in an Erasmus Mundus or Erasmus Plus Programme with a maximum duration of 3 years.

PROTRIP-WORLD-PLUS is a group contract consisting of legally independent insurance contracts that provide insurance cover for members of the LAC Living Abroad Community e. V. (LAC) and participants of affiliated partner companies and organizations.

By participating in this contract, you will receive a certificate of enrollment with details on the insured persons and the insured range of services.

The product PROTRIP-WORLD-PLUS is exclusively offered and managed by Dr. Walter GmbH (Dr. Walter) or its distribution partners.

2. Insurance cover

This document provides an overview on the most important benefits. For detailed conditions and exclusions of benefits, please refer to the insurance conditions.

PROTRIP-WORLD-PLUS	
International health insurance	
Inpatient and outpatient treatments, including operations	unlimited
Medicine, remedies and dressing material	unlimited
Dental treatment for pain relief and simple fillings as well as repair of existing dentures and dental prosthesis per case up to	€ 500
Medically necessary dental treatment as a result of an accident up to	€ 1,000
Outpatient initial treatment of mental illnesses up to	€ 1,500
Inpatient emergency treatment of first-time mental or emotional disorders up to	€ 20,000
Transport costs to the nearest hospital (e. g. with ambulance vehicles)	unlimited
Return transport to the insured person's place of residence in his/her home country	unlimited
Transport of the insured person's mortal remains	unlimited
General deductible per insured event	€ 0
Deductible for trips to the US only: in case of treatment in an emergency room; not applicable if medically necessary or in case of a resulting inpatient stay	€ 250
90 days extension of insurance cover in case of extended stay abroad for medical reasons	✓
Pre-existing conditions, if treatment could not be anticipated in case the trip was carried out as planned	✓
Home country cover in case of an interruption of the stay abroad	✓
Liability Insurance	
Personal liability insurance including "professional" liability insurance for au pairs with a lump sum for personal injury and/or property damage up to	€ 1,000,000
Property damage to host family's immovable property up to	€ 1,000,000
Damage to rented property covered by the policy up to	€ 100,000
Liability loss caused during activities as an intern up to	€ 10,000
Accident Insurance	
Accidental death benefit	€ 10,000
Disability benefit	€ 30,000
Disability classification	350%
Benefit in case of 100%accidental disability	€ 105,000
Rescue costs	€ 25,000
Plastic surgery as a result of an accident	€ 25,000
Assistance Insurance	
Compensation for loss of means of payment	✓
Compensation for loss of documents	✓
Assistance in case of criminal prosecution	✓
Return trip in case of an emergency	✓
Arrival of a person in a position of trust in case of an emergency per insured event up to a maximum amount of	€ 4,000

The policy does not cover every possible event; this would require that we demand an extremely high premium.

Not covered, for example, are

- **in health insurance:**
  Treatments of which the insured person knew at the start of the journey that they would have to take place under normal circumstances. (for details see §12 AVB-14PW).
- **in liability insurance:**
  damage to leased, rented or borrowed equipment (for details see §7 AHB 2008).
- **in accident insurance**
  intentionally caused insured events and damages as a result of an intentional criminal act (for details see §2 AUB 2008).

- **in assistance insurance**
  the following benefits: return journey in case of an emergency and arrival of a person in a position of trust in an emergency in case of chronic mental illness, also if said illness occurs in phases, and in case of addiction (for details see § VI PROTRIP-WORLD-PLUS Additional Assistance 2014).

3. Premium: Amount, due date and consequences of non-payment (all figures in €)

The monthly premium consists of the LAC membership fee (LAC share), health insurance premium (KV share), liability/accident insurance premium (HU share) and assistance insurance (AS share).

The daily premiums amount are as follows:
The premium including insurance tax is 0.90 € per person per day.

The premiums for accident, liability and assistance insurance each include 19% German insurance tax. The premiums for international health insurance are free of tax in accordance with § 4 no. 5 Insurance Tax Act (VersStg).

The premium is a single premium and is due for the entire term of the insurance after receipt of the certificate of enrollment and after expiry of the revocation period.

German and Austrian accounts only: In case of a term of the insurance of more than one month, the parties can agree on premium payment in monthly installments; such installments are in each case deemed deferred until they are due. The first installment of the premium shall be due at the start of insurance, the subsequent installments at the start of the following month. Any deferred installments are due immediately if the policyholder is in default with the payment of an installment.

4. Benefit exclusions

There is no liability to pay

- **in health insurance for:**
  - withdrawal and weaning treatments
  - treatments or rehabilitation measures at a health resort or sanitarium
  - dentures including dental crowns (except for simple repair), inlays and onlays as well as orthodontics and prophylaxis

  (for details see § 12 AVB-14PW)
- **in liability insurance for:**
  - damages as a result of keeping or operating motor vehicles
  - intentionally caused damages
  - damages caused by the exchange, transmission or provision of electronic data

  (for details see § 7 AHB 2008)
- **in accident insurance for:**
  - accidents caused directly or indirectly by nuclear power
  - accidents caused by mental illness or cognitive disorders
  - accidents directly or indirectly caused by foreseeable acts of war

  (for details see § 2 AUB 2008).
- **in assistance insurance:**
  - insofar as the illness is a psychological reaction to war, unrest, an act of terror, a plane crash or the fear of war, unrest or acts of terror
  - in case of mental illnesses, also if they occur in phases, and in case of addiction

  (for details see § VI PROTRIP-WORLD-PLUS Additional Assistance 2014)

5. Obligations at the conclusion of the contract

You are not required to fulfill any pre-contractual duties of disclosure. Please fill out the application form correctly and in full so that we can properly assess and process your application. Incorrect information can result in full or partial loss of insurance cover. For details, see the insurance conditions

6. Obligations during the contract period

During the contract period, you have no specific obligations to meet (except for payment of the premium). Please inform us immediately about any changes in the duration of your stay.

7. Obligations in the event of a claim

We depend on the cooperation of the insured persons for quick and easy processing of any claims.

With regard to health insurance, it might be necessary in individual cases that the insured person:

- releases the treating physicians from their physician-patient privilege so that we can gather the necessary information,
- is diagnosed by a physician of our choice,
- provides proof for start and end of the trip abroad.

Claims in liability, accident and assistance insurance

- need to be immediately reported to us by you. In addition, you have to meet further obligations that can help to clarify the claim or reduce the damage.

Failure to comply with obligations can result in full or partial loss of insurance cover.

8. Start of insurance cover

The membership is purchased for an agreed period. Insurance cover starts – subject to statutory rights to revoke – at the date stipulated in the certificate of enrollment, but

- not until payment of the premium and
- not prior to the start of the stay abroad.

Insured events that occurred prior to the start of the insurance cover are not covered.

9. Contract cancellation

Insurance cover automatically ends at the expiry of the contract period stipulated in the certificate of enrollment. The membership can be ended in advance in case of early cancellation of the stay abroad by the insured person.

Customer information

The product PROTRIP-WORLD-PLUS is an insurance combination exclusively offered and managed by Dr. Walter GmbH or its distribution partners. We, Dr. Walter GmbH, want to provide you as our customer with the following comprehensive information about the involved insurance companies and the underlying insurance policies:

1. Insurers

To offer you this insurance policy, Dr. Walter GmbH has teamed up with carefully selected and renowned insurance companies:

Health insurance is provided by:

Allianz Worldwide Care SA
Registration Court: Registre du Commerce et des Sociétés, Paris
Number 340234962
Headquarters: 87 rue de Richelieu, 75002 Paris, France
Postal address: Tour Neptune – 20 place de Seine – 92086 Paris la Défense cedex, France

Accident and liability insurance is provided by:

Generali Versicherung AG, Adenauerring 7, 81731 Munich, Germany.
Headquarters: Munich, Registration Court: District Court Munich HRB 177658

Assistance insurance is provided by:

Europ Assistance Versicherungs-AG, Adenauerring 9, 81737 Munich, Germany.
Headquarters and Registration Court Munich, HRB 61 405

The entire contract and service management is carried out by:

Dr. Walter GmbH, Eisenerzstrasse 34, 53819 Neunkirchen-Seelscheid, Germany
Head office: Neunkirchen-Seelscheid, Registration Court: District Court Siegburg HRB 4701

Dr. Walter GmbH has received the permission to act as an insurance broker from the competent Chamber of Industry and Commerce (IHK Bonn/Rhein-Sieg) in accordance with § 34d par. 1 Industrial Code (Gewerbeordnung).

Competent authority: IHK Bonn/Rhein-Sieg, Bonner Talweg 17, 53113 Bonn, T +49 (0) 228 2284-0, F +49 (0) 228 2284-170, info@bonn.ihk.de, www.ihk-bonn.de, of which we are a member.

Dr. Walter GmbH is registered in the Register of Insurance Brokers (Versicherungsvermittlerregister) under number D-QAMW-L7NVQ-57. This entry can be reviewed online at www.vermittlerregister.info or in the Register of Insurance Brokers (Versicherungsvermittlerregister) at Deutscher Industrie- und Handelskammertag (DIHK) e. V., Breite Strasse 29, 10178 Berlin, T +49 (0) 30 20308-0, F +49 (0) 30 20308-1000

Dr. Walter GmbH has no direct or indirect interest of more than 10% in voting rights or capital of any insurance company. No insurance company or parent company of an insurance company has a direct or indirect interest of more than 10% in voting rights or capital of Dr. Walter GmbH

2. Applicable law/Place of jurisdiction

Unless otherwise stipulated, the contract is governed by German law. Both German law and place of jurisdiction apply for all contractual arrangements affecting PROTRIP-WORLD-PLUS in general, the LAC membership and contract management by Dr. Walter GmbH. German law and place of jurisdiction apply for the insurance cover provided within accident, liability, baggage and assistance insurance. Whereas in the event of a dispute, French law and place of jurisdiction apply for the insurance cover provided within the international health insurance policy of Allianz France.

3. Languages

Our correspondence with you will be both in English and German.

4. Appeal proceedings

In the event of a disagreement, please contact Dr. Walter GmbH. Our contact data are:

Dr. Walter GmbH
Eisenerzstrasse 34, 53819 Neunkirchen-Seelscheid, Germany
T +49 (0) 22 47 91 94 -0
F +49 (0) 22 47 91 94 -40
E-mail: info@dr-walter.com

We will try to find a find a mutually acceptable solution as quickly as possible. If we don't succeed in this endeavor, you can also contact an extra-judicial arbitrator:

For complaints that do not affect health insurance, please contact

- Versicherungs-Ombudsmann (ombudsman for insurance matters), Postfach 080632, 10006 Berlin.

  This ombudsman is both responsible for extra-judicial arbitration in the event of a dispute arising from insurance contracts with consumers and between insurance brokers and policyholders. His decisions are not binding for the insurer. The right to take legal action shall remain unaffected hereby.

In addition, you can file a complaint with

- Bundesanstalt für Finanzdienstleistungsaufsicht (Federal Financial Supervisory Authority)
  Graurheindorfer Straße 108, 53117 Bonn.

For complaints that affect international health insurance, please send a letter or e-mail to

- Allianz Worldwide Care SA – Relations Clients
  Case Courrier BS, 20 place de Seine, 92086 Paris La Défense Cedex.
  E-mail: clients@allianz.fr

  Allianz Worldwide Care SA a signatory to the mediation charter of the French Federation of Insurance Companies (FFSA). Therefore, in the event of a persistent and definitive disagreement, and after exhaustion of all domestic remedies listed below, the policyholder association, the member firms or the insured persons have the option to contact the Mediator of the FFSA – without prejudice to other potential remedies – by mail to the following address: BP 290 – 75425 Paris cedex 09.

Definition of terms

The words and terms listed below and used in this product information have the following meanings:

- **Abroad/Foreign country/-ies**
  Abroad/foreign country/-ies means all countries except the country where the insured person has his/her permanent residence or had his/her permanent residence prior to the insured stay.
- **Acts of authorities**
  Acts of authorities are measures taken by governments (e.g. confiscation of exotic souvenirs by customs authorities or refusal of entry due to missing necessary documents).
- **Chronic illnesses**
  A chronic illness occurs when the insured person undergoes regular medical or psychotherapeutic treatment for at least a year due to an underlying illness. Chronic illnesses include illnesses that occur in phases.
- **Start of the journey**
  The journey starts when the insured person leaves his/her home.
- **Country of stay**
  Country of stay is the foreign country where the insured person temporarily stays, for example to study, to work as an au pair or intern, to visit school or take part in a Work and Travel program.
- **Home country**
  Home country is the country where the insured person has his/her permanent residence or had his/her permanent residence prior to the insured stay.
- **Home leave**
  Home leave is the interruption of the stay abroad for reasons of a temporary visit/vacation in the home country.
- **Host country**
  Host country means all countries worldwide except the country where the insured person has his/her permanent residence or had his/her permanent residence prior to the insured stay.
- **Host family**
  The host family includes one or more natural persons who are responsible for the provision of accommodation, livelihood and general care during the insured stay.
- **Immediately**
  Without undue delay.
- **Insured persons**
  Insured persons are the persons mentioned by name in the insurance certificate or the group of people described in the insurance certificate who are covered by the insurance policy.
- **Insured stay**
  Insurance cover is provided for the period mentioned in the insurance certificate. Insurance cover should always be purchased for the entire stay abroad and thereby include the entire outward and return journey to the country of stay or the home country.
- **LAC**
  LAC stands for LAC Living Abroad Community e.V. The LAC is an association that looks after the interests of people living abroad and provides them with information and services. Among these services is the framework agreement PROTRIP-WORLD-PLUS that LAC concluded as the policyholder, thereby providing insurance cover for its members during their stay abroad.
- **Medically necessary/Medically necessary treatment**
  1. Treatments and diagnostic procedures are only covered if they are used for diagnostic, curative and/or palliative purposes, are medically necessary or appropriate. It is required that they are carried out by a legally accredited physician, dentist or other therapist. Claims/costs are only paid/reimbursed if the medical diagnosis and/or prescribed treatment is consistent with generally accepted medical practice. Treatments that the insured person undergoes against medical advice are not deemed to be medically necessary.
  2. Medical services or healthcare are only deemed to be medically necessary and appropriate, if
     a) they are necessary in order to diagnose or treat the condition, illness or injury of a patient;
     b) ailments, diagnosis and treatment are consistent with the underlying illness;
     c) they are the most appropriate kind and level of healthcare; and
     d) if they are only carried out for an appropriate treatment duration.
- **Acts of god**
  Acts of god are: explosions, storm, hail, lightning, floods, avalanches, volcanic eruptions, earthquakes, landslides.
- **Policyholder**
  Policyholder is the association LAC Living Abroad Community e.V. for its members as well as for companies and organizations that cover stays abroad of their members through LAC.
- **Relatives**
  Relatives are spouses or life partners with whom the insured person has lived in cohabitation prior to the start of the insured stay, children, parents, adoptive children, adoptive parents, stepchildren, stepparents, grandparents, siblings, grandchildren, parents-in-law, children-in-law, brothers-in-law and sisters-in-law.
- **Journey/trip**
  Journey/trip within the meaning of this product information are all journeys undertaken during the insured stay if the distance between the whereabouts in the host country and the destination of the journey is more than 50 kilometers.

Insurance Conditions PROTRIP-WORLD-PLUS International Health Insurance (AVB-14PW) of Allianz Worldwide Care SA

Introduction

The association known as ''Living Abroad Community (L.A.C)"has taken out with Allianz Worldwide Care SA a Health Plan on behalf of one of its members, the Member Companies. The purpose of such Plan is to provide reimbursements complementary to the benefits in kind paid by the European Health Insurance Card.

The rights and obligations resulting therefrom,

- For the Policyholder Association taking out the policy, hereinafter referred to as the Policyholder Association, or the "L.A.C" Association,
- For the member of the Policyholder Association hereinafter referred to as "the Member Company",
- For international students and doctoral students, language and exchange students, and other persons, participating in an Erasmus Mundus, Erasmus Plus Programm, or similar with a maximum duration of 3 years,
- For the Insurer, represented by Allianz Worldwide Care SA and referred to as the Insurer,

are set out in this contract which is governed by the French law.

Title I – Purpose and bases of the contract

Article 1 – Purpose of the contract

This group insurance policy is governed by the French Insurance Code, and more particularly by the provisions stated in Title IV of Book I of the same Code, relating to Group Insurances. The statements from the Policyholder Association, the Member Company and the Covered Persons form its basis.

The purpose of such policy is to provide international students and doctoral students, language and exchange students, and other persons, participating in an Erasmus Mundus, Erasmus Plus Programm or similar of the Member Company as defined in this contract with the reimbursements complementary to the benefits in kind paid by the European Health Insurance Card.

The contract consists of:

- The membership certificate completed and signed by the representatives of the **L.A.C Association** and the Member Company.
- A booklet given to the **L.A.C Association** which specifies the coverage, its conditions of coming into effect and application, and the formalities to be fulfilled in the event of a claim.

Any and all aforementioned must be covered by this policy.

Article 2 – Effective date, duration and renewal date of the contract

This contract shall take effect on June 30th 2014 for a period ending on December 31th 2014, subject to the Policyholder Association's signature.

It is then renewed by tacit agreement from each 1st January for a one-year period, unless terminated by one of the parties by registered letter with acknowledgement of receipt sent on the last 31st October at the latest.

The contract may also be terminated on the Insurer's initiative:

- at any time when the number of covered people no longer represents the entire category of international students and doctorates participating in worldwide mobility programs before defined,
- in the event of non-payment of the premium in accordance with the terms defined in Article 21 of this policy,
- on the termination date of the Member Company's membership certificate,
- following a compulsory liquidation (or equivalent proceedings) of the Policyholder Association.

Article 3 – Effective date, duration and renewal date of the membership certificate

For the Member Company, the insurance membership is established by **a membership certificate, signed by the L.A.C Association and by the Member Company**, which includes in particular:

- the membership number,
- the effective date of the policy,
- the person concerned,
- the area of coverage,
- the type and the amount of coverage taken out,
- the premium amount.

For the Member Company, the insurance policy shall take effect on the date specified in the membership certificate, and, at the earliest, on August 1st 2014, for a period expiring on 31st December of the same year.

It is then renewed by tacit agreement from each 1st January for a one-year period, unless terminated by the Member Company by registered letter with acknowledgement of receipt sent to the Policyholder Association on the last 31st October at the latest; the termination shall take effect on 31st December of the current year. The Policyholder Association commits to informing the Insurer immediately.

The membership certificate may also be terminated in any of the following cases:

- On the date on which the Company ceases to be a member of the L.A.C Association,
- at any time when the number of covered persons no longer represents the entire category of international students and doctorates participating in worldwide mobility programs as defined in the membership certificate,
- following a recovery plan or a compulsory liquidation of the Member Company.

Article 4 – Obligations of the Policyholder Association and the Member Company

Obligations of the Policyholder Association

The L.A.C Association commits to:

- providing the Member Company with the booklet transmitted by the Insurer which summarizes the coverage, its conditions of coming into effect and application, and the formalities to be fulfilled in the event of a claim,
- informing in writing the Member Company of all modifications to be made, where relevant, to its rights and obligations, particularly before any reduction in coverage, any premium change or termination of the policy or the membership certificate.

Obligations of the Member Company:

The Policyholder Association L.A.C commits to informing the Member Company of the obligations listed below. The Member Company therefore commits:

4.1 to enrolling in the insurance all present and future members belonging to the international students and doctorates category defined in this contract and declared as such to the Insurer, for the full range of coverage taken out.

4.2 to providing the Insurer with the following documents through the Policyholder Association:

4.2.1 When applying for membership:

- a membership application form signed by the Member Company stating the exchange student to be covered and declared as such to the Insurer, the level and area of selected coverage and the premium rates, enclosing:
- Individual Applications for Membership by international students and doctorates to be covered, mentioning their countries of study.

The Member Company agrees to support its statements at any time.

In the event of omission or misstatement by the Policyholder Association or the Member Company, the Insurer is entitled, pursuant to articles L.113-8 and L.113-9 of the French Insurance Code, either to declare the policy null and void, or to continue applying it under new conditions set by it.

4.2.2 Within 15 days from the day they start to study abroad

- Individual Applications for Membership by new eligible members. If this deadline is not met, the membership shall only be effective from the date of receipt by the Insurer of this application for membership, even if premiums have already been paid by the Member Company for the international students and doctorates concerned.

4.2.3 Within 15 days following the end of each quarter:

- The premium payment, as provided for in Article 21, accompanied, when appropriate, by any new changes:
  - in the composition of the covered international students and doctorates, including dates of start or termination of the study abroad
  - in the country of study,
  - in the international students and doctoral students, language and exchange students, and other persons, participating in an Erasmus Mundus, Erasmus Plus Programm or similar, name or address.

4.2.4 At each annual renewal date and, at the latest, on 31st January of the following financial year:

- the annual run-off statement, stating the persons covered during the previous financial year and mentioning the dates of start and termination of study abroad.

4.3 To giving to each covered person at the time of membership, pursuant to Article L.141-4 of the French Insurance Code, the booklet drawn up by the Insurer and given to the Policyholder Association specifying the coverage, its conditions of coming into effect and application, and the formalities to be fulfilled in the event of a claim.

4.4 To informing in writing the Covered Persons of the modifications to be made, when appropriate, to their rights and obligations, in particular before any reduction in coverage, any change in the amount of premium or termination of the policy, pursuant to the French Insurance Code.

The Member Company shall be liable to its students and doctorates in case of non-compliance with the aforementioned obligations (for Paragraphs 4.3 and 4.4 pursuant to Article 12 of the Law no. 89-1009 of 31st December 1989 and Article L.141 – 4 of the French Insurance Code).

Article 5 – Other provisions

5.1 Income statements clause

For each calendar year and all similar contracts to which this policy belongs, the Insurer draws up common income statements according to the resources and costs attributable to it.

5.2 Revision

The conditions of this policy take into account the legislative and regulatory provisions in force on the policy's effective date.

However, if these ones are amended during the policy period, the Insurer reserves the possibility to revise the policy, at the earliest from the effective date of the new provisions.

Nevertheless, the Policyholder Association retains the possibility to request the termination of the policy without any notice period within thirty days following the notification by the Insurer.

This termination shall be effective from the first day of the calendar month following the Policyholder Association's request or from the effective date of the proposed modifications if later.

In the last case, the coverage and premium conditions are maintained on the existing basis prior to these modifications until the termination date.

The Policyholder Association shall inform the Member Company of the termination.

5.3 Scope of coverage

Unless otherwise stipulated in this policy, the coverage may be invoked 24 hours a day, both in professional and private life, in the event of sickness or accident and in the geographical area as indicated in Article 18.

5.4 Claims

Any event that may give entitlement to benefits must occur during the effective period of the coverage concerned and be declared within the periods stipulated therein or, if no period is stipulated, within six months following the effective insurance period.

5.5 Limitation of the actions arising from this insurance policy

Provisions relating to the limitation of actions arising from this insurance contract are laid down by Articles L.114-1 to L.114-3 of the French Insurance Code reproduced below:

Article L.114-1 of the French Insurance Code:

All legal actions arising from an insurance contract shall be barred two years as from the event that gave rise thereto.

However, the said period shall run:

1° in the event of non disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only as from the date on which the Insurer is aware thereof;

2° in the event of a claim, only as from the date the concerned parties are aware thereof, if they prove that they were unaware of such facts until then.

When the Covered Person's action against the Insurer arises from a third party's recourse, the limitation period shall run only from the date on which the said third party brings a legal action against the Covered Person or this one has paid it compensation.

The limitation period shall be increased to ten years for life insurance contract if the beneficiary is another person than the policyholder and, in insurance contracts covering personal injury, if the beneficiaries are the assigns of the deceased Covered Person.

Concerning Life insurance contract, notwithstanding the provisions of paragraph 2, the beneficiary's actions are subject to a maximum limitation period of thirty years from the date of the Covered Person's death.

Article L.114-2 of the French Insurance Code:

The limitation period shall be interrupted by one of the ordinary causes that interrupt the limitation period and by the appointment of experts following a claim. The limitation period of the legal action may also be interrupted by the Insurer sending the Covered Person a registered letter with acknowledgement of receipt in respect of the recovery for payment of the premium and by the Covered Person to the Insurer in respect of the payment of the claim.

Article L.114-3 of the French Insurance Code:

By way of derogation from Article 2254 of the French Civil Code, under no circumstance shall the limitation period be amended or further causes of suspension or interruption be added by the contracting parties, even if agreed by mutual agreement.

Further information:

The ordinary causes of interruption of the limitation period are set out in Articles 2240 et seq. of the French Civil Code; these ones include in particular: the debtor's acknowledgement of the right of the person against whom he was prescribing, a service of process, even for interim relief, enforcement proceedings. For more information about the completeness of the ordinary causes of interruption of the limitation period, see the aforementioned articles of the French Civil Code.

5.6 Recourse

Pursuant to the French Insurance Code, the Insurer may be subrogated to the right of the person entitled to benefits in order to exercise any recourse proceedings against any liable third party.

The Insurer waives its right of recourse proceedings against the Policyholder Association and the Member Company.

5.7 Complaint

In the event of a disagreement with the Insurer, the Policyholder Association, the Member Company or the Covered Persons shall first contact the usual representative at Allianz Life.

If the proposed solution does not meet the Covered Persons, the Policyholder Association or the Member Company's expectations, they can submit a complaint by ordinary letter or email to:

Allianz Worldwide Care SA – Relations Clients, Case Courrier BS, 20 place de Seine, 92086 Paris La Défense Cedex.
Email: clients@allianz.fr

Allianz Worldwide Care SA is a signatory to the mediation charter of the French Federation of Insurance Companies. Therefore, in the event of a persistent and definitive disagreement, and after exhaustion of all domestic remedies listed below, the Policyholder Association, the Member Company or the Covered Persons have the option to call for the **Mediator of the French Federation of Insurance Companies**, who can be contacted by post at:
BP 290 – 75425 Paris cedex 09,

and without prejudice to other possibilities of legal actions.

5.7 Administrative agreement

A management transfer protocol specifies the operations relating to this policy that the Insurer delegates to the Policyholder Association, and in particular the latter's obligations to the Insurer with respect to acceptance, statement, repayment of premium and compilation of statistics.

5.8 Clause relating to the French National Commission for Information Technology and Civil Liberties (CNIL)

All information concerning the Policyholder Association, the Member Company or the Covered Persons are used for contracts management.

The Member Company, the Policyholder Association or the Covered Persons have the right of access, rectification and opposition to their data, pursuant to Act n°78-17 of 6th January 1978 on Information Technology, Data Files and Civil Liberties.

5.9. Limitation of liability – Prior statement

In the event that several claims are caused by a same single event and subject to the provisions of the following paragraph, the accumulation of benefits provided by the Insurer in this regard for all Life & Disability group insurance policies taken out by the member Policyholder Association cannot exceed 60 million Euro. If this sum is reached, it shall be apportioned between all affected Covered Persons in proportion to the respective amounts of insured benefits before limitation.

Title II – The covered persons

Article 6 – Category of persons to be enrolled

All members belonging to the category of international students and doctoral students, language and exchange students, and other persons, participating in an Erasmus Mundus, Erasmus Plus Programm or similar, of the Member Company are members of this Group Insurance Plan.

A covered person should not have reached his/her 40th birthday at the start date of the insurance policy.

Article 7 – Membership conditions

The members of the aforementioned category to be covered must, at the time of their application for membership:

- Fill out and sign an Individual Application for Membership.

The Insurer reserves the right, on the basis of the aforementioned documents and information, to limit the coverage or to reassess the policy's premium stated in the application for membership, or even to refuse the Company's membership.

During the policy period, if the international students and doctorates category is joined by new eligible persons who present an aggravated risk, the Insurer may also reassess the premium rates on 1st January of the following financial year.

The Insurer shall inform the Policyholder Association of the new premium rates applicable to **new members only** by sending it an endorsement.

The Policyholder Association may refuse this increase and terminate the policy by sending the Insurer a registered letter with acknowledgement of receipt within thirty days from the date of receipt of the endorsement sent by the Insurer. The termination shall take effect on the first day of the calendar quarter following the refusal notification.

The Policyholder Association shall inform the Member Company of the termination.

In the event the Policyholder Association fails to terminate the policy within thirty days, the increase shall be deemed to have been accepted

Article 8 – Effective date of coverage

Once the policy has come into effect, the coverage becomes effective for each student and doctorate, who acquires the status of Covered Person, on the following dates:

8.1. Students enrolled on the effective date of the policy:

- from this date, subject to the compliance with Article 4.2.1.

8.2 Students enrolled after the effective date of the policy:

- on the date they join the category of international students and doctorates to be covered if their Individual Applications for Membership have been received within fifteen days following this date.
- otherwise, on the date of receipt of such application.

8.3 Students who stay abroad before or after the inception of the programme:

- up to 2 months maximum before the registered inception date of insurance, when the insured person has already entered the country of destination.

Article 9 – Termination or suspension of coverage

9.1 Except in the event of concealment, omission or misstatement made in bad faith, the Covered Person, once accepted, cannot be excluded from the Insurance against his/her will as long as he/she belongs to the category of international students and doctorates to be covered, subject to the provisions of Article L.141-3 of the French Insurance Code.

In any case, the coverage ceases to be effective:

9.1.1 For each Covered Person:

- as soon as he/she ceases to belong to the category of international students and doctoral students, language and exchange students, and other persons, participating in an Erasmus Mundus, Erasmus Plus Programm or similar to which this policy applies,
- **The insurance coverage is terminated after the maximum insurance duration of 36 months.**

9.1.2 For all Covered Persons belonging to the aforementioned international students and doctorates category:

- on the policy termination date,
- Up to 3 months maximum after the registered end of the programme, when the insured person has not yet left the country of destination.

The termination (or suspension) of the coverage results in the cancellation of the right to benefits for all medical care provided after the termination date, even if they have started or have been prescribed before this date.

Title III – Medical coverage

Article 10 – Coverage beneficiaries

The Covered Persons alone.

Article 11 – Medical Benefits

11.1 Cover provided

1. In the event of illnesses, which occur in acute form, and accidents abroad, the Insurer will pay the costs of
   a) medical treatment;
   b) medical transport;
   c) repatriation of the deceased person in the event of death.
2. Trips outside the rating area during the insured stay are covered in each case up to a maximum of 42 days, home holidays are covered.

11.2 Medical treatment

1. The Insurer will pay the costs of medical treatment required, which is performed or ordered by doctors. This includes in particular
   a) in-patient treatment in hospital including operations;
   b) out-patient treatment;
   c) drugs, medicines and bandages;
   d) out-patient first-response medical care of psychological illnesses up to a total of 1,500.00 €.
   e) in-patient emergency medical treatment for mental and psychological disorders occurring for the first time, up to a total of 20,000.00 €
   f) aids (e.g. aids for walking, rental of a wheelchair), if they are required for the first time on account of an accident or an illness during the insured stay.
2. Dental treatment
   a) The Insurer will reimburse the costs for dental treatment for the relief of pain, including simple or temporary fillings and repairs to restore the function of dentures and replacement teeth up to a total sum of 500 € for each insured event.
   b) If dental treatment is medically necessary as a result of an accident which the insured person has suffered during the insured stay, the Insurer will pay the costs up to a total of 1,000 € for each insured event. An accident is deemed to have occurred if the insured person suffers involuntary damage to his/her health as a result of an event which suddenly impinges on his/her body from outside.
3. If medical return transport is required by the end of the insured stay because it is not possible to move the insured person, the Insurer will pay the costs of medical treatment up until the day when it is possible to move the insured person.
4. Telephone costs

   Telephone costs to make contact with the Emergency Call Centre of the Insurer will be paid up to 25 € for each insured event.

11.3 Pregnancy/Labour

1. In the event of pregnancy occurring during the insured stay, the Insurer will pay the costs for
   a) antenatal checkups up to and including the 12th week of pregnancy;
   b) two ultrasound examinations, unless further scans are medically necessary on account of special circumstances;
   c) treatment for complications during pregnancy;
   d) out-patient or in-patient labour. Additional costs for a Caesarean operation are also eligible for repayment, provided it is medically necessary;
   e) medically necessary termination of pregnancy;
   f) birth assistants and midwives;
   g) postnatal care of the mother and the newborn. The payments for newborns are limited to 50,000 €.
2. Pregnancies at stage less than six months, at the moment of departure from the home country, to participate in this action, shall not be excluded from cover.

11.4 Medical transport/Repatriation

The Insurer will pay the costs for

a) medically necessary transport abroad for hospitalization or initial outpatient treatment in a hospital; transport must be provided by a recognized emergency medical service;

b) medically effective and reasonable evacuation of the insured person to his/her place of residence in the home country or to a suitable hospital nearest to his/her place of residence, if it is likely that the insured stay will have to be definitively terminated as a result of the illness/injury. In the case of trips, the Insurer will also pay the costs for medically effective and reasonable evacuation to the place of stay in the country of stay or to a suitable hospital nearest to his/her place of stay in the country of stay;

c) repatriation of mortal remains of the insured person to the place of residence prior to the trip or, optionally, burial abroad up to the amount of the repatriation costs.

11.5 Claims for medical costs

The medical costs claim form is provided by the Insurer and must be submitted to it with the relevant supporting documents.

No copy, photocopy or duplicate of invoice is accepted.

The Insurer may request, when relevant, any further document necessary for the application of the coverage.

The Covered Person shall be liable for any information provided by him/her which appear to be false, forged or exaggerated or any fraudulent or deceitful action by them; all undue payments paid by the Insurer on the basis of these incorrect data shall be recovered.

11.6 Benefits amount

The reimbursements of medical costs are paid in Euro up to the maximum amounts stated below in the coverage table, per covered person, per civil year and up to the limit of the actual costs.

The benefits amount is calculated for each reasonable and customary cost item and according to the terms of this policy.

The reasonableness and customariness are assessed according to the medical practise which prevails in the country where the care is provided (treatment type, care and medical equipment quality, geographical area and country) and are subject to coding and rating standards of the medical procedures and treatments referenced or nomenclatured in each country.

The unreasonableness and uncustomariness may lead to a refusal of reimbursement for the medical costs or a limitation of the reimbursement amount.

11.7 limitation to actual costs

Pursuant to Article 9 of the Act no. 89-1009 of 30th August 1990 and the Decree no. 90-769 of 30th August 1990, the reimbursements or compensations of the costs incurred by an illness, maternity or accident shall not exceed the amount of the costs remaining payable by the Covered Person after the payment of the benefits of any type he/she is entitled to.

Benefits of the same type taken out with several insuring bodies shall be enforceable up to the limit of each benefit, whatever the date it has been taken out. Within this limit, the policy beneficiary may obtain an additional compensation by submitting the breakdown of benefit(s) paid by the other insuring body(ies).

For the purpose of the aforementioned provisions, the limitation to the costs remaining payable by the Covered Person is determined by the Insurer for each medical procedure or cost item.

Article 12 – Excluded risks related to medical coverage

Any costs incurred by the following events are not covered by the Insurer:

- **A claim arising directly or indirectly from the decay of an atomic nucleus,**
- **The consequences of a civil or non-civil war, an insurrection, a riot, an attack, a commotion or an act of terrorism, whatever the place these events take place and their protagonists, except if the Covered Person does not take an active part in such event or if he/she is called upon to perform a maintenance or monitoring mission in order to ensure the security of people and goods for the Policyholder Association or the Member Company.**

The Insurer reserves the possibility of modifying the coverage for one or several specific territories, subject to a 15 days prior notice to the Policyholder Association. This one may refuse this modification and terminate the policy by sending the Insurer a registered letter with acknowledgement of receipt within 30 days from the date of receipt of the endorsement submitted by the Insurer. The termination shall take effect on the first day of the calendar quarter following the refusal notification.

The Policyholder Association shall inform the Member Company of the termination.

Article 13 – Excluded benefits related to medical coverage

It is specified that the following benefits are not covered by this policy, except benefits specified as covered in the coverage table attached to the policy:

- **costs for the treatment of prior illnesses including chronic illnesses, unless there is an acute and unforeseeable deterioration in health;**
- **medical treatment and other measures ordered by a doctor where the insured person was aware when starting the insured stay that, if the insured stay took place as planned, the treatment would have to be given for medical reasons(e. g. dialysis);**
- **procurement and repair of heart pacemakers, prostheses, aids to sight and hearing aids;**
- **costs of accident or illness caused by mental illness or impaired consciousness, if this is a result of the consumption of alcohol, drugs, intoxicants or sedatives, sleeping tablets or other narcotic substances;**
- **acupuncture, fango and massages;**
- **need for care or safe-keeping;**
- **psychoanalytical and psychotherapy treatment, if not covered under aforementioned details of benefits and hypnosis,;**
- **payments for pregnancy and labour, If the pregnancy has arisen longer than 6 months before the commencement of the insured stay, unless there is an acute and unforeseeable deterioration in the health of the mother.**

Insurance is provided during home holidays as follows:

- during a trip of less than six weeks, only for the costs resulting from an accident or an emergency illness, as these terms are defined in Title VI, provided the treatment was practised by a general or specialised practitioner or the hospitalisation was a necessity owing to the emergency and took place within twenty-four hours,
- in all other cases, after express approval by the Insurer.

Title IV – Medical emergency assistance coverage

It is agreed that the insurer delegates the execution of the following assistance services to Dr Walter GmbH as specified in the administrative agreement.

Cover provided

The Insurer will provide 24-hour assistance services through its Emergency Call Centre in the event of the insured person suffering any of the following medical emergencies during the insured stay.

The Medical Emergency Assistance is also applicable for trips during the insured stay up to a maximum of 42 days, but not during home holidays.

Illness/Accident

1. Information about medical care

   The Insurer will, on request, provide information before and after the start of the insured stay on the options for care of the insured person by a doctor. Where possible, it will appoint a German-speaking or English-speaking doctor.

2. Hospitalization

   Where the insured person is treated as an in-patient in a hospital, the insurer will provide the following services:

   a) Care
   Through a doctor appointed by The Insurer, contact will be established with the hospital doctors giving treatment and, where required, with the insured person's doctor at home and will ensure information is passed between the doctors involved. The insurer will, on request, ensure that relatives of the insured person are informed.

   b) Hospital visit
   If hospitalization looks likely to last for more than five days, the insurer will organize the outward journey for a person close to the insured person to the place of hospitalization and from there the return journey back to his/her place of residence. The insurer will pay the costs of the means of transport. Should the insured person require accommodation in the vicinity of the hospital or the place of the funeral, the insurer will arrange same and bear accommodation costs of up to 70 € per day for a maximum of seven days.

   c) Cost payment guarantee/settlement
   The insurer will give the hospital a guarantee to pay costs up to 15,000 €. In the name of and at the request of the _insured person, it will settle with the bodies responsible for bearing the costs of treatment. Any sums paid by the insurer that are not borne by the responsible insurance companies must be paid back to the insurer by the insured person within one month of the account being rendered.

3. Medical evacuation

   The insurer will organize the medically effective and reasonable evacuation of the insured person to his/her place of residence in the home country or to a suitable hospital closest to the place of residence of the insured person by a medically appropriate means of transport (including air ambulance), if it is likely that the insured stay will have to be definitively terminated as a result of the illness/injury.

   In the case of trips, the Insurer will also pay the costs for medically effective and reasonable evacuation to the place of stay in the country of stay or to a suitable hospital nearest to his/her place of stay in the country of stay.

Dispatch of medicines

1. Where the insured person requires medicines, which have been lost during the insured stay, the insurer will organize procurement or replacement medicines and send them to the insured person and pay for their dispatch.
2. The insured person must refund the cost of replacement medicines to the insurer within one month of the account being rendered.

Death

If the insured person dies during the insured stay, the insurer will, at the request of the relatives, organize burial abroad or repatriation of the deceased person to the place of burial.

Psychological counseling

If the insured person suffers acute mental trauma during the insured stay requiring psychological assistance, the insurer will provide an initial counseling by telephone.

Obligation following occurrence of an insured event

1. The insured person will be under an obligation to make contact with the Emergency Call Centre of the insurer immediately.
2. If this obligation is intentionally not met, the insurer will be released from its liability to make payment. The obligation to make payment remains to the extent that the failure to meet obligations is due neither to willful intent nor to gross negligence.

   If an obligation is not met by virtue of gross negligence, the insurer will be entitled to reduce the level of payment to be made pro rata with the seriousness of the negligence of the insured person. The insurer will still be liable to make payment to the extent that the failure to meet the obligation does not affect the process of establishing whether the insurer has an obligation to pay the claim and if so, the level of payment to be made, unless the insured person has acted fraudulently.

Title V – Table of benefits – Area of coverage

Article 14 – Table of benefits

The purpose of the Medical cover is to provide reimbursements complementary to the benefits paid by the European Health Insurance Card.

Medical cover	
In-patient and out-patient treatment including operations	unlimited
Drugs, medicines and bandages	unlimited
Dental treatment for the relief of pain including simple fillings as well as repairs to restore the function of dentures and replacement teeth per insured event up to	€ 500
Medically necessary dental treatment as a result of an accident per insured event up to	€ 1,000
Out-patient first-response medical care of psychological illnesses up to a total of	€ 1,500
In-patient emergency medical treatment for mental and psychological disorders occurring for the first time, up to a total of	€ 20,000
Transportation costs to the next hospital with recognised emergency medical services	unlimited
Medically effective and reasonable evacuation of the insured person to his or her place of residence	unlimited
Repatriation of the insured person in case of death	unlimited
General excess per case	€ 0
Excess only for stays in the USA: for treatment in the Emergency Room; the excess is waived in case of medical necessity or subsequent in-patient treatment	€ 250

Medical emergency assistance and full assistance coverage	
Information about medical care	service
Dispatch of medicines	costs of dispatch
Hospital visit of a person close to the insured person if hospitalisation looks likely to last more than 5 days	Transportation costs; hotel costs up to € 70 per day, up to a maximum of 7 days
Interruption of insured stay due to severe illness or accident of family members in case of in-patient treatment of more than 5 days.	Transportation costs

Article 15 – Area of coverage

The medical costs must have been incurred within the insurance period:

- In all countries where mobilities take place,
- in another country:
  during a trip of less than six weeks, only for the costs resulting from an accident or an emergency illness, as these terms are defined in Title VI, provided the treatment was practised by a general or specialised practitioner or the hospitalisation was a necessity owing to the emergency and took place within twenty-four hours,
- in all other cases, after express approval by the Insurer.

Title VI – Premiums

Article 16 – Rates and calculation basis

16.1 Premiums

The daily premiums amount are as follows:
The premium including insurance tax is 0.90 € per person per day.

16.2 Indexation

Premiums are automatically indexed on each 1st January, according to the annual consumption of medical care and medical goods, the costs of which are borne by households and supplementary insurance companies (amount in Euro of the medical care and goods included in the national health accounts under the headings "Household expenditure", "Mutual insurances and private insurances").

16.3 Revision in case of modification of the legislative and regulatory provisions

The premiums may be revised according to the provisions of Article 5.2.

16.4 Revision according to technical results

Pursuant to Article 5.1, the rates may be revised each 1st January according to the technical results of contracts of the same type.

In case of disagreement, the Policyholder Association may request the termination of the policy by registered letter within one month from the date of notification by the Insurer. The termination shall take effect on the first day of the month following the receipt of the registered letter by the Insurer.

The Policyholder Association commits to informing the Member Company of the termination.

The Insurer shall receive the premium proportion of the 1st January on the termination date, calculated on the basis of the premium rates previously in force.

Necessary Premium adjustments are implemented at each 1st day of the year but only for new memberships. The conditions for concluded individual Memberships shall not change during the contracted period

Article 17 – Premiums payment

The premiums are due by the Covered Person immediately after conclusion of the insurance and must be paid when the insurance certificate is issued,

The premium is then due monthly to the Insurer directly by the Policyholder Association which is solely responsible for their payment.

For that purpose, the Policyholder Association shall complete, according to the indications they contain, the quarterly statements and the annual run-off statements addressed to it.

If the premium has not been paid when the first event occurs, the Insurer will be released from the obligation to make payment. The policyholder is responsible for non-payment.

Article 18 – Non-payment of the premiums

Should the Policyholder Association fail to pay all the premiums within the month following their due date, the coverage is suspended THIRTY days after issuance by the Insurer of a registered letter enclosing the formal notice provided for in Article L.113-3 of the French Insurance Code.

If, beyond that period, the Policyholder Association has not made the requested payment, the policy may be terminated without any further formality within the ten following days.

General Liability Insurance Conditions of Generali Versicherung AG (AHB 2008)

Scope of insurance

1. Subject matter of the insurance, insured event

1.1 Insurance cover is provided within the frame of the insured risk if a third party makes a claim for damages against the policyholder in accordance with statutory liability provisions under private law and because of the occurrence of a loss event (insured event) that caused personal injury, property damage or a resulting financial loss while the insurance policy was in effect. Loss event is an event directly causing damage to a third party. The exact point in time, however, when the damage leading to the loss event was caused is not relevant in this context.

1.2 There is no insurance cover for claims, even if they are statutory claims,

1.2.1 for fulfillment of contracts, subsequent performance, for self-remedy of defects, rescission, reduction, for compensation instead of performance;

1.2.2 because of damages that are caused in order to carry out the subsequent performance;

1.2.3 because of the failure to use the subject matter of the contract or because of the absence of the success owed under the contract;

1.2.4 for compensation of unsuccessful expenses in reliance on proper fulfillment of contract;

1.2.5 for compensation of a financial loss caused by late performance;

1.2.6 because of other compensations replacing the fulfillment of contract.

2. Financial loss, loss of property

By means of a special agreement, this insurance cover can be extended to the policyholder's legal liability under private law because of

2.1 financial loss neither caused by personal injury nor property damages;

2.2 damages because of loss of property; such a case is governed by the conditions on property damage.

3. Insured risk

3.1 The insurance cover includes the legal liability

3.1.1 from the policyholder's risks stipulated in the insurance policy and its addendums,

3.1.2 from increases or extensions of the risks stipulated in the insurance policy and its addendums. This applies neither for risks from ownership or use of motor vehicles, aircraft or watercraft that are subject to insurance nor for other risks subject to compulsory insurance or the duty to provide for sufficient cover,

3.1.3 from risks that will newly arise for the policyholder after conclusion of the insurance contract (automatic extension of cover) and which are regulated in detail in clause 4.

3.2 The insurance cover also includes an increase of the insured risk as a result of a change in the existing legal regulations or the enactment of new ones. The insurer can, however, cancel the insurance contract in accordance with the requirements of clause 21.

4. Automatic extension of cover

4.1 Risks that newly arise after the conclusion of the insurance contract are covered within the existing contract with immediate effect.

4.1.1 The policyholder is obliged, at the insurer's request, to inform the insurer about every new risk within one month. This request can also be made together with the premium statement. If the policyholder fails to inform the insurer on time, the insurance cover will be retrospectively cancelled for the new risk starting at the point when it arose. If the insured event takes place before the policyholder informed the insurer about the new risk, the policyholder will have to prove that the new risk did not arise prior to conclusion of the insurance and was added at a point where the notification period had not yet expired.

4.1.2 The insurer shall be entitled to demand an appropriate premium for the new risk. If there is no agreement on the amount of the premium within one month after the policyholder informed the insurer about the new risk, the insurance cover will be retrospectively cancelled for the new risk starting at the point when it arose.

4.2 From the point when new risks arise until an agreement is made in accordance with clause 4.1.2, the insurance cover for new risks will be limited to € 500,000 for personal injury and € 150,000 for property damage.

4.3 Automatic extension of cover does not apply for risks

4.3.1 arising from ownership, possession, keeping or operation of motor vehicles, aircraft or watercraft, insofar as these vehicles require a driver's license and are subject to approval and insurance;

4.3.2 arising from ownership, possession, operation or driving of trains;

4.3.3 that are subject to compulsory insurance or the duty to provide for sufficient cover;

4.3.4 that will be in place for less than a year and therefore need to be covered within short-term insurance contracts.

5. Insurance benefits/Insurer's power of attorney

5.1 The insurance cover includes determination of liability, the defense against unjustified claims for compensation and the policyholder's release from justified claims for compensation. Claims for compensation are justified if the policyholder is obliged under law, final judgment, acknowledgement or settlement to pay compensation and if the insurer is bound to this. Acknowledgements and settlements that the policyholder made or accepted without the insurer's consent are only binding for the insurer insofar as the claim would also have been valid without an acknowledgement or settlement. If the policyholder's liability for damages has been determined with binding effect on the insurer, the latter has to release the policyholder from the third party's claim within two weeks.

5.2 The insurer is authorized to provide any statement on the policyholder's behalf he deems necessary to settle or defend against claims for compensation. In case of a dispute about claims for compensation against the policyholder within an insured event, the insurer is authorized to conduct the case on behalf of the policyholder and at the insurer's expense.

5.3 If the appointment of a defense counsel for the policyholder is desired or approved by the insurer in criminal proceedings because of a loss event that might cause a liability claim under the insurance cover, the insurer will bear the costs of the defense counsel in accordance with the fees regulations or the separately arranged additional costs.

5.4 If the policyholder or a co-insured person gains the right to demand the cancellation or reduction of a payable annuity, the insurer is authorized to exercise this right.

6. Benefit limitations

6.1 The insurer's compensations are limited for every insured event to the agreed sums insured. This shall also apply if the insurance cover includes several persons obliged to pay compensations.

6.2 Unless otherwise agreed, the insurer's compensations are limited for all insured events within an insurance year to twice the amount of the agreed sums insured.

6.3 Several insured events taking place during the validity of the insurance policy are deemed as a single insured event that occurred during the first of these insured events if they are based on

- the same cause,
- the same causes and if there was an internal, in particular material and temporal, coherence or
- the delivery of goods with the same defects.

6.4 Where separately agreed, the policyholder will contribute to the compensation in every insured event with an amount stipulated in the insurance policy and its addendums (deductible). Unless otherwise agreed, the insurer is also obliged in these cases to carry out the defense against unjustified claims for compensation.

6.5 The insurer's expenses for costs incurred will not be set off against the sums insured.

6.6 If the justified liability claims from one insured event exceed the sum insured, the insurer will bear the legal costs in the relation the sum insured has to the total amount of these claims.

6.7 If the policyholder has to pay annuity to the injured party and if the capital value of the annuity exceeds the sum insured or the rest of the sum insured after deduction of other benefits from the insured event, the insurer will only reimburse the payable annuity in the relation the sum insured or its rest has to the capital value of the annuity. The calculation of the annuity will take place in accordance with the regulation on the insurance cover in vehicle liability insurance in its version valid at the time of the insured event. When calculating the amount the policyholder needs to contribute to ongoing annuity payments, if the capital value of the annuity exceeds the sum insured or the rest of the sum insured after deduction of other benefits from the insured event, any other benefits will be set off against the sum insured in full.

6.8 Where the insurer requests the handling of a liability claim by acknowledgement, satisfaction or settlement and the claim cannot be handled because of the policyholder's behavior, the insurer is not obliged to pay for the additional expenses in the form of compensations, interest and costs resulting from the insured person's refusal

7. Exclusions

Unless otherwise agreed in the policy and its addendums, the insurance policy comes with the following exclusions:

7.1 Insurance claims of all persons who intentionally caused the damage.

7.2 Insurance claims of all persons who caused the damage by

- placing goods on the market or
- carrying out works or other services.

in knowledge of their defectiveness or harmfulness.

7.3 Liability claims that exceed the scope of the policyholder's statutory liability because of a contract or pledge.

7.4 Liability claims

7.4.1 of the policyholder or of the persons listed in clause 7.5 against co-insured persons,

7.4.2 between several policyholders of the same insurance contract,

7.4.3 between several additional insured persons of the same insurance contract. The above listed exclusions also extent to liability claims by relatives of the persons cited therein if they live in a joint household.

7.5 Liability claims against the policyholder

7.5.1 from claims of the policyholder's relatives who live with the policyholder in cohabitation or are co-insured persons as named in the insurance contract. Relatives are spouses, life partners in accordance with the Law on Civil Partnership or similar partnerships in accordance with the laws of other countries, parents and children, adoptive parents and children, parents-in-law and children-in-law, stepparents and stepchildren, grandparents and grandchildren, siblings as well as foster parents and children (persons connected by a family-like relationship set out for the long term such as parents and children)

7.5.2 of the policyholder's legal representatives or advisers if the policyholder is a legally incompetent person, a person with limited legal capacity or a person under care;

7.5.3 of the policyholder's legal representatives if the policyholder is a legal entity under private or public law or an association without legal capacity;

7.5.4 of the policyholder's partners with unlimited personal liability if the policyholder is a partnership, limited partnership or civil partnership;

7.5.5 of the policyholder's partners if the policyholder is a registered professional partnership;

7.5.6 of the policyholder's liquidators, receivers and insolvency administrators.

7.5.7 The exclusions under clause 7.5.2 to 7.5.6 also include liability claims of relatives of the persons mentioned therein and living in cohabitation with them.

7.6 Liability claims for damage to third-party property and any resulting financial loss where the policyholder rented, leased or borrowed the property or acquired the property through unlawful interference or if they are the matter of a separate deposit contract.

If the requirements for the exclusions are met in the person of the policyholder's salaried employees, workers, servants, authorized agents or representatives, the insurance cover shall likewise cease for both the policyholder and for other co-insured persons under the insurance contract

7.7 Liability claims for damage to third-party property and any resulting financial loss if

7.7.1 the damage is a result of the policyholder's commercial or professional work with said property (processing, repair, transport, inspection and the like); in case of immovable property this exclusion only applies if the property or parts thereof were immediately affected by the activity;

7.7.2. the damage was caused because the policyholder used the property to enable his/her commercial or professional activities (as a tool, aid, storage surface for material and the like); in case of immovable property this exclusion only applies if the property or parts thereof were immediately affected by the use;

7.7.3 the damage was caused by the policyholder's commercial or professional activity and if the property or – in the case of immovable property – parts thereof were situated in the area directly affected by the activity; this exclusion shall not apply if the policyholder can prove that, at the time of the activity, he/she had taken necessary protective measures to prevent damages.

If the requirements for the above exclusions are met in the person of the policyholder's salaried employees, workers, servants, authorized agents or representatives, the insurance cover shall likewise cease for both the policyholder and for other co-insured persons under the insurance contract.

7.8 Liability claims for damage to goods, works or other services produced, provided or delivered by the policyholder as a result of their production, delivery or service and any resulting financial loss. This shall also apply if the damage was caused by a defective part of the object or by a defective partial performance resulting in the object or service being damaged or destroyed. This exclusion is also applied if a third party produced or delivered the objects or carried out the works or other services on the policyholder's behalf and for the policyholder's account.

7.9 Liability claims from loss events happening abroad; claims in accordance with § 110 Social Code VII are also covered.

7.10 Liability claims for damages from environmental effects. This also includes damage caused by fire and/or explosion. This exclusion shall not apply

a) within insurance of personal liability risks;

b) for damages arising from products manufactured or supplied by the policyholder (including waste), or from work or other services following performance of the service or completion of the work (product liability).

There is, however, no insurance cover for damages from environmental effects as a result of planning, production, delivery, assembly, dismantling, repair or maintenance of

- installations intended for the production, processing, storage, depositing, conveying or disposal of substances harmful to waterways (Waterways Act [WHG] installations);
- installations in accordance with appendix 1 or 2 to the Environment Liability Law (UmweltHG installations);
- Installations for the purpose of environmental protection that need to be authorized or notified in accordance with environmental protection regulations;
- waste water installations or parts which are evidently intended for such installations;

7.11 Liability claims for damages from asbestos or substances or products containing asbestos.

7.12 Liability claims for damages directly or indirectly connected to energy-rich ionizing radiation (e.g. radiation emitted from radioactive substances or X-ray radiation).

7.13 Liability claims for damages from

7.13.1 genetic engineering,

7.13.2 genetically modified organisms (GMOs),

7.13.3 products that

- contain parts of GMOs,
- were produced from or with the aid of GMOs.

7.14 Liability claims from property damage caused by

7.14.1 sewage, insofar as domestic sewage is not involved,

7.14.2 subsidence of land or landslides,

7.14.3 flooding caused by standing or flowing water.

7.15 Liability claims for damages arising from the exchange, transmission or provision of electronic data, where such damages result from

7.15.1 deletion, suppression, spoiling or alteration of data,

7.15.2 failure to capture or faulty storage of data,

7.15.3 disruption of access to electronic data interchange,

7.15.4 transmission of confidential data or information.

7.16 Liability claims for damages arising from violations of personal rights or name rights.

7.17 Liability claims for damages due to hostility, vexatious harassment, unequal treatment or other discrimination.

7.18 Liability claims for personal injury arising from the transmission of a disease by the policyholder. The same applies for property damage arising from the illness of animals the policyholder owns, keeps or sells. In both cases, insurance cover is provided if the policyholder proves that he/she did not act with intent or gross negligence

Start of insurance cover/Payment of premium

8. Start of insurance cover/Premium and insurance tax

The insurance cover starts on the date stipulated in the insurance policy if the policyholder pays the first or single premium on time in accordance with clause 9.1. All invoiced premiums include insurance tax, the amount of which being stipulated by law and payable by the policyholder.

9. Payment and consequences of late payment/First or single premium

9.1 The first or single premium is due immediately on taking out the insurance policy, but not prior to the start of insurance cover. If payment of the annual premium in installments was agreed, only the first installment of the first annual premium shall be deemed to be the first premium.

9.2 If the policyholder fails to pay the first or single premium on time but at a later point in time, the insurance cover only starts from this later point in time. This shall not apply if the policyholder proves that he/she was not responsible for non-payment. In case of insured events that occur prior to payment of the premium, the insurer is only exempt from his liability to pay if he informed the policyholder about this legal consequence of non-payment of the premium by separate written notification or by placing a prominent notice in the insurance policy.

9.3 If the policyholder fails to pay the first or single premium on time, the insurer is authorized to withdraw from the contract until the policyholder makes the payment. The insurer is not allowed to withdraw if the policyholder proves that he/she is not responsible for non-payment.

9.4 If the first premium is not paid on time, the policyholder is considered to be in default 30 days after the expiry of the revocation period of 14 days as set out in the insurance certificate and after receipt of a request for payment, unless the policyholder is not responsible for the delayed payment. The insurer is entitled to request compensation for the loss incurred through the delay.

10. Payment and consequences of late payment/Renewal premium

10.1 If not otherwise agreed, the renewal premiums are due on the first day of the month of the agreed premium period. The payment shall be considered to be made on time if it is made at the point in time stipulated in the insurance policy or the premium statement.

10.2 Failure to pay a renewal premium on time shall constitute default without reminder unless the policyholder is not responsible for the late payment.

The insurer will send the policyholder a written request for payment with a set payment period of at least two weeks. Failure to pay a renewal premium on time authorizes the insurer to set a payment period of at least two weeks in writing and at the policyholder's expense. This provision is only valid if it provides details on the backlog of payments consisting of premium, interest and costs and informs about the legal consequences of expiry of the period in accordance with clause 10.3 and 10.4. The insurer is entitled to request compensation for the loss incurred through the delay.

10.3 If the policyholder is still in default of payment after expiry of the deadline, there will be no insurance cover from this point until payment is received, provided that the insurer informed the policyholder respectively in his request for payment according to clause 10.2 par. 2.

10.4 If the policyholder is still in default of payment after expiry of the deadline, the insurer can cancel the contract without notice provided that he informed the policyholder respectively in his request for payment according to clause 10.2 par. 3. Cancellation can also be announced when determining the payment deadline. In this case, the cancellation takes effect on expiry of the payment period if the policyholder is still in default with the payment at this time. This must be pointed out to the policyholder in the request for payment in accordance with clause 10.2 par. 3.

If the insurer has cancelled the contract and the policyholder pays the requested amount within one month after the cancellation, the contract remains in effect. There is, however, no insurance cover for insured events that occurred between the receipt of the cancellation and the payment.

11. Timeliness of payment in case of a direct debit mandate

Where the policyholder has issued a direct debit mandate, the payment shall be deemed on time if the premium can be collected on the due date and if the policyholder does not object to a justified debit. Where the insurer cannot collect the due premium through no fault of the policyholder, the payment shall also be deemed on time if it is made immediately after the insurer has sent the policyholder a written request for payment. Where the insurer cannot collect a due premium because the policyholder has revoked the direct debit mandate or if he/she is otherwise responsible that the premium could not be collected, the insurer is authorized to demand future payments be made outside the direct debiting system. The policyholder is only obliged to pay the premium when the insurer has sent him/her a written request for payment.

12. Partial payment and consequences of late payment

Where payment of the annual premium in installments has been agreed, any outstanding installments are due immediately if the policyholder is in default with the payment of an installment. The insurer may also require the premium to be paid annually in the future.

13. Premium adjustment

13.1 At the insurer's request, the policyholder is obliged to tell the insurer whether and what changes have been made to the insured risk compared with earlier information. This request may also be made by means of a note on the premium statement. The information must be provided within one month after the request was received, with proof being furnished should the insurer so require. Where incorrect information is given to the insurer's disadvantage, he shall be entitled to demand from the policyholder a contractual penalty of three times the amount of the difference in premium ascertained. This shall not apply where the policyholder proves that he/she is not responsible for the information being incorrect.

13.2 The premium shall be corrected from the time of the change (premium adjustment) on the basis of the policyholder's change notice or other findings; where insured risks cease to exist, however, the premium will only be adjusted from the time when the insurer receives the notification. The resulting adjusted premium may not fall below the contractually agreed minimum premium. Any increases and reductions in the minimum premium occurring in accordance with clause 15.1 after conclusion of the insurance contract shall be taken into account.

13.3 Should the policyholder fail to issue the notification on time, then for the period for which the information was to be given the insurer may demand an additional payment amounting to the premium already charged for that period. Where the policyholder subsequently provides the information, a premium adjustment shall take place. Any premium that the policyholder has overpaid shall only be reimbursed if the information was supplied within two months following receipt of the notification about the increased premium.

13.4 The above provisions shall also apply to insurance policies for which the premium is paid in advance for several years.

14. Premium in case of early contract cancellation

Where the contract is cancelled early, unless otherwise provided by law, the insurer shall be entitled to only that portion of the premium corresponding to the period during which insurance cover was in force.

15. Premium rate adjustment

15.1 Insurance premiums are subject to premium rate adjustment. Where premiums are calculated on the basis of payroll, contract price or amount of turnover, there shall be no premium rate adjustment. Regardless of the way in which premiums are calculated, minimum premiums shall be subject to premium rate adjustment.

15.2 An independent trustee shall determine each year, with effect for the premiums due from 1 July, the percentage by which the average of the claims payments made in the past calendar year by all insurers licensed to transact general liability insurance has increased or decreased compared to the previous year. The trustee shall round down the percentage determined to the next lower whole number divisible by five. Where an individual loss leads to special expenses being incurred in order to determine the basis and amount of indemnity, such expenses shall also be deemed to be claims payments. The average of the claims payments made in any one calendar year shall be the sum of the claims payments made in that year, divided by the number of new loss events reported over the same period.

15.3 In the event of an increase the insurer shall be entitled – and in the event of a reduction obliged – to adjust the premium for the following year by the percentage obtained from clause 15.2 (premium rate adjustment). The policyholder will be notified of the change to the premium for the following year with the next premium statement. Where the average level of the insurer's claims payments has increased in each of the last five calendar years by a lower percentage than that determined by the trustee for any of these years in accordance with clause 15.2, the insurer may increase the premium for the following year only by the percentage by which the average of the insurer's claims payments has increased in the last calendar year based on his own company figures; this increase may not exceed the one that would result under the previous paragraph.

15.4 Where the change in accordance with clauses 15.2 or 15.3 is less than five percent, there shall be no premium rate adjustment. Such change shall, however, be taken into account in subsequent years.

Duration and end of contract/Cancellation

16. Duration and end of contract

16.1 The contract is concluded for the period stipulated in the insurance policy.

16.2 Where a policy period of at least one year is agreed, the policy shall be renewed after expiry of the agreed period for a further year in each case unless the contract partner has received a cancellation at least three months prior to the expiry of the respective insurance year.

16.3 Where a policy period of less than one year is agreed, the policy shall end at the stipulated time without any notice of cancellation being required.

16.4 Where a policy period of more than three years is agreed, the contract may already be cancelled at expiry of the third year or of any subsequent year; the notice of cancellation must reach the contract partner at least three months prior to the expiry of the respective insurance year.

17. Cessation of the insured risk

Where risks cease to exist in part, in full or permanently, the respective insurance shall cease to apply. In this case, the insurer shall be entitled to the premium that he could have charged if insurance of these risks had been applied for only up to the time when the insurer became aware of their cessation.

18. Cancellation after a premium rate adjustment

Where the premium increases as a result of the premium rate adjustment in accordance with clause 15.3, without a change in the insurance cover, the policyholder may cancel the policy within one month of receiving the insurer's notification. The cancellation shall be effective immediately, but at the earliest from the time that the premium increase should have taken effect.

The insurer is obliged to inform the policyholder in the notification about the right of cancellation. The notification must reach the policyholder at least one month before the premium increase takes effect. An increase in insurance tax shall not establish any right of cancellation.

19. Cancellation following an insured event

19.1 The insurance contract may be cancelled where

- the insurer has made a compensation payment or
- the policyholder – in case of compulsory insurance the insurer – is served a legal writ in respect of a liability claim falling under the cover. The notice of cancellation must have reached the contract partner in writing at least one month after the compensation payment or the service of the writ.

19.2 If the policyholder cancels the insurance contract, his/her cancellation will take effect immediately after the insurer receives it. The policyholder may, however, stipulate that the cancellation shall take effect at a later date, though no later than the end of the current insurance period. If the insurer cancels the insurance contract, his cancellation shall take effect one month after the policyholder receives it.

20. Cancellation after sale of insured companies

20.1 Where a company for which liability insurance exists is sold to a third party, that party shall for the duration of its ownership be subrogated in the policyholder's place to the rights and obligations arising from the insurance contract. This shall also apply where a company is taken over by a third party as a result of a beneficial interest, lease agreement or similar relationship.

20.2 In this case, the insurance contract may be cancelled in writing

- by the insurer vis-à-vis the third party, subject to one month's notice,
- by the third party vis-à-vis the insurer, with immediate effect or at the end of the current insurance period.

20.3 The right of cancellation shall lapse when

- the insurer fails to exercise it within one month from the time he learns of the transfer to the third party;
- the third party fails to exercise it within one month following the transfer, with the right of cancellation continuing to exist for one month from the time when the third party becomes aware of the insurance.

20.4 Where the transfer to the third party happens during the current insurance period and the insurance contract is not cancelled, the previous policyholder and the third party shall be jointly and severally liable for the insurance premium for this period.

20.5 Where a company is transferred, the existing policyholder or the third party must notify the insurer of this immediately. Where the duty of disclosure is culpably breached, no cover shall apply in cases where an insured event occurs more than one month after the time when the insurer ought to have received the notification and the insurer would not have concluded with the purchaser the contract that existed with the seller.

The insurance cover shall be reinstated and shall apply for all insured events occurring no earlier than one month after the time when the insurer became aware of the sale. This shall apply only where the insurer has not made use of his right of cancellation in that month.

The insurance cover shall not cease, despite breach of the duty of disclosure, in cases where the insurer was aware of the sale at the time when he ought to have received the notification.

21. Cancellation after increase in risk as a result of a change in the existing legal regulations or the enactment of new ones

Where there is an increase in the insured risk as a result of a change in the existing legal regulations or the enactment of new ones, the insurer shall be entitled to cancel the insurance contract subject to a period of notice of one month. The right of cancellation shall cease if it is not exercised within one month from the time when the insurer becomes aware of the increase.

22. Multiple insurance

22.1 Multiple insurance exists where the risk is covered under several insurance contracts.

22.2 Where multiple insurance has come about without the policyholder's knowledge, he/she can ask for cancellation of the policy that was later arranged.

22.3 The right to cancel shall cease if the policyholder fails to assert it within one month of learning of the multiple insurance. The cancellation shall take effect when the insurer receives the declaration in which it is requested.

Obligations of the policyholder

23. Pre-contractual duties of disclosure of the policyholder

23.1 Providing complete and true information about risk-related circumstances

The policyholder is obliged, by the time he/she issues his/her contract statement, to provide complete and true information about all risk-related circumstances known to him/her about which the insurer has asked him/her in text form and which are material to the insurer's decision to arrange the policy with the agreed content. If the insurer asks questions within the meaning of the first sentence of this paragraph in text form after the policyholder's contract statement has been issued but before the contract has been accepted, the policyholder shall also be obliged to answer them. Risk-related circumstances are those circumstances that are material to the insurer's decision to arrange the policy at all or with the agreed content. Where a representative is acting for the policyholder and is aware of the risk-related circumstances, the policyholder shall be treated as if he/she himself/herself had known about it or had fraudulently concealed the fact.

23.2 Withdrawal

Where incomplete and incorrect information about risk-related circumstances is given, the insurer shall be entitled to withdraw from the insurance contract. This shall also apply if no information or incorrect information was given on a fact because the policyholder fraudulently concealed knowledge of the truth. Withdrawal can only take place within one month. The deadline begins at the time the insurer becomes aware of the breach of the duty of disclosure. Withdrawal takes place by way of a declaration vis-à-vis the policyholder.

23.2.2 The insurer has no right of withdrawal if the policyholder proves that the he/she or his/her representative neither acted with intent nor with gross negligence when providing incorrect or incomplete information. The insurer has no right of withdrawal due to a grossly negligent breach of the duty of disclosure if the policyholder proves that the insurer had also concluded the contract, although with different terms and conditions, had he known about the non-disclosed circumstances.

23.2.3 There will be no insurance cover in case of withdrawal. Where the insurer withdraws from the contract after the occurrence of an insured event, he is obliged to provide insurance cover if the policyholder proves that the circumstance about which he/she provided incorrect or incomplete information was not the reason for either the occurrence of the insured event or the ascertainment or extent of the benefits. There will be, however, no insurance cover in such a case if the policyholder fraudulently breached the duty of disclosure. The insurer is entitled to the part of the premium that relates to the contract period before the notice of withdrawal entered into effect.

23.3 Premium adjustment or right of cancellation

Where the insurer has no right of withdrawal because a breach of the duty of disclosure was caused neither by intent nor by gross negligence, the insurer shall be entitled to cancel the insurance contract in writing subject to a period of notice of one month. The insurer has no right of cancellation if the policyholder proves that the insurer had also concluded the contract, although with different terms and conditions, had he known about the non-disclosed circumstances.

Where the insurer cannot withdraw from the contract or cancel the contract because he had also concluded the contract, although with different terms and conditions, had he known about the non-disclosed circumstances, the remaining terms and conditions retrospectively become part of the contract at the insurer's request. If the policyholder is not responsible for the breach of obligation, the remaining terms and conditions become part of the contract from the current insurance period on.

If the insurer increases the premium by more than 10% due to alteration of the contract or if he excludes cover for the non-disclosed circumstance, the policyholder may cancel the contract in writing and without notice within one month after he/she received our notification.

The insurer has to assert his rights in accordance with clause 23.2 and 23.3 within one month in writing.

The period starts when the insurer becomes aware of the breach of the duty of disclosure that justifies his asserted right. The insurer is obliged to state the circumstances his statement is based on; within one month, the insurer can also subsequently state other circumstances to justify his statement.

The insurer is only entitled to the rights in accordance with clause 23.2 and 23.3 if he has drawn the policyholder's attention to the consequences of a breach of the duty of disclosure in writing by means of a separate notification. The insurer cannot invoke the rights stipulated in clause 23.2 and 23.3, if he was aware of the non-disclosed risk-related circumstance or the incorrectness of the disclosed information.

23.4 Cessation of rights of the insurer

The rights of the insurer in accordance with clause 23.2 and 23.3 cease with expiry of a period of five years after conclusion of the contract; this does not apply for insured events that occurred prior to the expiry of this period. The period has a duration of ten years if the policyholder or his/her representative intentionally or fraudulently breached the duty of disclosure.

23.5 Rescission

The insurer's right to rescind the contract due to fraudulent misrepresentation remains unaffected. In case of rescission, the insurer is entitled to the part of the premium that relates to the contract period before the declaration of rescission entered into effect.

24. Obligations prior to occurrence of the insured event

At the insurer's request, the policyholder must eliminate any particularly risk-related circumstances within a reasonable period of time. This shall not apply where, considering the parties' interests, elimination would be unreasonable. A circumstance that has led to a loss shall automatically be deemed to be particularly risk-related.

25. Obligations after occurrence of the insured event

25.1 The policyholder is obliged to notify the insurer immediately about every insured event, even if no claims for compensation have yet been made.

25.2 The policyholder must take steps to avert and minimize loss wherever possible. The policyholder must follow the insurer's instructions in this respect insofar as it is reasonable for him/her to do so. The policyholder is obliged to provide the insurer with detailed, truthful loss reports and assist the insurer with claims assessment and settlement. The insurer must be notified of all circumstances that in his view are important for processing the claim and any documents requested for this purpose must be forwarded.

25.3 The policyholder must likewise notify the insurer immediately if a liability claim is made against him/her, public prosecution, official or judicial proceedings are instituted against him/her, a summary notice to pay is issued, or a third party legal notice is served on the policyholder.

25.4 The policyholder must object to any summary notice to pay or any compensation order issued by the administrative authorities within the time specified, or lodge any other appeals that may be necessary. No instructions from the insurer will be required for this.

25.5 Where a liability claim is asserted against the policyholder through court action, he/she must leave the conduct of the case to the insurer. The insurer will engage a lawyer on the policyholder's behalf. The policyholder must grant the lawyer power of attorney and provide him with all necessary information and make the requested documents available to him.

26. Legal consequences in case of breach of obligations

26.1 Where the policyholder breaches an obligation arising from this contract that he/she has to fulfill prior to the occurrence of the insured event, the insurer may cancel the contract without notice and within one month after becoming aware of the breach of obligation. The insurer has no right of cancellation if the policyholder proves that the breach of obligation was neither caused by intent nor by gross negligence.

26.2 Where the policyholder intentionally breaches an obligation arising from this contract, he/she will lose his/her insurance cover. In case of a grossly negligent breach of obligations, the insurer is entitled to reduce his benefits according to the severity of the policyholder's fault.

For the policyholder to lose the insurance cover in full or in part when the breach of the obligation to provide information happened after the occurrence of the insured event, it is necessary that the insurer informed the policyholder about this legal consequence by separate written notification.

Where the policyholder proves that he/she did not breach the obligation with gross negligence, the insurance cover will continue. Insurance cover will also continue if the policyholder provides evidence that the breach of obligation was neither the cause for the occurrence or determination of the insured event nor for the determination or scope of the benefits the insurer is obliged to pay. This shall not apply if the policyholder fraudulently breached the obligation. The above conditions apply irrespective of the question if the insurer makes use of the right of cancellation that he is entitled to in accordance with clause 26.1.

Further provisions

27. Co-insured persons

27.1 Where the insurance also extends to liability claims against persons other than the policyholder, all provisions applying to the policyholder shall also be applicable to those insured persons accordingly. The provisions on automatic extension of cover (clause 4) shall not apply where the new risk arises only for a co-insured person.

27.2 The policyholder alone shall be entitled to exercise the rights arising from the insurance contract. The policyholder shall remain responsible along with the co-insured persons for fulfilling the obligations.

28. Non-assignment

Without the insurer's consent, the right of indemnity may be neither assigned nor pledged before it has been finally determined. Assignment to the injured third party is permissible.

29. Notifications, declarations of intent, change of address

29.1 All notifications and declarations intended for the insurer are to be directed to the insurer's head office or to the responsible branch office as stipulated in the insurance policy or its addendums.

29.2 Where the policyholder has failed to notify the insurer of a change in his/her address, the posting of a registered letter to the last address known to the insurer under the last name known to the insurer shall suffice for the purposes of submitting any declaration of intent to the policyholder. The declaration shall be deemed received three days after the letter is sent. The same shall apply in case of a change of the policyholder's name.

29.3 Where the policyholder has purchased insurance for his/her business establishment, clause 29.2 shall apply analogously to any relocation of the business establishment.

30. Statute of limitations

30.1 Any claims arising from the insurance contract are subject to a limitation period of three years. The period is calculated in accordance with the general conditions of the German Civil Code (BGB).

30.2 Where the policyholder has reported a claim under the insurance contract to the insurer, the limitation period shall be suspended from the report up to the time when the claimant receives the insurer's decision in text form.

31. Competent court

31.1 For actions against the insurer arising from the insurance contract, the competent court depends on the insurer's head office or branch office responsible for the insurance contract. Where the policyholder is a natural person, local responsibility also lies with the court in whose district the policyholder has his/her residence or, in the absence of such, his/her habitual residence at the time the action is brought.

31.2 Where the policyholder is a natural person, actions against the policyholder arising from the insurance contract need to be brought before the court responsible for his/her residence or, in the absence of such, his/her habitual residence. Where the policyholder is a legal entity, the competent court shall also be determined by the registered office or branch office of the policyholder. The same shall apply if the policyholder is a partnership, limited partnership, civil partnership or registered partner company.

31.3 Where the policyholder's residence or habitual residence is unknown at the time the action is brought, the competent court for actions arising from the insurance contract against the policyholder depends on the registered office of the insurer or its branch office responsible for the insurance contract.

32. Applicable law

German law applies to this contract.

General Accident Insurance Conditions of Generali Versicherung AG (AUB 2008)

§ 1 Insured event

I. The insurer provides insurance cover for accidents of insured persons during the validity of the contract. The types of benefits which can be insured are set out in § 7; the application and insurance certificate each show which types of benefits can be agreed in the policy.

II. The insurance policy covers accidents all around the world.

III. An accident shall be deemed to have occurred when the insured person has involuntarily suffered damage to his/her health due to an event (an accident) having a sudden effect on his/her body from the outside.

IV. An accident shall also be deemed to have occurred when, as a consequence of increased physical exertion to limbs or extremities or the spine,

1. a joint is dislocated or
2. muscles, tendons, ligaments or capsules are stretched, strained or torn.

§ 2 Exclusions

The following is not covered by the insurance:

I.

1. Accidents caused by mental illness or cognitive disorders, including those due to drunkenness, and strokes or seizures, epileptic fits or other spasmodic fits affecting the whole body of the insured person. Cover shall be granted, however, if such disorders, derangement, fits or paroxysms were caused by an accident under this policy.
2. Accidents that befall the insured person as a consequence of the insured person intentionally carrying out or attempting to carry out a criminal offense.
3. Accidents directly or indirectly caused by war or civil war. There is, however, insurance cover if the insured person faces sudden and unexpected war or civil war during his/her journeys abroad. Such insurance cover expires at the end of the 14th day after the outbreak of war or civil war in the country where the insured person stays.

   This expansion of cover does, however, not apply to trips in or through countries on whose territory war or civil war is already underway when the trip begins. It also does not apply to active participation in the war or civil war or to accidents caused by ABC weapons (atomic, biological or chemical weapons) and in connection with war or warlike events between the following countries: China, Germany, France, United Kingdom, Japan, Russia or USA. In case of acts of terror committed outside the territories of warring parties, the insurer will not invoke this exclusion.

   Accidents due to unrest if the policyholder participated on the side of those instigating the unrest.
4. Accidents suffered by the insured person
   a) as the pilot of an aircraft (including recreational aircraft) to the extent that this activity requires a permit under German law and as a member of the crew of an aircraft
   b) during professional activities for which an aircraft is necessary;
   c) when using spacecraft.
5. Accidents suffered by the insured person as a result of taking part in driving events, including the corresponding practice runs, with the aim of achieving high speeds as a driver, co-driver or passenger of a motor vehicle.
6. Accidents caused directly or indirectly by nuclear power.

II.

1. Health damage caused by radiation.
2. Health damage caused by therapeutic treatments or surgery, which the policyholder carries out or has carried out on his/her body. However, this exclusion does not apply if therapeutic treatments or surgery, including radiodiagnostic and radio-therapeutic treatment or surgery, is carried out as the result of an accident covered by this insurance.
3. Infections

   Insurance cover is provided if the disease pathogens entered the body through an accident injury covered by this policy. Accident injuries do not include skin or mucous membrane injuries, which are minor as such, and via which disease pathogens immediately or subsequently enter the body; this restriction does not apply to rabies and tetanus. For infections caused by treatment measures, clause 2. par. 2 applies accordingly.
4. Poisoning as a result of taking solid or liquid substances via the gullet.

III.

1. Stomach or lower abdominal hernias.

   However, insurance cover is provided if they have occurred through a violent external effect covered by this policy.
2. Damage to spinal discs as well as bleeding from internal organs and cerebral hemorrhage unless directly caused by an accident event covered by this insurance in accordance with § 1 III.

IV.

Pathological disorders as a result of psychological reactions, irrespective of their cause.

§ 3 Uninsurable persons

I. Uninsurable are persons who predominantly require the help of others in managing their daily life. These requirements are met by persons who at least classify as long-term care level II in accordance with German compulsory long-term care insurance (§ 15 par. 1 no. 2 German Social Code (SGB) XI in its version of 14 June 1996).

II. Cover and insurance policy expire as soon as the insured person is no longer insurable within the meaning of I.

III. Any premium that was paid for uninsurable persons since the contract was concluded or since the persons started to be uninsurable shall be reimbursed.

§ 3a Pre-contractual duties of disclosure of the policyholder or his/her representative prior to conclusion of the contract

I.

1. The policyholder is obliged, by the time he/she issues his/her contract statement, to provide complete and true information about all risk-related circumstances known to the policyholder about which the insurer has asked him/her in text form and which are material to the insurer's decision to arrange the policy with the agreed content. If the insurer asks questions within the meaning of the first sentence of this paragraph in text form after the policyholder's contract statement has been issued but before the contract has been accepted, the policyholder shall also be obliged to answer them. Risk-related circumstances are those circumstances that are material to the insurer's decision to arrange the policy at all or with the agreed content.
2. If another person is to be insured, he/she is also obliged to provide complete and true information about all risk-related circumstances and to also answer the questions he/she is asked by the insurer.
3. Where a representative of the policyholder concludes the contract and is aware of the risk-related circumstance, the policyholder shall be treated as if he/she himself/herself had known about it or had fraudulently concealed the fact.

II.

1. Where incomplete and incorrect information about the risk-related circumstances is given, the insurer shall be entitled to withdraw from the insurance contract. The insurer has to assert his right of withdrawal within one month in writing to the policyholder. In doing so, the insurer has to name the circumstances his statement is based on. The period starts when the insurer becomes aware of the breach of the duty of disclosure that justifies his right of withdrawal.
2. The insurer has no right of withdrawal if
   a) the policyholder proves that he/she or his/her representative neither acted with intent nor with gross negligence when providing incorrect or incomplete information;
   b) the policyholder – in case of a grossly negligent breach of the duty of disclosure – proves that the insurer had also concluded the contract, although with different terms and conditions, had he known about the non-disclosed circumstances.
3. There will be no insurance cover in case of withdrawal. Where the insurer withdraws from the contract after the occurrence of an insured event, he is obliged to provide insurance cover if the policyholder proves that the circumstance about which he/she provided incorrect or incomplete information was not the reason for either the occurrence of the insured event or the ascertainment or the extent of the benefits. There will be, however, no insurance cover in such a case if the policyholder fraudulently breached the duty of disclosure. The insurer is entitled to the part of the premium that relates to the contract period before the notice of withdrawal entered into effect.

II.

1. Where the insurer has no right of withdrawal because the policyholder's breach of the duty of disclosure was caused neither by intent nor by gross negligence, the insurer shall be entitled to cancel the insurance contract in writing subject to a period of notice of one month. In doing so, the insurer has to name the circumstances his statement is based on. The period starts when the insurer becomes aware of the breach of the duty of disclosure.
2. The insurer has no right of withdrawal if the policyholder proves that the insurer had also concluded the contract, although with different terms and conditions, had he known about the non-disclosed circumstances.

IV. Where the insurer cannot withdraw from the contract or cancel the contract because he had also concluded the contract, although with different terms and conditions, had he known about the non-disclosed circumstances, the remaining terms and conditions retrospectively become part of the contract at the insurer's request. If the policyholder is not responsible for the breach of obligation, the remaining terms and conditions become part of the contract from the current insurance period. If the insurer increases the premium by more than 10% due to alteration of the contract or if he excludes cover for the non-disclosed circumstance, the policyholder may cancel the contract in writing and without notice within one month after he/she received our notification.

V.

1. The insurer has to assert his rights in accordance with clause II. to IV. within one month in writing. The period starts when the insurer becomes aware of the breach of the duty of disclosure that entitles him to adjust the contract. In doing so, the insurer has to name the circumstances his statement is based on. Within one month, the insurer can also subsequently state other circumstances to justify his statement.
2. The insurer is only entitled to his rights in accordance with clause II. to IV. if he has drawn the policyholder's attention to the consequences of a breach of the duty of disclosure by means of a separate written notification.
3. The insurer cannot invoke his rights in accordance with clause II. to IV. if he was aware of the non-disclosed risk-related circumstance or the incorrectness of the disclosed information.

VI. The insurer's right to rescind the contract due to fraudulent misrepresentation remains unaffected. In case of rescission, the insurer is entitled to the part of the premium that relates to the contract period before the declaration of rescission entered into effect.

VII. The rights of the insurer in accordance with clause II. to IV. cease with expiry of a period of five years after conclusion of the contract. The period has a duration of ten years if the policyholder or his/her representative intentionally or fraudulently breached the duty of disclosure.

§ 4 Start and end of insurance cover/Right to alter a legal relationship

I. The insurance cover starts on the date stipulated in the insurance policy when the policyholder pays the first or single premium immediately after it is due in accordance with § 5 I.

II. The policy can be ended through written notification by one of the contracting parties

1. on expiry of the agreed period.

   The notice of cancellation must be received at least 3 months before expiry; otherwise the policy is renewed for a year each time.

2. at the end of the third or each following year if a policy is taken out for the duration of more than three years. The notice of cancellation must be received by the contracting party at least three months before the expiry of the third or appropriate following year;

3. if the insurer has made a payment in accordance with § 7 or a claim has been made against him for such a payment. The notice of cancellation must be received at least one month after the payment – or, in the event of a legal dispute, after withdrawal of the claim, acceptance, settlement or legal enforcement of the decision. If the policyholder cancels the contract, his notice of cancellation comes into effect immediately after being received by the insurer. The policyholder can, however, determine that the notice of cancellation comes into effect at a later point in time, but not later than at the end of the current insurance year. A notice of cancellation by the insurer comes into effect one month after being received by the policyholder.

III. The policy ends without notice at the date stipulated in the insurance certificate if the agreed duration is less than one year.

IV. The insurance cover shall be suspended for the insured person when he/she fulfills his/her service in a military or likewise formation that participates in war or warlike operations between the countries China, Germany, France, United Kingdom, Japan, Russia or USA. The insurance cover will continue to apply as soon as the insurer receives the notification about the end of such service.

§ 5 Premiums, due date and default

I. The premiums include the relevant insurance tax and agreed additional costs. Unless otherwise agreed, the first or single premium is due immediately on taking out the insurance policy, but not prior to the start of insurance cover. If payment of the annual premium in installments was agreed, only the first installment of the first annual premium shall be deemed to be the first premium. If not otherwise agreed, the renewal premiums are due on the first day of the due month. The payment shall be considered to be made on time if it is made at the point in time stipulated in the insurance policy or the premium statement.

II. Where the policyholder has issued a direct debit mandate, the payment shall be deemed on time if the premium can be collected on the due date and if the policyholder does not object to a justified debit. Where the insurer cannot collect the due premium through no fault of the policyholder, the payment shall also be deemed on time if it is made immediately after the insurer has sent the policyholder a written request for payment. Where the insurer cannot collect a due premium because the policyholder has revoked the direct debit mandate or if he/she is otherwise responsible that the premium could not be collected, the insurer is authorized to demand future payments be made outside the direct debiting system. The policyholder is only obliged to pay the premium when the insurer has sent him/her a written request for payment.

III.

1. In the event of payment not being made on time, the provisions of §§ 37 and 38 of the German Insurance Contract Act (VVG) apply.

2. Failure to pay the first or single premium on time shall constitute default of the policyholder 30 days after expiry of the revocation period of two weeks stipulated in the insurance policy and after receipt of a request for payment, unless he/she is not responsible for the delay of payment.

3. If the policyholder fails to pay the first or single premium on time but at a later point in time, the insurance cover only starts from this later point in time. This shall not apply if the policyholder proves that he/she was not responsible for non-payment. In case of insured events that occur prior to payment of the premium, the insurer is only exempt from his liability to pay if he informed the policyholder about this legal consequence of non-payment of the premium by separate written notification or by placing a prominent notice in the insurance policy.

4. If the policyholder does not pay the first or single premium on time, the insurer is authorized to withdraw from the contract until the policyholder makes the payment. The insurer is not allowed to withdraw if the policyholder proves that he/she is not responsible for non-payment.

5. Failure to pay a renewal premium on time shall constitute default without reminder unless the policyholder is not responsible for the late payment. Failure to pay a renewal premium on time authorizes the insurer to set a payment period of at least two weeks in writing and at the policyholder's expense. This provision is only valid if it provides details on the backlog of payments consisting of premium, interest and costs and informs about the legal consequences of expiry of the period.

   If the policyholder is still in default of payment after expiry of the deadline, there will be no insurance cover from this point until payment is received, provided that the insurer informed the policyholder respectively in his request for payment according to clause 5 par. 2.

6. Where payment of the annual premium in installments has been agreed, any outstanding installments are due immediately if the policyholder is in default with the payment of an installment. The insurer may also require the premium to be paid annually in future.

7. In case of default, the insurer is entitled to claim compensation for the loss incurred through the default of payment.

8. If the policyholder is still in default of payment after expiry of the deadline, the insurer can cancel the contract without notice provided that he informed the policyholder respectively in his request for payment according to clause III. 5. par. 2. Cancellation may already be given at the determination of a deadline. In this case, it becomes effective upon expiry of the deadline if the policyholder is still in default of payment at this point in time. The policyholder must be explicitly informed about this provision in case of cancellation in accordance with clause III. 5. par. 2.

IV. Where the contract is cancelled early, the insurer shall be entitled to only that portion of the premium corresponding to the period during which insurance cover was in force.

V. In case of § 4 IV. (military activities), the obligation to pay premiums is suspended.

§ 6 Change of job or occupation, military service

I. The amount of the sums insured or of the premium mainly depends on the job or occupation of the insured person. The basis for calculating the sums insured as well as the premiums is the prevailing occupational classification of the insurer (for details on the classification criteria, see application documents). The policyholder is therefore obliged to inform the insurer about any change of the insured person's profession or occupation immediately. Compulsory military service, civilian service or military reserve training are not considered to be changes.

II.

1. If the policyholder's new job or occupation results in a lower premium in accordance with the insurer's rates applicable at the time of the change, these lower sums insured will be valid after the expiry of one month after the change.

2. If the calculation, however, provides higher sums insured and unchanged premiums, these shall apply as soon as the insurer becomes aware of the change, but no later than one month after the change.

3. On the policyholder's request, the insurer will continue the contract with the previous sums insured and with increased or reduced premiums, as soon as the insurer becomes aware of the change.

4. If the insurer does not offer insurance cover for a new job or occupation of the insured person, the insurer can cancel the policy within one month after becoming aware of the change. The cancellation becomes effective one month after receipt.

§ 7 Types of benefits

The agreed types of benefits and their amount (sums insured) are set out in the policy. The following conditions apply for the arising of the claim and the assessment of the benefits.

I. Disability benefit

1. If the physical or mental fitness of the insured person is permanently impaired due to an accident (disability), a claim for disability benefit from the sum insured in case of disability arises. Impairment is deemed permanent if it can be expected to last more than three years and when a change of the insured person's condition cannot be expected. Disability needs to have occurred within one year after the accident. The diagnosis thereof by a physician needs to be made and the claim thereof to be asserted to the insurer before the expiry of a deadline of another three months.

2. The benefit amount is determined by the degree of disability.

   a) The following fixed degrees of disability apply – without evidence of greater or lesser disability – in the event of loss or functional incapacity of

      - an arm ..... 70 %
      - an arm up until the upper part of the elbow joint ..... 65 %
      - an arm below the elbow joint ..... 60 %
      - a hand ..... 55 %
      - a thumb ..... 20 %
      - an index finger ..... 10 %
      - another finger ..... 5 %
      - a leg above the mid-thigh ..... 70 %
      - a leg up to the mid-thigh ..... 60 %
      - a leg below the knee ..... 50 %
      - a leg up to the middle of the lower leg ..... 45 %
      - a foot ..... 40 %
      - a big toe ..... 5 %
      - other toes ..... 2 %
      - an eye ..... 50 %
      - hearing in one ear ..... 30 %
      - sense of smell ..... 10 %
      - sense of taste ..... 5 %

   b) Upon partial loss or partial loss of use of any of these parts of the body or sensory organs, the corresponding proportion of the percentage in accordance with a) is assumed.

   c) If through the accident parts of the body or sensory organs are affected, the loss or functional impairment of which is not set out in a) or b), the decisive aspect is the extent to which normal physical or mental performance is impaired from an exclusively medical point of view.

   d) If through the accident several physical or mental functions are impaired, the degrees of disability in accordance with 2. are added together. However, more than 100 % is not accepted.

3. If through the accident a physical or mental function is affected, which was already permanently impaired prior to the accident, a deduction in accordance with the degree of this pre-existing disability is made. This is assessed in accordance with 2.

4. If death occurs within one year of the accident as a result of the accident, disability benefits cannot be claimed.

5. If the policyholder dies within one year after the accident from causes unrelated to the accident – irrespective of what caused the death – and if a claim for disability benefits in accordance with 1. had arisen, payment is made in accordance with the degree of disability that could have been anticipated on the basis of the most recent medical findings.

II. Transition payment

If after the end of a period of six months of the accident and without the joint effect of illnesses or disabilities there is still accident-related impairment of

the normal physical or mental performance both at work and outside work of more than 50 percent and if this impairment has existed until then without interruption, the transition payment agreed in the policy is paid. Appropriate claims can be asserted in accordance with §9 VI.

III. Daily allowance

1. If the accident leads to impairment of the ability to work, a daily allowance is paid for the duration of medical treatment. The daily allowance is graded in accordance with the degree of impairment. Assessment of the degree of impairment depends on the job or occupation of the policyholder.
2. The allowance is paid for a maximum of one year, calculated from the day of the accident.

IV. Daily hospital allowance

1. A daily hospital allowance is paid for each calendar day the policyholder is receiving medically necessary inpatient treatment at a hospital, but only for a maximum of two years calculated as of the day of the accident.
2. Daily hospital allowance is not paid for stays in sanitariums, rehabilitation centers or health resorts.

V. Convalescence allowance

1. For the same number of calendar days for which the policyholder has received accident-related daily hospital allowance, he/she receives convalescence allowance amounting to the insured daily hospital allowance, but for a maximum duration of 4 weeks per accident.
2. Several full admissions to a hospital as a result of the same accident count as one uninterrupted stay at a hospital.
3. Convalescence allowance can be claimed on discharge from hospital.

VI. Death benefits

If the accident results in death within one year, payment of the sum insured in the event of death can be claimed. Appropriate claims can be asserted in accordance with §9 VI.

§8 Benefit restrictions

If illnesses or disabilities have also contributed to the health damage brought about by an accident or to the consequences thereof, the payment is reduced in accordance with the proportion of the illness or disability if this proportion is at least 25%.

§9 Obligations after the occurrence of an accident

I. After an accident, which is expected to result in a claim, a physician must be consulted immediately and the insurer must be informed immediately. The insured person must observe the physician's directions and must also help to reduce the consequences of the accident if possible.

II. The accident report form forwarded by the insurer must be completed truthfully and returned to the insurer immediately. Any other information requested in relation to the matter must also be provided immediately.

III. The insured person must allow himself/herself to be examined by the physicians appointed by the insurer. The costs of this, including the resulting loss of earnings, shall be borne by the insurer.

IV. The physicians who have examined or treated the insured person (also for other reasons), other insurers, insurance carriers and authorities must be empowered to provide all required information.

V. The policyholder shall be obliged to claim the transition payment at the latest seven months after the occurrence of the accident and substantiate it with a medical report.

VI. If the accident results in death, this must be notified within 48 hours, even if the accident has already been reported. The insurer must be granted the right to have a post-mortem carried out by a physician appointed by the insurer

§10 Consequences of a breach of obligations

An intentional breach of an obligation to be fulfilled after the occurrence of an accident or of an obligation in accordance with §9 or one of the obligations mentioned in the Special Conditions will result in loss of insurance cover for the policyholder. In case of a grossly negligent breach of obligations, the insurer is entitled to reduce his benefits according to the severity of the policyholder's fault.

Where the policyholder breaches an obligation to provide information, which has been in place after an insured event takes place, the insurer is only exempt from performance in full or in part if he provided the policyholder with a separate written notification about this legal consequence. Where the policyholder proves that he/she did not breach the obligation with gross negligence, the insurance cover will continue.

Insurance cover will also continue if the policyholder proves that the breach of obligation was neither the cause for the occurrence or determination of the insured event nor for the determination or scope of the benefits. This shall not apply if the policyholder fraudulently breached the obligation. The above conditions apply irrespective of the question if the insurer makes use of the right of cancellation that he is entitled to due to the breach of a pre-contractual duty of disclosure.

§11 Due date of payment

I. As soon as the insurer has received the documents which the policyholder must provide as evidence of occurrence of the accident and the consequences of the accident as well as of completion of the treatment necessary for assessing disability, the insurer is obliged to declare in writing within one month – or within three months in the case of disability claims – whether and to which extent he accepts a claim. The medical charges incurred by the policyholder as evidence of the right to receive benefits are assumed by the insurer

- in the event of disability up to 1% of the sum insured
- in the case of transition payment up to 1% of the sum insured
- in the case of daily allowance up to one daily allowance payment
- in the case of daily hospital allowance up to one daily hospital allowance payment

The insurer will not pay for any further costs.

II. If the insurer accepts the claim or if policyholder and insurer have agreed on the basis and amount, the insurer makes the payment within two weeks. Before completion of treatment, disability benefits can only be claimed within one year of the accident if and insofar as death benefits have been insured.

III. If the liability to pay has only been accepted in principle, the insurer makes appropriate advance payments at the request of the policyholder.

IV. Policyholder and insurer are entitled to have the degree of disability medically re-assessed on an annual basis, for at most up to three years after the accident. However, on the part of the insurer, this right must be exercised submitting a declaration in accordance with 1. and on the part of the policyholder prior to expiry of the respective period. If the final assessment results in higher disability benefits than already paid by the insurer, annual interest of 5 percent is payable on the additional sum.

§12 Legal relationships of persons involved in the policy

I. If the policy has been taken out for accidents that happen to others (insurance for the benefit of third parties), it is not the insured person but the policyholder who is entitled to exercise the rights in accordance with the policy. In addition to the insured person, the policyholder is responsible for fulfilling the obligations.

II. All provisions applying to the policyholder are applicable accordingly to his/her legal successors and other claimants.

III. Without the permission of the insurer, the insurance claims cannot be transferred or pledged before they are due.

§13 Notifications and declaration of intent

I. All notifications and declarations intended for the insurer are to be directed to the insurer's head office or to the responsible branch office as stipulated in the insurance policy or its addendums.

II. Where the policyholder has failed to notify the insurer of a change in his/her address, the posting of a registered letter to the last address known to the insurer under the last name known to the insurer shall suffice for the purposes of submitting any declaration of intent to the policyholder. The declaration shall be deemed received three days after the letter is sent. The same shall apply in case of a change of the policyholder's name.

III. Where the policyholder has purchased insurance for his/her business establishment, clause II. shall apply analogously to any relocation of the business establishment

§14 Statute of limitations

I. Any claims arising from the insurance contract are subject to a limitation period of three years. The period is calculated in accordance with the general conditions of the German Civil Code (BGB).

II. Where the policyholder has reported a claim under the insurance contract to the insurer, the limitation period shall be suspended from the report up to the time when the claimant receives the insurer's decision in text form

§15 Competent courts

I. For actions against the insurer arising from the insurance contract, the competent court depends on the insurer's head office or branch office responsible for the insurance contract. Where the policyholder is a natural person, local responsibility also lies with the court in whose district the policyholder has his/her residence or, in the absence of such, his/her habitual residence at the time the action is brought.

II. Where the policyholder is a natural person, actions against the policyholder arising from the insurance contract need to be brought before the court responsible for his/her residence or, in the absence of such, his/her habitual residence. Where the policyholder is a legal entity, the competent court shall also be determined by the registered office or branch office of the policyholder. The same shall apply if the policyholder is a partnership, limited partnership, civil partnership or registered partner company.

III. Where the policyholder's residence or habitual residence is unknown at the time the action is brought, the competent court for actions arising from the insurance contract against the policyholder depends on the registered office of the insurer or its branch office responsible for the insurance contract.

IV. German law applies to this contract.

Additional Conditions for Group Accident Insurance

§1 Insurance without giving a name

1. Insurance cover is provided for persons that are part of the group mentioned in the contract.
2. The persons to be insured must be named and recorded by the policyholder so that in the event of an insurance claim there can be no doubt that the injured belongs to the insured group of people.
3. At the end of the period of time for which the annual premium is proportionally paid, the insurer requests the policyholder to indicate the number of persons who were insured during this period. These details must be given by month and the highest number per month is to be indicated. Averaging is not permitted.
4. Based on the stated numbers, the insurer calculates the premium to be paid for the elapsed period of time. The policyholder receives a premium statement about the calculated numbers.
5. Insurance cover for individual people will end if their current employment or membership ends.

§2 Insurance with disclosure of names

1. Insurance cover is provided for the persons mentioned by name.
2. Uninsured persons can be registered for insurance at any time if their job or occupation and the sums insured are the same as that of the already insured persons. Insurance cover for the newly added persons is provided within the agreed scope as soon as the insurer receives their application.
3. Persons in other jobs or other occupations or with higher sums insured are only considered as insured after agreement on the sums insured and the premiums.
4. The insurer is entitled to decline the insurance of individuals due to a risk assessment. In the event of rejection, insurance cover ends one month after the date of rejection.
5. Insurance cover ends for insured persons intended to no longer be part of the contract at the earliest when we receive notification thereof.

§ 3 Contract period (Addition to § 4 of the General Accident Insurance Conditions)

1. The contract partners can end insurance cover of insured individuals by written notification if – after an accident – the insurer paid benefits to the policyholder or if the policyholder made a claim for benefits against the insurer. The notification must have been received in writing no later than one month after the payment of benefit or – in the event of a legal dispute – after the discontinuance of the action, the acknowledgement, the settlement or the final judgment by the court. Insurance cover expires one month after the notification is received.
2. The insurance policy ends if the company or association is ceased. A transfer of undertakings does not constitute a cessation of a business.
3. The insurer is entitled to cancel the insurance policy with one month's notice if insolvency proceedings have been opened over the policyholder's assets or if the application to institute such proceedings has been rejected for lack of assets.

Limitation of sums insured

1. Air passenger risk

1.1 Insurance cover for air passenger risk (see also § 2 1. (4) of the General Accident Insurance Conditions (AUB)) is provided per insured person in accordance with the agreed sums insured, but not exceeding the following sums insured:

- in the event of death ..... € 1,000,000
- in the event of disability (max. compensation in the case of 100% disability) ..... € 2,000,000
- daily allowance ..... € 250
- for daily hospital allowance/convalescence allowance ..... € 250
- for treatment costs ..... € 10,000
- for transition payment ..... € 50,000

1.2 If several persons insured by this group accident insurance are travelling in the same aircraft and if the sums insured in accordance with this policy for these persons exceed in total

- in the event of death ..... € 10,000,000
- in the event of disability (max. compensation in the case of 100% disability) ..... € 20,000,000
- for daily allowance ..... € 2,500
- for daily hospital allowance/convalescence allowance ..... € 2,500
- for treatment costs ..... € 100,000
- for transition payment ..... € 500,000

these sums are considered as maximum sums insured for the persons and the sums insured for each person are reduced accordingly.

In the case of all other accidents, the following applies:
If several insured persons are affected by the same accident, the maximum payment by the insurer for all the insured persons is limited to € 10,000,000.

Expansions of AUB 88 Version 2008 of Generali Versicherung AG

Special conditions for the insurance against poisoning as a result of vapors and gases

§ 1 III of the agreed General Accident Insurance Conditions is expanded as follows:

In the event of poisoning as a result of the sudden escape of gases or vapors, the suddenness of the event is also assumed if the insured person was involuntarily exposed to the effects of gases and vapors for several hours due to extraordinary circumstances. Occupational and industrial illnesses are, however, excluded.

Special conditions for the insurance of typical diving injuries as part of accident insurance

In addition to § 1 III of the agreed General Accident Insurance Conditions, the insurer also provides insurance cover for

- typical diving injuries such as decompression sickness (DCS) or eardrum injuries, as well as
- for death by drowning or suffocation under water, even if no accident has occurred.

Special conditions for accidents as a result of heart attack, stroke or medication

By way of derogation from § 2 I (1) of the agreed General Accident Insurance Conditions, insurance cover is provided for accidents as a result of mental illness or cognitive disorders if they were caused by heart attack, stroke or prescribed medication. Damages as a direct result of heart attack, stroke or prescribed medication are excluded from insurance cover.

Special conditions for accidents as a result of epileptic fits

By way of derogation from § 2 I (1) of the agreed General Accident Insurance Conditions, insurance cover is provided for accidents if they were caused by epileptic fits.

Special conditions for the insurance of an alcohol-induced cognitive disorder

By way of derogation from § 2 I (1) of the agreed General Accident Insurance Conditions, insurance cover is provided for accidents as a result of an alcohol-induced cognitive disorder; in case of operation of motor vehicles, however, this shall only apply if the blood alcohol level was below 1,5‰ at the time of the accident.

Special conditions for the insurance of accidents as a result of unrest/violent conflicts

§ 2 I (3) of the agreed General Accident Insurance Conditions is altered as follows:

accidents as a result of unrest or other violent conflicts are covered if the insured person did not actively participate in the acts of violence or, if he/she did actively participate but not on the side of those instigating the unrest.

Special conditions for co-insurance of passive war risk in accident insurance (BB Kriegsrisiko 92)

1. In amendment of § 2 I (3) of the agreed General Accident Insurance Conditions (AUB 88), the insurance cover extends to accidents suffered by the insured person through war-related events without him/her belonging to the active participants in the war or civil war (passive war risk).

   An active participant is also a person who supplies, transports or otherwise handles certain installations, equipment, devices, vehicles, weapons or other materials intended for waging war on behalf of a warring party. Co-insured are accidents through terrorist attacks causally connected to a war or civil war and carried out outside the territories of the warring parties.
2. The following are excluded from the insurance cover:
   - Accidents if the insured person travels to the warzone after the outbreak of the war or civil war
   - Accidents if the insured person travels to the crisis area in anticipation of a possible outbreak of war for professional reasons (journalist, cameraman)
   - Accidents as a result of the use of ABC weapons (atomic, biological or chemical weapons)
   - Accidents in connection with a war or warlike situation between world powers (China, France, Great Britain, Japan, Russia, USA)
   - Accidents in connection with a war or civil war if the state in which the insured person is domiciled or normally resides is involved as a warring party or if the war in conducted on the territory of this state.
3. Insurance cover in accordance with these Special Conditions only applies for a maximum duration of 14 days as of midnight of the day when the hostilities started.

Special conditions for the insurance of accidents as a result of taking part in unlicensed motor sport events

In amendment of § 2 I (5) of the agreed General Accident Insurance Conditions, the following is agreed:

Accidents as a result of actively taking part in authorized driving events with motor vehicles with the aim of achieving high speeds are covered by the policy if said events require no license (e.g. in case of occasional runs with rented carts at an indoor track). This expansion of the policy only applies within Europe and only for persons who have attained the age of 18 years.

Accidents as a result of radiation

In amendment of § 2 II (1) of the agreed General Accident Insurance Conditions (AUB), insurance cover is provided in the event of damages to health as a result of radiation if the damages were the result of an accident covered by the insurance policy. The exclusion of § 2 I (6) AUB (nuclear power) remains unaffected by this and is applied in its original form.

Special conditions for the insurance of infections caused by ticks

In amendment of § 2 II (3) of the agreed General Accident Insurance Conditions (AUB), insurance cover is also provided for the consequences of the infectious diseases tick-borne encephalitis (TBE) and Lyme borreliosis caused by tick bites. Insured event is the first-time infection with the causative agent of these infectious diseases. By way of derogation from § 9 AUB, the insurer is to be immediately informed when a first-time infection has been diagnosed by a physician.

By way of derogation from § 4 I. AUB, insurance cover for these infections only starts after a waiting period of one month after the start/date of change stipulated in the insurance policy. For insured events that occurred prior to the waiting period, there is no liability to pay. For the insurer to pay benefits, it is required that the evidence for the occurrence of infectious diseases is provided in the form of an objective medical report together with the appropriate laboratory results in accordance with latest medical knowledge.

Special conditions for the insurance of infections in the event of minor skin injuries

By way of derogation from § 2 II (3) of the agreed General Accident Insurance Conditions, the policy also covers infections in the case of which is it clear from the case history, findings or nature of the illness that the causative agents must have entered the body through injury to the skin, whereby at least the outer layer of the skin must have been penetrated. This expansion does not include influenza or AIDS.

Special conditions for the insurance of poisoning as a result of the ingestion of liquid or solid substances

§ 2 II (4) of the agreed General Accident Insurance Conditions is altered as follows:

poisoning as a result of the accidental ingestion of hazardous substances is covered if said substances are not food.

Special conditions for the insurance of food poisoning

By way of derogation from § 2 II (4) of the agreed General Accident Insurance Conditions, the consequences of food poisoning are covered. The policy does not cover alcohol poisoning. This does not apply, however, for children who were under the age of 10 at the time the accident occurred.

Psychological reactions

In amendment of § 2 IV of the agreed General Accident Insurance Conditions, it is deemed agreed that insurance cover is provided for the consequences of mental and nervous disorders following an accident if and insofar as such disorders are the result of an organic disease of the nervous system or of an epilepsy caused by an accident covered by the policy.

Special conditions for asserting a claim for disability benefits

By way of derogation from §7 I (1) of the agreed General Accident Insurance Conditions, disability needs

- to have occurred within 15 months after the accident; and
- to be diagnosed in writing by a physician at the latest prior to expiry of a period of another 6 months and to be asserted by the policyholder or the insured person.

Special conditions for improved disability benefits

§7 I (2) a) of the agreed General Accident Insurance Conditions and insofar as agreed, clause 1 of the Special Conditions for the Insurance of Accident Disability Benefits are altered as follows:

The following fixed degrees of disability apply – without evidence of greater or lesser disability – in the event of loss or functional incapacity of

- an arm 80%
- an arm up until the upper part of the elbow joint 75%
- an arm below the elbow joint 70%
- a hand 70%
- a thumb 28%
- an index finger 20%
- another finger 15%
  (in the event of loss of all fingers of one hand, a maximum of 70% is reimbursed)
- a leg above the mid-thigh 80%
- a leg up to the mid-thigh 70%
- a leg below the knee 60%
- a leg up to the middle of the lower leg 55%
- a foot 50%
- a big toe 15%
- other toes 8%
- an eye 50%
- in the event of loss of the other eye prior to the accident 70%
- hearing in one ear 30%
- in the event of loss of hearing in the other ear prior to the accident 45%
- sense of smell 20%
- sense of taste 15%
- a kidney if the other kidney remains unaffected 20%
- the spleen 10%
- the ability to speak 100%

Upon partial loss or partial loss of use, the corresponding proportion of the relevant percentage is assumed.

Payment of disability benefits following diagnosis

By way of partial derogation from §7 I of the agreed General Accident Insurance Conditions, the insurer will pay disability benefits amounting to the stated degree of disability immediately after a diagnosis has been made in the following cases:

Diagnosis	Share of the value of the agreed schedule of compensation
Cruciate ligament rupture	1/10 of the value for the leg above the mid-thigh
Calcaneus fracture	2/10 of the value for the foot
Ankle joint fracture	1/20 of the value for the leg above the mid-thigh
Tibia fracture	1/7 of the value for the leg above the mid-thigh
Patella fracture	1/7 of the value for the leg above the mid-thigh
Femoral neck fracture	1/7 of the value for the leg above the mid-thigh
Colles fracture or radial head fracture	1/10 of the value for the arm
Humeral head fracture	1/7 of the value for the arm
Compression fracture of a vertebral body	10% of the agreed basic sum insured for disability

The insured person's right to provide evidence for a greater degree of disability in the form of a medical opinion remains unaffected by this condition.

Special conditions for improved transition payment

§7 II of the agreed General Accident Insurance Conditions is expanded as follows:

If there is still accident-related impairment of the normal physical or mental performance of the insured person both at work and outside work and if this impairment has existed until then without interruption, the insurer will pay

a) after 3 months and 100% impairment 50% of the agreed sum insured and

b) after 6 months and an at least 50% impairment 100% of the agreed sum insured minus the payment made in accordance with a). The transition payment needs to be asserted by the policyholder or the insured person at the latest 1 month after expiry of the period stipulated under a) or b) and together with the provision of a medical certificate.

Special conditions for daily hospital allowance in the event of a treatment in medical facilities that offer both treatment and rehabilitation

In amendment of §7 IV of the agreed General Accident Insurance Conditions, the following is agreed:

If inpatient treatment takes place in a facility that offers treatment as well as rehabilitation services, the entitlement to daily hospital allowance continues to apply

- in the event of an emergency hospitalization;

or

- if the medical institution is the only hospital in the vicinity of the insured person's place of residence.

Special conditions for daily hospital and convalescence allowance in the event of an outpatient operation

By way of derogation from §7 IV of the agreed General Accident Insurance Conditions, the insurer will pay the agreed daily hospital and convalescence allowance also according to the following conditions:

1. Benefit requirements:

The insured person undergoes an operation on at least a full limb under general or regional anesthesia as a result of an accident.

2. Benefit amount

2.1 The agreed daily hospital and convalescence allowance is paid for at least 3 days.

2.2 The insurer will also pay if the accident-related operation in accordance with clause 1 is carried out as an outpatient operation, thereby preventing the need for a hospital stay.

Special conditions for extended daily hospital allowance

In amendment of §7 IV 1 of the agreed General Accident Insurance Conditions, the daily hospital allowance for accident-related inpatient hospital stays is paid within 5 years from the day of the accident, but no longer than for a maximum period of two years for the sum of all inpatient hospital stays necessary as a result of the accident.

Special conditions for the inclusion of a combination of rooming-in allowance and school absence allowance

In amendment of §7 of the agreed General Accident Insurance Conditions (AUB) and in accordance with the following conditions, the insurer will pay a

Rooming-in allowance

1. Benefit requirements:

The insured child

- is under the age of 8 at the time of the accident;
- is in medically necessary inpatient treatment as a result of the accident;

and

- a parent or legal guardian stays overnight at the hospital together with the insured child (rooming-in).

The policyholder needs to prove that these requirements have been fulfilled by providing a medical certificate. Stays at a health resort or sanitarium do not constitute medically necessary treatment.

2. Benefit amount and duration:

The insurer will pay the rooming-in allowance for a maximum period of 1 year from the day of the accident and amounting to a sum insured of € 40 for each night a parent or legal guardian spends at the hospital. The conditions of §8 AUB are taken into account.

School absence allowance

1. Benefit requirements:

The insured child

- is under the age of 8 at the time of the accident
- cannot attend a school providing general education or a similar institution for more than 6 weeks as a result of the accident; several absences from school as a result of the same accident are considered as one uninterrupted period of absence from school.

The policyholder needs to prove that these requirements have been fulfilled by providing a medical certificate and a respective statement by the school. School holidays or temporary closing of the school do not constitute school absence.

2. Benefit amount and duration:

The insurer will pay the school absence allowance from week 7 of school absence for every school day and up to a maximum period of 1 year from the day of the accident; the allowance amounts to € 40 (daily rate). The conditions of §8 AUB are taken into account.

Special conditions for the insurance against robbery or hostage-taking

In amendment of §7 of the agreed General Accident Insurance Conditions, the insurer will pay if the insured person has become the victim of robbery or hostage-taking, even if the insured person was not injured in the process.

1. Benefit requirements

The robbery or hostage-taking have been reported to and recorded by the police as a criminal act.

2. Benefit amount

Benefits are paid up to the amount of € 3,000.

Special conditions for the insurance of assistance in the event of severe injury

In amendment of §7 of the agreed General Accident Insurance Conditions, the insurer will pay benefits in the event of severe injury in accordance with the following conditions:

After an accident and in accordance with the following conditions, the insurer pays an advance payment for any of the following severe injuries:

- Paraplegia as a result of spinal cord injuries
- Amputation of at least an entire foot or of an entire hand
- Craniocerebral injuries after an unequivocally established cerebral contusion or cerebral hemorrhage

- Severe multiple injuries/polytrauma
- Fracture of two long bones in different parts of the body (e. g. leg and arm fracture) or
- Damages to two inner organs resulting in destroyed tissue or
- Combination of at least two of the following injuries: fracture of a long bone, fractured pelvis, spinal fracture, damage to an inner organ resulting in destroyed tissue
- 2nd and 3rd degree burns of more than 30% of the body surface
- Loss of sight or severe visual impairment of both eyes; in the event of visual impairment: visual acuity of not more than 1/20.

The right to benefits arises after the occurrence of the accident. The policyholder is required to provide evidence for a severe injury by means of a medical certificate. The right to benefits ceases if such claims are not asserted within one year from the day of the accident. If the insured person has several accident insurance policies with the same insurer, the respective benefits can only be claimed from one of these policies.

Benefit amount

Benefits are paid up to the amount of € 5,000.

Special conditions for the insurance of rehabilitation allowance within accident insurance

In amendment of §7 of the agreed General Accident Insurance Conditions (AUB), the insurer will pay rehabilitation allowance in accordance with the following conditions:

1. Benefit requirements:

1.1 The insured person has undergone

- a medically necessary inpatient rehabilitation measure
- as a result of an accident subject to compensation in accordance with §1 AUB
- because of the health damage or its consequences suffered through the accident
- within three years from the date of accident
- for a continuous period of at least three weeks.

The fulfilment of these requirements shall be proven by the policyholder or the insured person by providing a medical certificate.

1.2 Inpatient treatment with a focus on medical treatment of the consequences of the accident is not considered to be a rehabilitation measure.

2. Benefit amount:

Rehabilitation allowance of € 3,000 is paid once per accident in accordance with §8 AUB.

Where the insured person is covered through several accident insurance policies with the same insurer, this benefit can only be claimed for one of these policies.

Special conditions for the insurance of plastic surgery costs within accident insurance

In amendment of §7 of the agreed General Accident Insurance Conditions, the insurer will reimburse plastic surgery costs as a result of an accident in accordance with the following conditions:

1. Benefit requirements:

1.1 The insured person has undergone plastic surgery after an accident. Plastic surgery is defined herein as a separate medical treatment after the end of the regular remedial treatment with the objective to repair an impairment of the insured person's physical appearance that was a result of the accident.

1.2 Plastic surgery shall take place within three years after the accident; in case of an accident suffered by an underage person, surgery must take place before the person reaches the age of 21.

1.3 A third party is not liable to pay or denies its liability to pay.

2. Benefit type and amount:

The insurer pays up to € 10,000 in compensation for proven

- physicians' fees and other surgery expenses,
- necessary costs for accommodation and catering in a hospital.

The insurer will also reimburse proven costs for dental treatment and dentures because of full or partial loss of incisors and canines as a result of the accident.

Where the insured person is covered through several accident insurance policies with the same insurer, this benefit can only be claimed for one of these policies.

Special conditions for the insurance of rescue costs within accident insurance

In amendment of §7 of the agreed General Accident Insurance Conditions, the insurer will reimburse rescue costs in accordance with the following conditions:

1. Benefit type:

1.1 The insurer will reimburse the costs for search, rescue, or recovery operations of rescue services organized in accordance with public law or private law insofar as fees are normally charged for this. The costs will also be reimbursed by the insurer if the accident was immediately threatening or to be expected due to the specific circumstances

1.2 The insurer will reimburse the costs for transport of the injured person to the nearest hospital or to a special clinic, insofar as this is medically necessary and has been ordered by a physician

1.3 The insurer will reimburse the additional expenses in connection with the return of the injured person to the location of his/her permanent residence, insofar as the additional costs arise from what has been ordered by a physician or were unavoidable because of the nature of the injury

1.4 In case of a fatal accident, the insurer will reimburse the costs for transport of mortal remains of the insured person to his/her last permanent residence.

2. Benefit amount:

The benefit amount is limited to a total of € 25,000. Insofar as a third party (e. g. motor vehicle liability insurer, social insurance agency) is liable to pay in case of an insured event or where compensation can be claimed from other insurance contracts, such liabilities shall prevail. Where the policyholder can claim compensation from other insurance contracts, he/she is free to choose to which insurer he/she wants to report the insured event. If the policyholder reports the damage to Generali Versicherung AG, the latter will make an advance payment in accordance with the present conditions.

Where another party denies its liability for damages, the policyholder or the insured person can contact the insurer directly. In this case, potential claims against other parties liable for damages have to be assigned to the insurer. Where the insured person is covered through several accident insurance policies with the same insurer, this benefit can only be claimed for one of these policies.

Special conditions for the joint effect of illnesses or ailments

By way of derogation from §8 of the General Accident Insurance Conditions, the degree of disability or the benefit will not be reduced if the joint effect of illnesses or ailments is less than 45%.

Special conditions for family insurance within accident insurance

In accordance with the following provision, the insurer offers family insurance without the need to pay an extra premium:

1. Benefit type:

Insurance cover is provided for the below listed joining relatives of the insured person for a duration of 15 months during the validity of the present contract:

- the spouse from the date of civil marriage or the civil partner from the starting date of civil partnership,
- the natural children from their date of birth.

Insurance cover is provided within family insurance exclusively for disability benefits and – insofar as one of these types of benefit was agreed for the insured person and/or the other parent – for death benefits and daily hospital allowance.

2. Benefit amount:

The sums insured in case of disability and death as well as for daily hospital allowance are

- for the spouse 50% of the insured person's sum insured up to a maximum of € 25,000 for disability (basic sum insured) or death and a maximum of € 20 for daily hospital allowance,
- for the natural children 50% of the insured person's sum insured and the sum insured of the co-insured other parent, insofar as the co-insurance of this parent is not a result of this family insurance, up to a maximum of € 25,000 for disability (basic sum insured) and € 5,000 for death and a daily hospital allowance of € 20.

Special conditions for the evidence of the right to receive benefits

§ 11 I of the General Accident Insurance Conditions is altered as follows:

The medical charges incurred by the policyholder as evidence of the right to receive benefits are assumed in full by the insurer.

Special conditions for chemists, disinfection personnel and members of the medical professions

I. Inclusion of infections in accident insurance

Insured persons who work/are

- as chemists or disinfection personnel,
- as physicians, dentists, dental technicians, non-medical practitioners, (male) midwives, veterinaries,
- in nursing care (male or female nurses, children's nurses, nurse assistants),
- students in the field of medicine, dentistry or veterinary science

are, by way of derogation from §2 II (3) of the agreed General Accident Insurance Conditions (AUB), provided with the following insurance cover:

1. Benefit requirements:

1.1 The insured person became infected while performing his/her occupation as stipulated in the contract.

1.2 From

- the patient's medical records,
- medical findings or
- the nature of the illness

it is clear that the causative agents have entered the body in one of the ways described in clause 1.3.

1.3 The causative agents have entered the body either

- through injury to the skin, whereby at least the outer layer of the skin must have been severed, or
- through the injection of infectious substances into the eye, mouth or nose.

Being breathed on, sneezed at or coughed at are not deemed as injection. Insured persons who work in medical professions are insured, however, against diphtheria and tuberculosis.

1.4 For insured persons who work as chemists or disinfection personnel cover does not include gradually occurring harm caused by their normal work with chemicals (occupational diseases).

2. Extended cover in case of disability:

By way of derogation from §7 I. 1. AUB, disability claims can still be made where disability as a result of an infection and in accordance with the present Special Conditions

- has occurred within three years after the accident and
- has been diagnosed by a physician in writing within this period and where you have asserted this claim against us within another three months.

II. Inclusion of health damage through X-ray and laser radiation in accident insurance

Insured persons who work/are

- as chemists or disinfection personnel,
- as physicians, dentists, dental technicians, non-medical practitioners, (male) midwives, veterinaries,
- in nursing care (male or female nurses, children's nurses, nurse assistants),
- students in the field of medicine, dentistry or veterinary science,

are, by way of derogation from §2 II (1) of the agreed General Accident Insurance Conditions (AUB), provided with the following insurance cover:

The insurance cover includes health damage through X-ray and laser radiation as well as artificially generated ultraviolet radiation. Excluded from the cover are damages as a result of the normal handling of radiation generating equipment.

Special conditions for increased benefits in case of simultaneously valid motor vehicle liability insurance

Where the insured person suffers an accident as operator or passenger of a motor vehicle covered under liability insurance by Generali Versicherung AG, the potential benefits from accident insurance increase by 25%.

This only applies for the following benefit types:

- disability
- accident benefits
- daily hospital allowance
- convalescence allowance
- daily allowance
- transition payment
- damages for pain and suffering in case of bone fractures
- fatal accident,

insofar as they are actually agreed on.

Errors and omissions clause

In addition to §10 of the General Accident Insurance Conditions, the following condition shall apply:

Where the policyholder fails to make a required notification or to fulfil any other obligation, the insurer is not exempt from his liability to pay when the policyholder or the insured person proves that his/her failure was the result of an error or omission and that he/she immediately made up for it.

In case of notification of a situation that results in the payment of an additional premium, such premium must be paid retrospectively for the period during which this situation occurred.

General Insurance Conditions for the Insurance of Assistance Services (PRO TRIP-WORLD Zusatzassistance 2014) of Europ Assistance AG

I. Compensation for loss of means of payment

1. Where the insured person finds himself/herself in a financial emergency during a trip abroad as a result of theft, robbery or other loss of his/her travel funds, the insurer will establish contact to the insured person's main bank.

   If contacting the main bank is not successful within 24 hours after the working day following the notice of claim, the insured person can take out a loan with the insurer up to € 1,600 per insured event.
2. Loan payment will only be made on submission of a written unconditional letter of commitment of the insured person to the insurer to pay back the loan at the latest 30 days after receiving it.
3. Any loss in case of a suspected criminal act must be reported immediately to the responsible police department; the insured person needs to have his/her notification confirmed by the police. In any case, inquiries need to be made with and confirmed by the lost property office.

II. Compensation for loss of documents

1. Where the insured person finds himself/herself in an emergency situation during a trip abroad as a result of theft, robbery or other loss of his/her travel documents, the insurer will provide him/her with information about the responsible authorities and documents required to issue the necessary replacement documents for finishing the trip.
2. The insurer will reimburse the costs for obtaining the replacement documents required abroad to finish the trip. Any costs incurred by issuing replacement documents after the end of the trip are not covered.
3. Any loss in case of a suspected criminal act must be reported immediately to the responsible police department; the insured person needs to have his/her notification confirmed by the police. In any case, inquiries need to be made with and confirmed by the lost property office.

III. Assistance in case of criminal prosecution

1. Where the insured person is arrested or threatened to be arrested, the insurer will provide help in finding a lawyer and an interpreter.
2. The insured person can take out a loan with the insurer of up to € 12,000 for the payment of court, lawyer and interpreter fees or for the payment of a bail.
3. Loan payment will only be made on submission of a written unconditional letter of commitment of the insured person to the insurer to pay back the loan at the latest 30 days after receiving it.

IV. Return trip in case of an emergency

1. In the event of death, severe injury or unexpected serious illness of a relative, the insurer will organize the return trip from abroad and reimburse the additional expenses for travelling by train or plane (economy class).

   Relatives of the insured person according to the policy are spouses, children, parents, partners (cohabitation), life partners (in accordance with Law on Civil Partnership (LPartG)), stepparents, stepchildren, grandparents, grandchildren, siblings, parents-in-law, children-in-law, brothers-in-law and sisters-in-law.
2. In the event of damage to property of the insured person as a result of fire, acts of god or criminal acts of a third party, the insurer will organize the return trip from abroad and reimburse the additional expenses for travelling by train or plane (economy class).

   Precondition for the payment of the claim: the damage is substantial with regard to the financial situation and personal assets of the damaged party or the presence of the insured person is required for damage assessment.
3. Travel services that were not made use of will not be reimbursed. For every insurance year, the insurer will provide payment for a maximum of two insured events of this kind.

V. Arrival of a person in a position of trust in case of an emergency

1. Where the insured person undergoes inpatient treatment for more than five days during a trip abroad due to severe injuries as a result of an accident or due to unexpected serious illness, the insurer will, at the request of the insured person, organize the arrival and departure of a person in a position of trust to the hospital and from there back to his/her home; the insurer will further pay his/her travel expenses by train or plane (economy class) as well as the costs for simple accommodation. Benefits are paid per insured event up to a maximum amount of € 4,000.

VI. Special exclusions

No insurance cover is provided for benefits under IV. and V.

1. insofar as the illness is a psychological reaction to war, unrest, an act of terror, a plane crash or the fear of war, unrest or acts of terror
2. in case of chronic mental illnesses, also if they occur in phases, and in case of addiction;

VII. Obligations after occurrence of the insured event

1. The insured person has to submit the following documents to the insurer:
   a) proof of insurance, booking records and invoices;
   b) in case of severe injuries as a result of an accident and unexpected serious illness: a medical certificate; in case of mental illness: a certificate from a psychiatry specialist;
   c) death certificate in case of death;
   d) appropriate proof in case of damages to property and in case of fire or acts of god during the journey (e.g. police records);
   e) in case of loss of means of payment or loss of documents: a certificate of the lost property office and (if necessary) evidence that the loss was reported to the police;
   f) evidence for imminent or actual criminal prosecution
2. As evidence for the insured event, the insured person is further obliged to grant the insurer the right (if requested) to verify any severe injuries as a result of an accident or any unexpected serious illness by means of a certificate of a medical specialist.
3. If one of these obligations is intentionally breached, EA is exempt from its liability to pay. In case of a grossly negligent breach of the obligation, EA is entitled to reduce its benefits according to the severity of the fault of the insured person. The policyholder must prove that he/she did not act with gross negligence. EA remains liable to pay if the breach had no influence on either the ascertainment or the extent of EA's liability to pay, unless the insured person acted fraudulently.

Special conditions for personal liability and accident insurance of Generali Versicherung AG PRO TRIP-WORLD (2014)

By way of derogation from or in addition to the General Insurance Conditions, the following Special Insurance Conditions apply for the product PRO TRIP-WORLD:

I. General information

1. Insured persons

Insurance cover can be provided to all persons who are under the age of 69 at the start of insurance and who are on a temporary stay abroad.

2. Area of validity

Abroad/foreign country/-ies means all countries except the country where the insured person has his/her permanent residence. In case of an interruption of the stay abroad during the contract period for reasons of a temporary stay in the country where the insured person has his/her permanent residence, benefits are provided for immediately occurring claims on site if the insurance contract was concluded for a period of at least 3 months and if the temporary stay in the country of permanent residence, the start of which needs to be proven by the policyholder in the event of a claim, has not yet exceeded a duration of 6 weeks

3. Conclusion of the contract

a) The insurance contract comes into effect upon receipt of the correctly completed application form (e.g. by handing out the insurance policy).

b) If insurance is applied for in the valid application form issued by the insurer for this purpose and if the premium is paid, the contract is already valid (subject to receipt of the correctly completed form by the insurer) on the date of payment or transfer of the premium (date of the postmark or date on the receipt slip of the bank). The copy of the application form remaining with the applicant is deemed as the insurance policy.

c) If insurance is applied for in the valid application form issued by the insurer for this purpose and if the intended direct debit mandate is given, the contract is already valid (subject to receipt of the correctly completed form by the insurer) on the date the application is sent (date of the postmark). The copy of the application form remaining with the applicant is deemed as the insurance policy.

d) If insurance is applied for electronically through the provided online form and if the direct debit mandate is given, the contract is already valid (subject to receipt of the completed online form by the insurer) on the date the application is sent (sending date of the email). The insurance certificate electronically sent to the applicant is deemed as the insurance policy.

The following conditions apply for points a) to d): the insurance contract only comes into final effect if you made no use of your right of revocation within the revocation period. For persons who are not insurable, no insurance contract comes into effect even in case of payment or receipt of the premium. If the premium is paid for an uninsurable person nonetheless, the premium is available to the sender (less the expenses of the insurer).

4. Payment and due dates of the premiums

The premium is a single premium and is due for the entire term of the insurance after receipt of the insurance policy and after expiry of the revocation period. In case of a term of the insurance of more than one month, the parties can agree on premium payment in monthly installments; such installments are in each case deemed deferred until they are due. The first installment of the premium shall be due at the start of insurance, the subsequent installments at the start of the following month. Any deferred installments are due immediately if the policyholder is in default with the payment of an installment.

5. Contract period

The insurance contract is concluded for the single journey. The minimum term of insurance is one month, the maximum term of insurance is five years.

6. Cancellation right of the policyholder

After expiry of the term of insurance applied for, insurance cover will end automatically. Please inform us immediately if the insured person returns in advance from his/her trip. It only takes one call. You will then only have to pay the monthly premiums for the period prior to our receipt of this notification. The direct debit mandate will be stopped and we will pay back any overpaid premiums immediately in full and you don't need to pay any service fees. Where you change your au pair or host family, we will calculate the premium based exactly on the actual number of days spent in the respective family. You only need pay for the actual insurance period and not for the full month. Reimbursement starts from a minimum reimbursement amount of € 10. No service fees will be charged for reimbursement.

II. Personal liability insurance

1. Sums insured and scope of services

The total sum of benefits paid by the insurer for all insured events in one insurance year within personal liability insurance per insured person is twice the amount of the following sums insured:

- € 1,000,000 lump sum for personal injury and/or property damage
- € 100,000 for damage to rented property
- € 10,000 for damage caused during activities carried out as an intern.

Damages to a host family's immovable property are covered.

2. Special conditions for personal liability insurance

2.1 Insured risk

2.1.1 Within the agreed General Liability Insurance Conditions (AHB) and the following terms and conditions, the insurance policy covers your compulsory personal liability arising from the dangers of everyday life.

2.1.2 Excluded are the risks

2.1.2.1 of your own or an external business or commerce, profession, service or post (including honorary posts);

2.1.2.2 of a responsible position in associations of any kind;

2.1.2.3 of unusual or dangerous activities.

2.2 Family, household and sports

The policy covers your compulsory liability

2.2.1 as head of family and household (e. g. responsibility for minors);

2.2.2 as employer of persons working in your household;

2.2.3 from the use of bicycles;

2.2.4 from practicing sports, except for hunting and taking part in horse, bicycle or motor vehicle racing and the respective preparations (training)

2.3 Vehicles, aircraft or watercraft

No cover is provided for your liability as the owner, proprietor, holder or operator of motor vehicles, aircraft or watercraft as well as trailers and resulting from damages caused by the use of such vehicle/trailer.

3. Special conditions for the insurance of au pair activities

Insurance cover includes the compulsory liability of au pairs (professional liability insurance) from activities which the insured person is allowed to carry out due to his/her level of training. This protection also applies for language travelers who live in families with children and carry out activities similar to those of an au pair. The cover also includes personal injuries of the host parents and their children culpably caused by the au pair. Depending on the selected insurance tariff, the policy might also cover damage to immovable property of the host family.

4. Inclusion of damage to rented property

4.1 By way of derogation from clause 7.6 of the agreed General Liability Insurance Conditions, the cover includes your compulsory liability for property damage and all resulting financial losses to rented buildings, residential property and other rooms in buildings rented for private use.

4.2 No cover is provided for

4.2.1 liability claims arising from

- wear and tear as well as excessive use;
- damage to heating installations, machinery, boiler plants and water heating systems, and to electrical and gas appliances as well as all resulting financial losses;
- damage to glass insofar as you are able to take out a separate policy for this purpose;
- damage caused by mold;

4.2.2 rights of recourse that fall under the waiver of recourse in accordance with the agreement of fire insurers for overall insurance claims.

4.3 The maximum compensation per loss event is stipulated in the insurance policy and amounts to twice the amount of this sum for all insured events of an insurance year. The compensation for damage to rented property is set off against the sum insured for property damage.

5. Subsidiary cover

Where the insured persons are covered by other personal or professional liability insurance policies, insurance cover is only provided if and insofar as the other insurer is not liable to pay.

III. Accident insurance

1. Scope of services

The insurance policy covers occupational and non-occupational accidents worldwide (24-hour cover)

2. Sums insured

The sums insured per person are:

- € 10,000 death benefit
- € 30,000 disability benefit
- Progression (increase in the sum insured in proportion to the degree of disability) of 350%
- € 25,000 for rescue costs
- € 10,000 for plastic surgery

3. Disability classification

Special conditions for accident insurance with a progressive disability classification of 350% – if agreed

In amendment of clause 2.1 and clause 3 of the agreed General Accident Insurance Conditions, disability benefits will be paid based on the following table:

Degree of disability in % / Payment in % of the basic disability benefits

1 to 25 / 1 to 25	44 / 82	63 / 165	82 / 260
26 / 28	45 / 85	64 / 170	83 / 265
27 / 31	46 / 88	65 / 175	84 / 270
28 / 34	47 / 91	66 / 180	85 / 275
29 / 37	48 / 94	67 / 185	86 / 280
30 / 40	49 / 97	68 / 190	87 / 285
31 / 43	50 / 100	69 / 195	88 / 290
32 / 46	51 / 105	70 / 200	89 / 295
33 / 49	52 / 110	71 / 205	90 / 300
34 / 52	53 / 115	72 / 210	91 / 305
35 / 55	54 / 120	73 / 215	92 / 310
36 / 58	55 / 125	74 / 220	93 / 315
37 / 61	56 / 130	75 / 225	94 / 320
38 / 64	57 / 135	76 / 230	95 / 325
39 / 67	58 / 140	77 / 235	96 / 330
40 / 70	59 / 145	78 / 240	97 / 335
41 / 73	60 / 150	79 / 245	98 / 340
42 / 76	61 / 155	80 / 250	99 / 345
43 / 79	62 / 160	81 / 255	100 / 350

Law excerpts

§ 14 Due date of the payment

(1) Payments of the insurer are due after the end of the assessment required to determine the occurrence of an insured event and the amount of compensation payable by the insurer.

(2) If such assessment is not finished after expiry of one month since the notification of the insured event, the policyholder can request payment by installments amounting to the minimum that the insurer can be expected to be required to pay. The period shall be suspended as long as the assessment cannot be finished due to a fault of the policyholder.

(3) Any agreement under which the insurer is exempt from his obligation to pay default interest shall be invalid.

§ 28 Breach of a contractual obligation

(1) In case of a breach of a contractual obligation towards the insurer that the policyholder needs to fulfill prior to the occurrence of the insured event, the insurer may cancel the contract without notice within one month from the time he becomes aware of the breach, unless the breach is not the result of intention or gross negligence.

(2) Where the contract stipulates that the insurer is exempt from its liability to pay in case of a breach of a contractual obligation that the policyholder needs to fulfill, the insurer is only exempt from its liability to pay if the policyholder has deliberately breached the obligation. In the event of a grossly negligent breach of the obligation, the insurer shall be entitled to reduce its benefits according to the severity of the fault of the policyholder; the burden of proof for the non-existence of a grossly negligent behavior lies with the policyholder.

(3) By way of derogation from paragraph 2, the insurer is obliged to pay if the breach of the obligation was neither the cause for the occurrence or determination of the insured event nor for the determination or scope of the insurer's liability to pay. Sentence 1 shall not apply if the policyholder has fraudulently breached the obligation.

(4) Where an obligation to provide information is breached after the occurrence of the insured event, the insurer's full or partial exemption from performance according to paragraph 2 requires that the insurer has informed the policyholder in writing by separate notification about this legal consequence.

[...]

§ 86 Subrogation of claims for compensation

(1) Where the policyholder has a claim for compensation against a third party, the insurer is subrogated to this claim if he compensates the damage. This subrogation cannot be asserted to the policyholder's disadvantage.

(2) The policyholder has to assert his/her claim for compensation or any right to secure this claim properly and in due time and assist the insurer, as far as necessary, in enforcing such claim for compensation. Where the policyholder breaches this obligation intentionally, the insurer is exempt from his liability to pay insofar as he can consequently not claim compensation from the third party. In case of a grossly negligent breach of obligations, the insurer is entitled to reduce his benefits according to the severity of the policyholder's fault. The burden of proof for the non-existence of a grossly negligent behavior lies with the policyholder.

(3) If the policyholder's claim for compensation is against a person with whom he/she lived in cohabitation when the damage occurred, the subrogation in accordance with paragraph 1 cannot be asserted unless this person has intentionally caused the damage.

§ 213 Collection of personal health data from third parties

(1) The insurer is only allowed to collect personal health data from the following third parties: physicians, any kind of hospitals, nursing homes and staff, other personal insurance providers and providers of compulsory health insurance as well as employers' liability insurance associations and authorities; such collection of data is only allowed if knowledge of said data is necessary to assess the insured risk or the liability to pay and if the affected party has given his/her declaration of consent.

(2) The declaration of consent in accordance with paragraph 1 can be given prior to issuing the contract statement. The affected person must be informed about data collection as stipulated in paragraph 1 and may object to the collection.

(3) The affected person can request at any time that a collection of data is only carried out if he/she gave his/her consent for each individual data collection.

(4) The affected person must be informed about his/her rights, in particular about the right of objection in accordance with paragraph 2 when being informed about data collection.

Excerpts from the German Civil Code (BGB)

§ 195 Regular limitation period

The regular limitation period is three years.

Data protection notice

a) Data protection principles of Dr. Walter GmbH (hereinafter referred to as Dr. Walter)

The protection of your privacy and of your personal data is paramount to us. We guarantee that we will always treat your data with the utmost confidentiality. Nowadays, insurance companies can only carry out their tasks with the aid of electronic data processing (EDP). Our state-of-the-art EDP enables us to handle contractual relationships correctly, quickly and in a cost-effective manner.

Both our behavior and our tools are in accordance with the Federal Data Protection Act (BDSG) as well as with other specific regulations for online data protection. Our data protection officer ensures that our data protection principles and any relating regulations are fully met. For further information, please go to www.dr-walter.com/datenschutz.

b) Information about the use of your data by Dr. Walter

We need your personal data to process your applications and contracts, for claims handling and for individual supervision and consultancy. Collection, processing and use of your data are regulated by law. We have adopted a code of conduct for the handling of personal data that complies with the code of conduct of the German Insurance Association (GDV). Our code of conduct is based on data protection regulations of the German Insurance Contract Act (VVG), the Federal Data Protection Act as well as other significant laws but also on further measures to strengthen data protection. For more information, go to www.dr-walter.com/datenschutz/personenbezogenedaten to learn about our code of conduct with regard to handling your personal data.

Dr. Walter cooperates with several service providers in the use of health data and other data protected under § 203 German Criminal Code (StGB). At www.dr-walter.com/datenschutz/dienstleisterliste, we provide you with an overview of the service providers we work with. At your request, we can send you a printed list of the service providers as well as our code of conduct. Please contact:

Dr. Walter GmbH, Eisenerzstrasse 34, 53819 Neunkirchen-Seelscheid, Germany
T +49 (0) 2247 9194-0, F +49 (0) 2247 9194-40.

c) Responsible body

Collection of your personal data is carried out by Dr. Walter GmbH, Eisenerzstrasse 34, 53819 Neunkirchen-Seelscheid (responsible body).

d) Your rights

You have the right to obtain information free of charge about your data stored by us. You also have the right to withdraw any granted consent to the collection, processing and use of your personal data at any time and with future effect as well as the right to correct any incorrect data or to delete or block any impermissible or no longer needed data.

You can assert these rights to the above address directly against Dr. Walter. For further questions with regard to data protection, please contact our data protection officer at Dr. Walter, Eisenerzstrasse 34, 53819 Neunkirchen-Seelscheid, T +49 (0) 2247 9194-0.

Right of revocation

You can revoke your contractual declaration in writing (e. g. letter, fax, e-mail) without giving reasons within two weeks after conclusion of the contract. Timely sending of the revocation statement is sufficient for complying with the revocation period. Please send your revocation to

PROTRIP-WORLD-PLUS
Dr. Walter GmbH
Eisenerzstrasse 34
53819 Neunkirchen-Seelscheid
Germany

In case of an effective revocation, you are no longer bound to the contract. If insurance cover was provided prior to the end of the revocation period, the insurer is entitled to the part of the premium attributable to the time until the revocation is received. Any premiums paid in addition to that shall be reimbursed by the insurer.

You can use the following text sample for your revocation:

I hereby revoke the contract I concluded.

Insurance policy number:

Concluded on:

Name of the policyholder:

Address of the policyholder:

Signature of the policyholder (in case of written notification)

Date:

For more information on this product, go to

www.dr-walter.com/protrip-world-plus.html