Collective insurance disability "company manager"

General terms and conditions

This translation is provided as an aid for policyholders or insured parties who are English-speaking. In the event of any differences arising as to the meaning or interpretation of any part of the general conditions, only the original French/Dutch wording will be considered valid.

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Any swindle or attempt to swindle the insurance company entails not only the cancellation of the insurance agreement, but also criminal prosecution on the basis of Article 496 of the Penal Code.

For a complaint relating to the present contract, the policyholder may contact:

- In the first instance: VIVIUM's Complaints Management service, Rue Royale/Koningsstraat 151, 1210 Brussels, tel.: 02 250 90 60, e-mail: klacht@vivium.be
- For appeals: Insurance Ombudsman, Square de Meeûs/de Meeûsplantsoen 35, 1000 Brussels, www.ombudsman-insurance.be.

Such a complaint does not preclude the possibility of bringing legal proceedings.

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Article 1 Definitions

Affiliate:
The company manager who belongs to the category for which the organiser took out a collective insurance disability and who meets the conditions for affiliation.

Company manager:
The person(s) referred to in article 32 first indent, 1° and 2° of the income tax code 1992, who are attached to the company in that capacity and provided they are not bound by an employment contract.

Benefit statement:
The overview of guarantees.

Waiting period:
The waiting period is the initial period of covered incapacity for work for which no annuity is paid.

Free cover limit:
The free cover limit is the maximum annuity:
- for which no medical acceptance applies; or
- where the affiliate can rely on
  - in case of exclusion, additional premium or clause in case of medical acceptance; or
  - awaiting medical acceptance; or
  - in case of pre-existent conditions.

This annuity is laid down by the insurer by way of general measure in the context of the acceptance policy and may vary in function of the number of affiliates.

Disability / incapacity for work:
Disability is understood to be any harm to the physical integrity of the affiliate, which may lead to incapacity for work.

The disability percentage is established by means of a medical decision based on the Official Belgian Scale for the establishment of the Degree of Disability and the relevant applicable Belgian laws.

The disability is considered permanent if it can be proven that the disability will affect the affiliate for the rest of his life, without a chance of any relevant improvement, even if adequate medical treatment is provided.

When incapacity for work is referred to it is always understood to be economic incapacity for work. Economic incapacity for work is the unfitness of the affiliate to exercise any professional activity corresponding to his knowledge, skill and professional past. It is fully independent of any other economic criterion and is defined by means of a medical decision.

Organiser:
The company concluding the rules with the insurer.

Annual adjustment date:
The annual adjustment date is the date when the rights for every affiliate are recalculated in line with the elements of calculation to be taken into account at that time.

Modifications made to the elements of calculation in the course of an insurance year only take effect from the next annual adjustment date.

Change date:
The change date is the date when the rights are administratively adjusted in function of:

- change in family situation (insofar as it results in a change according to these pension rules);
- termination of the mandate of company manager;
- change of the mandate due to incapacity for work.

The change date is the first day of the month coinciding with or following one of the above-mentioned events. However, the insurer grants immediate cover as from the moment of change.

The organiser forwards the request for changes to the insurer using the modification form.

Company:
The legal entity who subscribes to a collective insurance disability for its company manager.

However, the company can only grant a right if it is a company, association, institution or institute that is lawfully incorporated, has legal personality and runs a company or is involved in profitable transactions.

Companies, organisations, institutions and institutes with legal personality incorporated under Belgian law and which are not considered to have legal personality in terms of income taxation, are not considered to be a company.

Accident:
An accident will exclusively be understood to be every sudden event which directly results in a physical injury of the affiliate and insofar as the cause or one of the causes of the injury is external to the affiliate's body.

Rules:
The general terms and conditions, the special terms and conditions and the benefit statement together form the pension rules. Any schedules and annexes to the special terms and conditions form an integral part of these rules. However, the provisions contained in the special terms and conditions and any schedules and annexes take precedence over the general terms and conditions.

The insurer reserves the right to settle all issues not expressly provided for by these special terms and conditions in accordance with the general terms and conditions.

Insurer:
VIVIUM, a brand of P&V Insurances sc/cv, insurance company authorised under code 0058.

Insurance year:
The period from the annual adjustment date of any year up to and including the day immediately preceding the next annual adjustment date.

If the rules are cancelled between two annual adjustment dates, the last insurance year will run over the period between the last annual adjustment date and the day when the rules are cancelled.

Illness:
Illness is every harm to a person's health not caused by an accident and established by a physician who is authorised to practice medicine in Belgium.

Article 2 Cover

If the affiliate suffers a disability caused by a covered event, the affiliate will be entitled, during the period of incapacity for work, to the payment or grant of the annuity mentioned in the special terms and conditions. The special terms and conditions also mention which causes of disability are covered by the guarantee.

In order to be entitled to this annuity and to remain entitled to it, the incapacity for work has to be at least 25%. The annuity is proportionally paid for a level of partial incapacity for work as of 25%. The annuity is paid in full as from a level of incapacity for work of at least 67%.

In case the level of incapacity for work changes, the amount of the annuity will be adjusted in function of the new level.

The insurer will pay the annuity as from the moment the waiting period specified in the special terms and conditions expires. The annuity is paid at the latest on the end date specified in the special terms and conditions.

In case of intervention in case of incapacity for work, the organiser and the affiliate are also exempt of paying any further premiums for this guarantee for the disabled affiliate, in proportion to the level and the duration of the incapacity for work and according to the same rules applicable to the granting of the annuity.

Article 3 Claim settlement

In case of total incapacity for work the affiliate is granted 1/365th part of the insured annuity. In case of partial incapacity for work the annuity is proportional to the level of incapacity for work.

The annuity is payable per month, for the first time 30 days after the expiry of the waiting period. The payment is settled with a proportional payment at the end of the incapacity for work.

The waiting period starts on the date established by the medical doctor as the beginning of the incapacity for work.

Article 4 Beginning and ending of affiliation

For administrative purposes, affiliation occurs on the first of the month coinciding with or following the date on which the company manager meets the imposed conditions for affiliation. However, the insurer grants immediate cover from the date on which the conditions for affiliation are met.

The affiliation is terminated on:
- the first of the month coinciding with or following the date on which the affiliate no longer meets the definition of affiliate and/or the conditions for affiliation;
- the first of the month coinciding with or following the date on which the affiliate's mandate is terminated before the maturity date;
- the maturity date;
- the date on which the affiliate dies if prior to the policy maturity date.

Article 5 Indexation after claim

If the special terms and conditions provide for an indexation after claim, the amount of the annuity will be annually increased on the anniversary of the commencement date of the incapacity for work (if the minimum level of incapacity for work is reached). This occurs by multiplying the amount of the annuity with the indexation factor equal to (1 + indexation percentage) to the n^{th} power, in which n represents the number of full years since the commencement date of the incapacity for work. The indexation percentage is specified in the special terms and conditions.

When the affiliate is no longer affected by the incapacity for work for which the cover was applied, the insured amount of the annuity is brought back to the level of before the period of incapacity for work.

Article 6 Incapacity for work of the company manager at the time of affiliation or due to an event that is not covered

In case of partial incapacity for work the following provisions apply:

- for a company manager who is partially unable to work on the day that he meets the conditions for affiliation and for an affiliate who becomes partially unable to work, the rights are proportionally adjusted in function of the level of capacity for work as of the affiliation date or the change date respectively.

In case of complete incapacity for work the following provisions apply:

- for a company manager who is completely unable to work on the day that he meets the conditions for affiliation, the affiliation will be postponed until work is resumed;
- for an employee who becomes fully unable to work, premiums are no longer due as from the change date and the collective insurance disability for the company manager in question is terminated.

On resumption of work, the premiums are again due in function of the rights that are proportionally adjusted to the affiliate's percentage of capacity for work at that time.

If the period of incapacity for work due to an event that is not covered lasts less than 30 days, the above procedure is not applied but the rights and the organiser still has to pay the premiums.

Article 7 Transfers

If the affiliation defined in the special terms and conditions is determined in function of the number of years and months that the mandate was performed with the organiser, years and full months worked elsewhere will also be taken into account:

- in case of a collective transfer of affiliates;
- in case of transfer of an affiliate within the group of companies with legal-economic ties to which the organiser belongs.

Article 8 Postponement of the maturity date

Postponement means that the policy maturity date is deferred by one year at a time (year of postponement) if the affiliate is still holding his mandate at the organiser on this date. This policy maturity date may be deferred annually for up to five years after the original policy maturity date and until not later than the affiliate's 65th birthday. The provisions of the rules remain effective during the year of postponement.

In case of incapacity for work originated before the original maturity date, the insured annuity is paid at the latest until the original maturity date. In case of incapacity for work originated during the year of postponement, the insured annuity is paid at the latest until the end of the year of postponement in course.

The affiliate is not permitted to defer the maturity date or the maturity date that has already been deferred if, on the date the year of postponement commences:
- no longer receives monthly paid remunerations; or
- is completely unfit for work.

If the affiliate is partially unfit for work on reaching the policy maturity date or the deferred policy maturity date, the postponement only relates to his rights in respect of his part-time employment.

Postponement is only possible if provided in the special terms and conditions and on the basis of the rate specified in the special terms and conditions.

Article 9 Geographical scope

The cover is valid worldwide insofar as the affiliate remains subject to the Belgian social security system.

In case of damage suffered abroad the provisions of article 17 ("Reporting a claim and medical follow-up") will still apply. Upon request of the insurer the affiliate shall see a physician in Belgium for a medical examination.

Article 10 Medical acceptance

Medical acceptance refers to defining the scope of the cover for each individual affiliate on the basis of his health. The medical condition is defined on the basis of a health statement and/or a medical questionnaire and/or medical tests carried out at expenses of the insurer. The choice of how the medical condition will be established depends on the acceptance criteria of the insurer at the time a request for affiliation or increase is submitted.

In case of medical acceptance the insurer can, if an increased risk is found, in application of its medical acceptance policy and insofar as permitted by current legislation, charge an additional premium or refuse the risk in whole or in part.

In case of a collective transfer of affiliates to this collective insurance disability without periods of interrupted guarantee, the level of guarantee in the previous collective insurance disability is taken into account to determine the medical formalities. Existing additional premiums and/or exclusion clauses remain in force. To determine the pre-existent conditions the original affiliation date is taken into account.

When an affiliate is transferred to this collective insurance disability from a company belonging to the group of companies with legal-economic ties to which the organiser belongs, the above provisions in relation to medical formalities, additional premiums, exclusion clauses and pre-existent conditions also apply, on the condition that the company manager was affiliated to the

collective insurance disability subscribed to by the previous company with the insurer and that the guarantee is continued without interruption.

Article 11 Pre-existent conditions

Injuries and disorders that previously existed if they were medically established before the date of affiliation. Injuries and disorders of which the symptoms were medically established before the date of affiliation are also pre-existent.

Affiliates who have not undergone medical acceptance, will get paid the annuity for full incapacity for work as a result of a pre-existent injury or disorders occurring within the first year after the date of affiliation, though with a maximum of the free cover limit applied by the insurer in the context of his medical acceptance policy. The annuity thus defined applies for all future incapacities for work, even after the first year has passed, as a result of such pre-existent injuries or disorders. In case of partial incapacity for work the benefit will be calculated proportionally on the basis of this annuity.

If the incapacity for work due to a pre-existent injury or disorder occurs more than one year after the affiliation date and if no incapacity for work has occurred during the first year of affiliation as a result of these injuries or disorders, the insured annuity will be paid and no upper limit will apply.

Affiliates who underwent the medical acceptance procedure and for whom pre-existent injuries or disorders were found will, regardless of the moment when full incapacity for work occurs as a result of the found pre-existent injuries or disorders, get paid the annuity that was communicated to the affiliate in writing after the medical acceptance. In case of partial incapacity for work the benefit will be calculated proportionally on the basis of this annuity.

Article 12 Financial acceptance

The insurer may request additional information to check whether the insured annuity is in accordance with its financial acceptance policy.

Article 13 Excluded risks

The guarantee does not include, incapacity for work caused, promoted or aggravated by:

- a suicide attempt of the affiliate;
- a direct consequence of revolt, civil riots, all collective acts of violence of a political, ideological or social nature, whether or not accompanied by rebellion against the government or any established power whatsoever;
- as a result of an event of war, i.e. an event which is the direct or indirect consequence of an offensive or defensive action by a warring power or any other event of a military nature;
- the consequences of an accident involving an aircraft on which he/she embarked as pilot or member of the flight crew;
- an accident involving an aircraft on which the affiliate embarked as passenger, where an aircraft is involved:
  - which the affiliate knew or could have known had no flying licence for the transport of persons or goods;
  - of an air force with is not intended for passenger transport;
  - that transports products with strategic characteristics in areas where hostilities are in progress or rebellion prevails;
  - which is preparing for or participating in a sports competition;
  - which is carrying out test flights;
  - of the "ultra light motorised" type;

- by the effect of the change of a material's atomic structure, artificial acceleration of the atomic particles and radiation of radioisotopes, unless for the performance of medical and/or paramedical professions;
- due to plastic surgery, of any kind;
- by chronic abuse of alcohol, narcotics or drugs, addiction or any other form of toxicomania;
- by subjective or psychological disorders, except if the diagnosis thereof is supported by organic signs or objective symptoms;
- an allergic disorder with a disability of less than 25%.
- by a pregnancy or childbirth, unless as from the start of the fourth month after the delivery. A pathological pregnancy is, however, covered insofar as the incapacity for work is not the result of unhealthy working conditions.
  A pathological pregnancy is understood to be the pregnancy complications, both for the insured party and her fetus, as a result of a pathological or abnormal condition.
  Unhealthy activities are activities involving exposure to a professional risk causing a hazard, either or not potential, for the mother and/or the fetus, such as:
  - working with chemical substances;
  - working with infectious agents;
  - working with ionising radiation;
  - working with cytostatics (such as e.g. anti cancer drugs);
  - works involving lifting loads;
  - working in high temperatures;
  - working nights.

Sports

The risks involved in doing sports are guaranteed, except when the fact leading to the claim occurred:

- as a result of professional sportsmanship or doing sports in the context of a contract of employment, even as a secondary activity, including training exercises;
- as a result of participating in an attempt on a record, explorations or sporty expeditions.

Article 14 Criminal intent and gross negligence

The cover does not include incapacity for work caused, promoted or aggravated by:

- a deliberate act committed by the person who has an interest in the benefit, aided and abetted by him; a deliberate act committed with the intention of causing injury to the affiliate.

- the cases of gross negligence committed by the affiliate or the person interested in the benefit as listed below:

  - any participation in crimes, offences or fights, which are either or not the result of a provocation or dispute, except cases of legal self-defence;
  - obvious reckless acts of which it is known that they form a threat to the physical integrity, unless in cases of saving persons or goods;
  - obvious reckless acts, committed by a third party with the approval of the affiliate or any other person with an interest in the benefit, which cause injury/damage to the affiliate;
  - being under the influence of alcoholic beverages or narcotics or drugs, except if there is no causal relation between this condition and the claim.

Article 15 Relapse

A relapse means the affiliate is unable to work as a result of a previously covered accident or sickness.

In case of a relapse within 30 days no new waiting period will be applied.

The annuity at the start of the continued incapacity for work is the same as the annuity last paid during the previous period of incapacity for work, as if there had been no interruption of the incapacity for work.

Article 16 Restriction of the annuity

If the level of incapacity for work can be reduced by means of a surgical intervention, a special treatment or wearing a prosthesis and the affiliate refuses to undergo such treatment or use such aids, the insurer will only have to pay the reduced benefit as if the affiliate had undergone such treatment or used such aids and insofar as the thus reduced level of incapacity for work qualifies for compensation.

Article 17 Reporting a claim and medical follow-up

Claims that may give rise to an intervention must be notified to the insurer within 30 days at the latest. In the event of late notification, the insurer may reduce its intervention by the loss it has incurred, unless evidence is supplied that the accident report was submitted as soon as reasonably possible.

The report must be made using the form intended for this purpose and must be accompanied by all original documents, certificates and reports which can demonstrate the existence and seriousness of the accident.

The medical reports of the attending physician will be submitted by the affiliate to the insurer's consulting physician. The insurer may request additional information from the affiliate or invite him to undergo additional medical examinations.

Where appropriate, the insurer will await the results before adopting a standpoint on whether or not the claim is covered.

If one of these obligations is not met, the insurer may reduce its intervention by the loss it has incurred.

The affiliate will report within 15 days after their detection any changes in his health condition which results or may result in an increase or reduction of his level of incapacity for work. The granted annuity will be adjusted to the changes of the level of incapacity for work. The insurer is entitled to reclaim any wrongfully paid sums, plus interest at the statutory rate.

If false reports are presented, false declarations are given or certain facts of circumstances are deliberately withheld which are clearly of importance in assessing the claim, the insurer may refuse its intervention and demand back any sum unduly paid, plus interest at the statutory rate.

Article 18 Beginning and termination of the guarantee

The cover period starts and ends at the latest on the respective date indicated in the special terms and conditions. The rules do not become effective before the insurer received the first premium.

Article 19 Duration and cancellation of the rules

The rules are concluded for a duration of 1 year. Barring notice, the rules are automatically renewed for one year at the end of every insurance year.

Both the organiser and the insurer can cancel these rules, by registered letter, on every annual adjustment date, provided a notice period of at least three months is observed.

The organiser can also terminate the rules by registered letter at least three months before the anniversary of the insurance's effective date.

Article 20 Rate change

When the insurer changes the rates, the organiser is entitled to cancel the rules. The rate change shall be notified at least 4 months before the rules' annual adjustment date and the organiser can cancel the rules within one month after the notification by means of registered letter. If the rate change is notified within 4 months before the annual adjustment date, the organiser can give notice within a term of three months after the notification.

Article 21 Obligations of the insurer when the rules are terminated

When the rules are terminated, for any reason whatsoever, the insurer will intervene for every covered incapacity for work that started before the date when the rules were terminated.

No intervention will take place for the aggravation of this incapacity for work which started after the rules are terminated. A doctor will establish the date of the start or aggravation of the incapacity for work.

Article 22 Premium payment

The insurer provides the organiser with a periodical paying-in slip of the premium to be paid. The frequency of premium payment is specified in the special terms and conditions.

When the premium is not paid on the due date, the insurer will send a registered notice to the organiser. If the premium is not paid within the set payment term, the insurer can suspend the coverage or cancel the rules.

The suspension of the cover ends on the day following payment of the premium arrears, increased with interests and costs, to the insurer.

Article 23 Premiums and taxes due

Premiums fall due for each affiliate:
- the premiums are due as of the administrative affiliation for the respective rights;
- if affiliation commences during a year of insurance, the premiums are payable on a pro rata basis for that year.

Amending and cancelling the premium due date:
- when amending rights or items used for the calculation, the due date for new premiums takes effect on the annual adjustment or change date;
- if the affiliate does no longer comply with the conditions of affiliation, the payment of premiums will no longer be due as from the first day of the month coinciding with or following the resignation;

- when reaching the maturity date;
- when the affiliate dies, premiums are no longer due as of the due date preceding the death, unless premiums are paid at the beginning of the period, premiums will no longer be due on the due date following the death.

Taxes are due as of the moment that premiums are due.

The premiums and taxes are paid by the organiser to the insurer on the due date.

The organiser withholds any premiums and taxes to be paid by the affiliate from his remuneration in the same instalments as those in which the remuneration is paid.

Article 24 Termination of the mandate of an affiliate

If an affiliate terminates his mandate with the organiser, the insurer is obliged to pay the compensations related to any guaranteed incapacity for work that started during his mandate with the organiser.

No interventions will take place for any aggravations of the incapacity for work started after the mandate was finished. A doctor will establish the date when the incapacity for work starts or becomes worse.

Article 25 Data protection

The data relating to the affiliate are entered in files kept to be able to draw up, manage and implement the insurance agreements.

Pursuant to the Act of 8 December 1992 on the protection of privacy concerning the processing of personal details and any later amendment which replaces and/or supplements the binding provisions of this Act, the affiliate may inspect his personal details and have them corrected if necessary.

P&V Insurances sc/cv is responsible for the processing.

Article 26 Violations of the duty of disclosure

If the organiser deliberately concealed or incorrectly reported information about the risk, thus misleading the insurer in the assessment of the risk, the rules will be null and void.

If the affiliate commits such a violation of the duty of disclosure, the rules will be null and void vis-à-vis that affiliate.

The premiums due up to the moment the insurer became aware of the deliberate concealment or deliberate incorrect information will be payable.

Article 27 Medical disputes

Disputes about medical matters can be settled in an out-of-court medical expertise, provided the insurer and the person to be examined or his representative agree. Both parties each appoint their own doctor. The third party doctor appointed by both doctors will only intervene when no agreement can be reached between both doctors.

Every party will pay the fees and expenses of the doctor appointed by it. The fees and expenses of the third party doctor and the specialised tests will be paid by both parties, for 50% each.

However, on pain of nullity of their decision, the doctors may not deviate from the provisions of the rules.

Article 28 Correspondence

Letters will be validly sent to the address stated by the addressee. If one of the parties changes address, the new address shall be notified to the other party without delay. If a party fails to communicate the new address, letters will be validly sent to the previous address.