globalhealth
Foyer Group

General Terms and Conditions

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GENERAL TERMS AND CONDITIONS

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Contractual basis

The *Insurer* underwriting the *Insurance Policy* is Foyer Global Health S.A., a health insurance company established in Luxembourg under the form of a [*société anonyme*] having its registered office at 12, Rue Léon Laval L-3372 Leudelange, registered under no. B134471 in the Luxembourg Trade and Companies Register, supervised by the Commissariat aux Assurances (11, rue Robert Stumper, L-2557 Luxembourg; +352226911-1; caa@caa.lu).

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

- the *Application Form*;
- these *General Terms and Conditions*;
- the *Glossary* included at the end of these *General Terms and Conditions*;
- the *Particular Conditions* and the relevant medical documents attached thereto;
- the *Special Conditions* and
- as the case may be, the *Terms and Conditions for Medical Assistance Services and Additional Services*.

In the event of inconsistencies between the *General Terms and Conditions*, the *Special Conditions* and the *Particular Conditions*, the *Particular Conditions* shall prevail over the *Special Conditions* and the *General Terms and Conditions*, and the *Special Conditions* shall prevail over the *General Terms and Conditions*.

1. Insurance Framework

The legal framework of the insurance cover provided under the *Insurance Policy* and any *Benefits* received thereunder result from the *Insurance Policy*, as amended from time to time, as well as all relevant applicable legal provisions.

2. General Terms and Conditions

2.1. Existence of the Insurance Policy

2.1.1. Declarations made upon entering into the Insurance Policy and throughout its term

2.1.1.1. Upon entering into the Insurance Policy

2.1.1.1.1. Duty to declare

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

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

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

2.1.1.1.2. Failure to declare, omission in declaration or inaccurate declaration

2.1.1.1.2.1. Intentional omission or inaccuracy

The *Insurance Policy* is void in the event of any intentional omission or inaccuracy affecting the aforementioned responses and declarations that misleads the *Insurer* in its risk assessment. In such circumstances, the *Insurer* shall remain entitled to premiums already paid.

2.1.1.1.2.2. Unintentional omission or inaccuracy

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

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

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

2.1.1.2. During the term of the Insurance Policy

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

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

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

If the *Policyholder* refuses the proposal to amend the *Insurance Policy* submitted by the *Insurer* or if, after a period of 1 month from receipt of the relevant proposal, the proposal has not been accepted, the *Insurer* may terminate the *Insurance Policy* within 15 calendar days.
If a *Claim* occurs before either the amendment of the *Insurance Policy* or the termination of the *Insurance Policy* has taken effect, and if the *Policyholder* has fulfilled the obligation referred to in paragraph 1 of this Article 2.1.1.2, the *Insurer* shall be obliged to pay the agreed *Benefit*.

If a *Claim* arises and the *Policyholder* has not fulfilled the obligation referred to in paragraph 1 of this Article 2.1.1.2:

a) the *Insurer* shall be obliged to pay the agreed *Benefit*, if the failure to declare is not the fault of the *Policyholder*;

b) the *Insurer* shall only be obliged to pay compensation in accordance with the proportion of the premium actually paid by the *Policyholder* to the premium that the *Policyholder* would have been required to pay if the aggravation had been taken into account, if the failure to declare is not the fault of the *Policyholder*. However, if the *Insurer* proves that it would never have insured the aggravated risk, its liability in the event of a *Claim* shall be limited to the reimbursement of the premiums paid in respect of the period following the occurrence of the relevant aggravation;

c) if the *Policyholder* has acted with fraudulent intent, the *Insurer* may refuse all *Benefits*. Premiums due up to the time when the *Insurer* became aware of the fraud shall be due to the *Insurer* as damages.

The provisions of this Article 2.1.1.2 shall not apply in respect of a subsequent change in an *Insured Party*'s state of health.

2.1.1.3. Cumulative insurance

If another health *Insurance Policy* with mandatory *Benefits* exists in addition to this policy, such mandatory health insurance shall take precedence over the *Insurance Policy*.

2.1.1.4. Right of withdrawal

If the *Insurance Policy* is entered into remotely, the *Policyholder* shall have a period of 14 calendar days to withdraw from it, without penalty and without providing an explanation or reason.

The period during which this right of withdrawal may be exercised begins to run:

- from the date on which the *Insurance Policy* is entered into remotely or
- from the date on which the *Policyholder* receives the *Insurance Policy* if this date is subsequent to the date referred to in the first indent.

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

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

Where the *Policyholder* exercises his/her right of withdrawal, he/she may only be required to pay, as soon as possible, for the insurance cover actually provided by the *Insurer* under the *Insurance Policy*, and provided that the amount due has been duly communicated to the *Policyholder*. The execution of the *Insurance Policy* may only begin after the *Policyholder* has given his/her consent. The amount to be paid:

- shall not exceed an amount proportionate to the insurance services already provided in relation to the entirety of the services provided for under the *Insurance Policy*;
- shall in no case be such as to be construed as a penalty.

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

The *Insurer* shall be obliged to reimburse to the *Policyholder*, as soon as possible and at the latest within 30 calendar days, all sums received from the *Policyholder* in accordance with the *Insurance Policy*, with the exception of the amount due by the *Policyholder* for the insurance cover actually provided and referred to in the previous paragraphs. Such 30-day period shall begin to run on the date on which the *Insurer* receives notification of the withdrawal. If reimbursement is not made within 30 calendar days, the amount due shall be increased by operation of law at the statutory interest rate applicable from the first day after expiry of the relevant payment period.

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

2.1.2. Entry into force and Effective Date

The *Insurance Policy* is deemed to have been concluded as of the date of the signature of the *Application Form* and the *Particular Conditions* by the *Insurer*, the *Policyholder* and the *Insured Party*.

However, the *Insurance Policy* and the cover and *Benefits* provided for therein enter into force and take effect on the *Effective Date*.

No *Benefits* are granted for *Claims* occurring before the *Insurance Policy* takes effect.

For newborns, health care insurance Benefits are granted as of the date of birth, with no Waiting Period, without risk assessment, if the parent has been Insured under an Insurance Policy for at least 3 months before the date of birth of the child and if the new Application Form including the newborn as an Insured Party is received by the Insurer no later than 2 months after the birth. In such case, the relevant Benefits for the newborn apply retroactively as of the child's birth. The insurance Benefits granted to the newborn as a result of a new Application may not be higher or more extensive than the Benefits granted to the parents as Insured Parties under the existing Insurance Policy. Newborns can only be insured at the tariffs applicable to any new Insurance Policy concluded as of the date of the relevant birth.

If an under-age child is adopted, then an individual medical risk assessment shall be carried out for insurance purposes. For technical reasons a surcharge of up to 500% of the tariff rate may be applied after the risk assessment.

2.1.3. Term

The *Insurance Policy* is entered into for a period of 1 year and is thereafter tacitly renewed year after year for a period of 1 year per renewal, if none of the parties opposes such renewal in accordance with the formalities and notice periods provided for under Article 2.2.3 of these *General Terms and Conditions*.

2.1.4. Premiums

2.1.4.1. Payment methods

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

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

The premium is an annual premium that can be paid in different instalments. The first premium payment is due as of the date of the signature of the *Particular Conditions* by the *Policyholder*.
Subsequent premiums are due at the renewal date of the *Insurance Policy*.

The payment terms for the premiums are specified in the *Application Form*. Any amendment to the payment terms requires the express written agreement of the *Insurer*.

For newborns that are already *Insured Parties* on the day of their birth, premiums are due as of the date of the child's birth.

2.1.4.2. Consequences of late payment

In the event of non-payment of premiums or of a fraction of a premium within 60 calendar days of the due date, the *Benefits* of the *Insurance Policy* shall be suspended after a grace period of 30 calendar days subsequent to the sending, by the *Insurer*, of a registered letter to the *Policyholder* at his/her last known place of domicile. The *Insurer* shall also send the relevant registered letter to the last known email address of the *Policyholder*.

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

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

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

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

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

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

2.1.4.3. Change of tariffs or terms and conditions

If the *Insurer* intends to change the terms and conditions of insurance and/or its tariffs, it can undertake this change only in accordance with the provisions of the amended law of 27 July 1997 on insurance policies and any subsequent legal amendments made to said law.

2.1.5. Benefits

2.1.5.1. Waiting Periods

Waiting Periods begin to run on the *Effective Date*.

Without prejudice to the *Special Conditions*, the following specific *Waiting Periods* apply to the *Insurance Policy*:

- In the case of pregnancy (as well as related complications), childbirth, psychiatric *Benefits*, psychotherapy and major dental *Benefits*, the applicable *Waiting Period* is 10 months.
- In the case of infertility *Medical Treatment*, the *Waiting Period* is 24 months for both spouses or partners.

If the *Insurance Policy* is amended in order to upgrade the *Benefits* provided thereunder, the *Waiting Periods* shall apply to the relevant new *Benefits* granted under the amended *Insurance Policy*.

2.1.5.2. Timeline for the reporting of Claims

Without prejudice to the provisions of Article 2.1.5.6 of these *General Terms and Conditions*, the *Policyholder* and/or the *Insured Party* must report any *Claim* to the *Insurer* as quickly as reasonably possible.

2.1.5.3. Obligations and formalities to be observed when making a Claim

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

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

At the request of the *Insurer*, the *Insured Party* is required to be examined by a *Medical Authority* appointed by the *Insurer*.

If the *Policyholder* and/or the *Insured Party* do not comply with one of the obligations provided for in Articles 2.1.5.2 and 2.1.5.3 of these *General Terms and Conditions*, causing a loss to the *Insurer*, the *Insurer* shall be entitled to reduce the insurance *Benefits* due under the *Insurance Policy* in proportion to the loss suffered.

If the *Policyholder* and/or the *Insured Party* do not comply with one of the obligations provided for in Articles 2.1.5.2 and 2.1.5.3 of these *General Terms and Conditions* with fraudulent intent, the *Insurer* shall be entitled to decline the cover provided for under the *Insurance Policy* and to refuse the payment of any insurance *Benefits*.

2.1.5.4. Payment of insurance benefits

If the *Policyholder* or *Insured Party* is also entitled to *Benefits* from a national health insurance fund or from another insurance body or institution, the *Insurer* is only required to cover the costs incurred by the *Policyholder* or *Insured Party* that exceed the *Benefits* already received from such other fund, body or institution.

The *Insurer* must only pay if the supporting documents and information requested from the *Policyholder* and *Insured Party* are provided to the *Insurer*. Said documents shall thereafter become the property of the *Insurer*. The *Insurer* further reserves the right to archive the relevant documents according to the applicable rules and regulations.

The invoices and proof of payment provided by the *Policyholder* and/or *Insured Party* must be original documents, which must comply with the law of the issuing country. Such invoices and proof of payment may be provided to the *Insurer* by mail, email, fax or via an upload to the client portal, provided that they are legible and that the transmission quality of the documents is high enough for them to be processed.

Notwithstanding the foregoing, the *Insurer* may at any time request to be provided with the original supporting documents.

If another insurer and/or other institution has contributed to reimbursement costs, duplicate invoices and proof of payment shall be sufficient, provided that the *Insurer* is also provided with a document evidencing the amount reimbursed by the other insurer and/or other institution.

The following information must appear on all invoices: the first name and surname, as well as the date of birth of the *Insured Party* (and any potential co-insured persons), an exact statement of the *Disease* by a *Doctor* (diagnosis) or a precise description of the whole *Disease* or a reference to an international accepted codification (e.g. International Classification of Diseases) as well as an itemised list of costs for the Medical Treatment in respect of which Benefits are to be paid, with treatment data and unit prices. For dental care, the individual teeth treated or replaced and the services relating thereto must be indicated.

The following information must be included on all medical prescriptions: the first name and surname, as well as the date of birth of the *Insured Party* (and any potential co-insured persons), the prescribed *Medication*, the price and the payment reference. Prescriptions must be provided with the *Doctor*'s invoice including the medical diagnosis and/or the bill for *Medications* and remedies.

If the *Insured Party* requests daily hospitalisation *Benefits* in lieu of reimbursement for costs, he/she must submit a certificate of inpatient treatment, which must include the first name, surname and date of birth of the person treated, the designation of the *Disease*, the dates of admission and discharge.
The *Insurer* is entitled to request that the supporting documents and information be submitted on its own forms. The relevant forms must be duly completed by the *Policyholder* or the *Insured Party* and the attending *Medical Authority*, as the case may be.

The *Insurer* is entitled to pay the *Benefits* to the person who submits the supporting documents and information in due form to the *Insurer*. In the event of doubt, the *Insurer* shall pay the reimbursement amount to the *Policyholder*, and any such payment shall validly discharge the *Insurer* from its relevant obligations under the *Insurance Policy*.

Health care costs incurred in a foreign currency shall be converted into euros at the exchange rate applicable on the date on which the supporting documents are submitted to the *Insurer*.

All supporting documents and information must be submitted in English, German or French. Any fees incurred by the *Insurer* in relation to translations of documents and information submitted in any other language may be deducted from the insurance *Benefits* granted under the *Insurance Policy*.

The rights to insurance *Benefits* granted under the *Insurance Policy* shall not be assigned, transferred or pledged.

2.1.5.5. Subrogation

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

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

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

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

2.1.5.6. Limitation period

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

The limitation period begins to run as of the date on which the event that gives rise to the relevant legal action occurs. If the person who is entitled to take action can prove that he/she became aware of the actionable event only at a later date, the limitation period shall begin to run only at such later date, without, however, exceeding 5 years from the date of occurrence of the actionable event, except in the case of fraud.

The limitation period also runs against minors or other persons who lack legal capacity.
The limitation period does not run against an *Insured Party* that is unable to act within the prescribed time period due to *force majeure*.

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

2.1.6. End of the Insurance Policy

The rights to the payment of any insurance *Benefits* under the *Insurance Policy* are automatically terminated at the date on which the *Insurance Policy* is terminated, even for *Claims* that have already occurred and/or that were reported to the *Insurer* before the termination date.

2.2. Termination

2.2.1. Automatic termination

The *Insurance Policy* shall terminate automatically if it has been suspended continuously for 2 years.

The insurance Policy shall terminate with respect to a particular *Insured Party* if one of the conditions of insurability specified in the tariffs ends for this *Insured Party*

The *Insurance Policy* shall also terminate automatically in the event of the death of the *Policyholder*. However, the surviving *Insured Parties* may renew the *Insurance Policy* by appointing a new *Policyholder*, provided that the relevant appointment is declared to the *Insurer* within 2 months following the death of the initial *Policyholder*.

A divorce or equivalent separation does not trigger the automatic termination of the *Insurance Policy*, which remains in force.

2.2.2. Optional termination

In the case of multiple covers or insured risks, the termination may relate to one or several of such insurance covers and/or risks.

2.2.2.1. Termination by the Policyholder

The *Policyholder* may terminate the *Insurance Policy* in its entirety or terminate the *Insurance Policy* for certain *Insured Parties* or tariffs at each renewal of the *Insurance Policy* upon receipt of the payment notice from the *Insurer* advising the *Policyholder* of the renewal of the *Insurance Policy*, of the due date of the next premium and of the *Policyholder's* right to terminate. The relevant termination letter must be sent by the *Policyholder* to the *Insurer* no later than 30 calendar days after the date on which the aforementioned payment notice is postmarked. The termination shall take effect on the second business day following the date on which the termination letter is postmarked, but no earlier than the date of renewal of the *Insurance Policy*.

If these *General Terms and Conditions* are amended according to Article 2.1.4.3 of these *General Terms and Conditions*, the *Policyholder* may terminate the *Insurance Policy* within 1 month of the postmarked date of the *Insurer's* dispatch of the notification letter informing the *Policyholder* of the relevant amendment. The termination shall take effect after 1 month following the date of the bailiff notification of the termination letter, the date indicated on the receipt for the termination letter or the day following the delivery of the termination letter to the postal services, as the case may be.

If the premiums are increased according to Article 2.1.4.3 of these *General Terms and Conditions*, the *Policyholder* is entitled to terminate the *Insurance Policy* within 60 days of the postmarked date of the *Insurer's* dispatch of the notification letter informing the *Policyholder* of the relevant premium increase. The termination shall take effect on the second business day following the postmarked date of dispatch of the termination letter, but no earlier than the date of renewal of the *Insurance Policy*.

The *Policyholder* may furthermore terminate the *Insurance Policy* in its entirety if the *Insurer* has terminated one or more insured risks covered by the *Insurance Policy*. The termination must occur within 1 month of the postmarked date of dispatch of the termination letter from the *Insurer* and shall take effect within 1 month following the date of the bailiff notification of the *Policyholder*'s termination letter, the date indicated on the receipt or the day following the date of remittance of the *Policyholder*'s termination letter to the postal services, as the case may be.

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

2.2.2.2. Voidness of the Insurance Policy and termination by the Insurer

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

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

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

2.2.3. Termination formalities and notice periods

Any termination of the *Insurance Policy* must be made by registered letter, by bailiff notification or by delivery of the termination letter against receipt.

Unless otherwise provided for herein, the termination shall take effect after a period of 1 month following the date of the bailiff notification of the termination letter, the date indicated on the receipt for the termination letter or the day following the delivery of the termination letter to the postal services, as the case may be.

2.2.4. Repayment of premiums in the event of termination

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

2.2.5. Limitation of liability

In the absence of gross negligence or wilful misconduct on its part, the *Insurer* shall not be liable to the *Policyholder* or the *Insured Party* for any loss, claim, liability, expense or damage arising from any action taken or omitted by the *Insurer* in connection with the provision of services or with the taking of any action contemplated under the *Insurance Policy*.

2.2.6. Force majeure

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

In the interest of all parties, the *Insurer* must comply with applicable local, European and international rules and regulations, including sanctions regulations. The *Insurer* is not required to grant or pay any insurance.

Benefits or to guarantee any insurance cover under this *Insurance Policy* if the performance of the insurance cover or the provision of a *Benefit* would expose the *Insurer* to the risk of incurring any sanction, penalty, prohibition or restriction under such rules and regulations.

2.3. Miscellaneous provisions

2.3.1. Multiple Policyholders

If there are several *Policyholders*, all the *Policyholders* are jointly and severally liable for the performance of the contractual obligations deriving from the *Insurance Policy*.

Subsequently to any partial termination of the *Insurance Policy* or other reduction in cover under the *Insurance Policy* that does not terminate the *Insurance Policy* in full, the preceding paragraph applies only in respect of the residual obligations of the *Policyholders* and in proportion to the reduction.

2.3.2. Authorisation for data processing

The *Policyholder*, who acts not only in his/her own name, but also in the name and on behalf of the other *Insured Parties*, authorises the *Insurer* to process medical or sensitive data concerning not only his/her person, but also those of the other *Insured Parties*, including if necessary for the execution or performance of the *Insurance Policy*. The *Policyholder* undertakes that the *Insured Parties* consent to, accept and authorise the relevant processing of their medical and sensitive data for the purposes of executing and performing the *Insurance Policy*.

2.3.3. Notifications

All notifications from the *Insurer* to the *Policyholder* are deemed validly made if mailed by post to the *Policyholder*'s last known address as reflected in the *Insurer*'s records. If there are several *Policyholders*, any notification of the *Insurer* that is sent to one of them is considered validly made to all.

Notifications from the *Insurer* to the *Policyholder* are deemed to have been received by the *Policyholder* 10 calendar days after the postmarked date of their dispatch by the *Insurer*.

Notifications made to the *Insurer* must be sent to the *Insurer*'s registered office, the address of which is stated in these *General Terms and Conditions*.

2.3.4. Disputes

Should a dispute arise concerning the *Insurance Policy*, the *Policyholder* must make a written complaint:

- either to the **senior management of the *Insurer***,
- or to the **Insurance Ombudsman**: c/o: Association des Compagnies d'Assurances et de Réassurances du Grand-Duché de Luxembourg (Luxembourg Insurance and Reinsurance Association), 12 rue Erasme, L-1468 Luxembourg,
- or to the **Consumer Ombudsman**: Union Luxembourgeoise des Consommateurs (Luxembourg Consumer Protection Association), 55 rue des Bruyères, L-1274 Howald,
- or to the **National Consumer Ombudsman Service**: Service National du Médiateur de la Consommation, 6 rue du Palais de Justice L-1841 Luxembourg
- or to the **Luxembourg Insurance Commission**: Commissariat aux Assurances, 11, rue Robert Stumper, L-2557 Luxembourg,

without prejudice to the possibility that the *Policyholder* may bring legal action in court.

Please also refer to the detailed out-of-court complaint resolution procedure [appended to these GTCs] [available on the *Insurer*'s website https://www.foyerglobalhealth.com/].

2.3.5. Applicable law and competent court

The *Insurance Policy* shall be governed by and construed in accordance with Luxembourg law. Matters not expressly provided for in these *General Terms and Conditions* shall be governed by the applicable provisions of Luxembourg law.

For any dispute arising under or in connection with to the *Insurance Policy*, only the courts of Luxembourg, Grand Duchy of Luxembourg shall be competent, without prejudice to the application of relevant European regulations or of international treaties or agreements.

For any claim in tort against the *Insurer*, the courts of Luxembourg, Grand Duchy of Luxembourg, shall have exclusive jurisdiction.

2.3.6. Local legislation

The *Policyholder* and/or the *Insured Party* may be subject to mandatory local health insurance legislation and obligations. The insurance cover provided under the *Insurance Policy* does not purport to comply with such local health insurance legislation and obligations and is not a substitute for any mandatory health insurance scheme that may be imposed upon the *Policyholder* and/or the *Insured Party*.

The *Policyholder* and the *Insured Party* expressly acknowledge, accept and consent to the fact that the *Insurer* may not be held liable for breaches of any local health insurance legislation or obligations to which the *Policyholder* and/or the *Insured Party* may be subject, and further expressly acknowledge, accept and agree to indemnify and hold harmless the *Insurer* against any direct or indirect loss, damage, cost, sanction, penalty, fee or other measure incurred in relation to such mandatory local health insurance legislation or obligations.

In this respect, the *Policyholder* and the *Insured Party* undertake to verify and ensure that the conclusion of the *Insurance Policy* complies with any legal requirements to which they are subject.

2.3.7. Outsourcing

As part of the performance of the *Insurance Policy* and in order to enable the optimal provision of the related insurance services according to high standards of quality, the *Insurer* relies on outsourcing service providers located in Ireland, France, Germany and the Netherlands and on cloud arrangements. In this context, information and data pertaining to the *Policyholder* and/or the *Insured Party* including, in particular, personal identification data (such as title, surname, first name, physical address, email address, telephone number and date of birth) and communication data (such as reports of exchanges by call, email, social networks or via a portal) are made available and disclosed to the relevant service providers.

The *Policyholder* and the *Insured Party* expressly acknowledge, accept, agree, and consent to the aforementioned outsourcing and use of the cloud and the related necessary transfer and disclosure of information and data.

2.3.8. Communication

The *Policyholder* and the *Insured Party* expressly require that these *General Terms and Conditions* and, more generally, the *Insurance Policy* and all supporting documents and information be submitted to the *Policyholder* and the *Insured Party* in English. The *Policyholder* and the *Insured Party* expressly acknowledge that they fully understand the English language.

Correspondence and, more generally, all other types of communications between the *Insurer*, the *Policyholder* and the *Insured Party* shall be in English.

2.3.9. Solvency and financial condition report

The solvency and financial condition report published from time to time by the *Insurer* is available on the *Insurer*'s website under the following address, https://www.foyerglobalhealth.com.

2.3.10. Guarantee Fund

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

3. Glossary

Additional Services	The additional services described in and governed by the *Terms and Conditions for Medical Assistance Services and Additional Services*.
Application Form	The application for health insurance which contains the insurance proposal within the meaning of the applicable legislation, signed by the *Policyholder* and, as the case may be, the *Insured Party*.
Claim	*Medical Treatment* of an *Insured Party* following a *Disease* or *Bodily Injury* prescribed and administered by a *Medical Authority*. The *Claim* begins on the date of the *Start of Treatment* and ends when a medical examination performed by a *Medical Authority* confirms that the treatment is no longer necessary. If the treatment must be extended for a *Disease* or due to consequences of a *Bodily Injury* not directly related to such treatment, a new *Claim* is deemed to have arisen. If the *Benefits* consist in daily *Benefits*, such *Benefits* are only due if the *Claim* results in a permanent *Incapacity to Work*. The *Claim* shall conclude when *Incapacity to Work* and treatment are no longer necessary. If the *Incapacity to Work* has been caused by several *Diseases* or *Bodily Injuries* that occurred simultaneously, the daily *Benefits* will be paid only once.
Doctor	A physician (general practitioner or specialist) or holder of a medical diploma that is recognised by law in the country in which the treatment is provided, who is authorised to provide medical care (see *Medical Treatment*).
Dressings	Material applied as a bandage.
Drugs	Active substances which are used, alone or mixed with other substances, in the diagnosis or treatment of *Disease*, ailment, *Bodily Injury* or pathological complaint. Food, cosmetics and toiletries are not considered to be *Drugs*. *Drugs* must be prescribed by a *doctor* and must be delivered by a pharmacy. *Drugs* are commonly referred to as: "medicines"; "pharmaceuticals".
Effective Date	Date on which the concluded *Insurance Policy* and the cover and *Benefits* provided for therein enter into effect, *i.e.* the date and time indicated in the *Particular Conditions* or the date of the payment of the first insurance premium, whichever is later, without prejudice to any applicable *Waiting Period*.
General Terms and Conditions	These terms and conditions governing all the risks insured by the *Insurer*.
Glossary	This glossary of defined terms, which forms an integral part of the *General Terms and Conditions* and of the *Insurance Policy*.
ICD Codes	The classification codes used under the International Classification of Diseases, an international system for coding and classification of all known diagnoses.
Incapacity to Work	When the *Insured Party* is temporarily unable to carry out his/her usual professional activity or any other gainful activity. *Incapacity to Work* must be reported by a *Medical Authority*.

Insurance Policy	The contractual framework for health insurance constituted by the *General Terms and Conditions* together with this *Glossary*, the *Special Conditions*, the *Particular Conditions,* the *Application Form* and the *Terms and Conditions for Medical Assistance Services and Additional Services*, as the case may be.
Insurer	The insurance company underwriting the *Insurance Policy*, *i.e.* [Foyer Global Health S.A.], a Luxembourg health insurance company having its registered office at [12, Rue Léon Laval, L-3372 Leudelange], registered under no. [B134471] in the Luxembourg Trade and Companies Register, supervised by the Commissariat aux Assurances (11, rue Robert Stumper, L-2557 Luxembourg; +352226911-1; caa@caa.lu).
Medication	Any substance or composition with curative properties relating to a *Disease*.
Medical Assistance Services	The medical assistance services described in and governed by the *Terms and Conditions for Medical Assistance Services and Additional Services*.
Medical Authority	A person authorised to practice medicine on the basis of a recognised and official medical degree. He/she can make a diagnosis related to a *Disease* and/or a *Bodily Injury*.
Medical Treatment	Diagnostic and therapeutic measures classified as medical services, including medical advice, aids and interventions as well as *Drugs* and *Dressings*, that serve to recognise, alleviate or cure a *Disease* or *Bodily Injury* and that are deemed *Medically Necessary* on the basis of objective medical findings and scientific knowledge at the time of treatment.
Medically Necessary	All actions that are suitable for healing or alleviating a *Disease* / an illness.
Particular Conditions	The terms and conditions specific to each individual *Insurance Policy*.
Special Conditions	The terms and conditions specifying the exact scope of the insurance cover and the insurance *Benefits* for the health insurance product subscribed to under the *Insurance Policy*.
Start of Treatment	The date on which a *Medical Treatment*, prescribed and administered by a *Medical Authority* subsequent to a *Disease* or *Bodily Injury*, commences.
Disease	The deterioration of the state of physical or mental health of the *Insured Party*, the origin and symptoms of which can be determined and objectively ascertained by a *Medical Authority* in order to diagnose and administer a *Medical Treatment*; the deterioration must not, however, be due to a *Bodily Injury*.
Benefit	The reimbursement of health care costs and expenses and/or the payment of the daily *Benefits* by the *Insurer* to the *Insured Party* subsequent to a *Claim* covered by the *Insurance Policy*.

Bodily Injury	A sudden event affecting the *Insured Party* that is beyond the *Insured Party*'s control and results in bodily harm, the cause of which is external to the *Insured Party*'s body and the symptoms of which can be determined and objectively ascertained by a *Medical Authority* in order to diagnose and administer a *Medical Treatment*.
Insured Party	The person designated in the *Particular Conditions* as the person whose health is insured under the *Insurance Policy*.
Policyholder	The person who enters into the *Insurance Policy*.
Terms and Conditions for Medical Assistance and Additional Services	The contractual terms and conditions governing the ancillary services that the *Insurer* may agree to provide to the *Policyholder* and/or *Insured Party* in connection with the insurance cover provided under the *Insurance Policy* with respect to *Medical Treatments*.
Waiting Period	Period after the *Effective Date* during which no cover and no *Benefits* are granted under the *Insurance Policy* for the risks subject to the *Waiting Period*.