FIRST' EXPAT+//RELAIS' EXPAT+
MEMBERS' GUIDE - LIFE & DISABILITY

// INFORMATION BOOKLET AND GENERAL TERMS & CONDITIONS

MSH INTERNATIONAL on behalf of asfe
SIACI SAINT HONORE GROUP

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MEMBERS' GUIDE - LIFE & DISABILITY

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SUMMARY

1 / PRESENTATION OF ASFE AND ITS ADMINISTRATOR MSH INTERNATIONAL

You have chosen an ASFE international insurance plan from Groupama Gan Vie, managed by MSH INTERNATIONAL, and we are delighted to welcome you as a member.
ASFE, the Association of Services For Expatriates, was created in 1992 and is governed by the French law of 1901 on associations. Its purpose is to provide expatriates all over the world with solutions in the fields of healthcare coverage, life & disability, medical assistance / repatriation and third-party liability. Throughout this document AFSE will be referred to as "**ASFE**" or the "**Contracting association**".
MSH INTERNATIONAL, the designer and **Administrator** of ASFE plans, is a world leader in international benefits with over 330,000 globally-mobile individuals insured worldwide. **MSH INTERNATIONAL** provides you with the services of a dedicated team which is on hand to support and advise you day after day. **MSH INTERNATIONAL**, an organization mandated by the **Insurer** and the **Contracting Association** to administer the plan will be referred to throughout this document as "**MSH INTERNATIONAL**", "the **Administrator**", "the **Administrating Organization**" or "the **Insurer**" whenever this term is used in the context of the administrative management of the plan.
The plan is insured by **Groupama Gan Vie** – a French société anonyme with a capital of 1,371,100,605 euros (fully paid) - RCS Paris 340 427 616 - APE 6511 Z Head office: 8-10 rue d'Astorg - 75383 PARIS Cedex 08 - Company regulated by the French Insurance Code and subject to the Prudential Supervision Authority (ACP) - 61 rue Taitbout - 75009 Paris hereinafter referred to as "the **Insurer**".

2 / GENERAL PROVISIONS OF THE LIFE & DISABILITY BENEFITS

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2.1 / GENERAL

ARTICLE 1 – PURPOSE OF THE INSURANCE

The purpose of this group insurance plan with optional membership is:
- the payment of a lump sum to the designated beneficiaries in the event of the member's death (Article 4),
- the payment of a lump sum to the member him / herself in the event of permanent total disability (Article 5),

and, if optional benefits have been purchased by the member:
- the payment of an additional lump sum to the designated beneficiaries in the event of the accidental death of the member (Article 6),
- the payment to the member of a lump sum proportional to the degree of infirmity, in the event of his or her total or partial infirmity (Article 7),
- the provision to the member of benefits in the event of sick leave from work following an illness or accident (Article 8),

In respect of this Sick Leave benefit, three options are available to the member: "Standard Sick Leave benefit", "Short-Term Disability benefit" and "Long-Term Disability benefit". Reference numbers specific to each particular plan, as described in Article 3 below, are assigned to these different options.
The benefits and options purchased by the member are shown on the Certificate of enrollment.

ARTICLE 2 – DEFINITIONS AND GEOGRAPHICAL LIMITS

• DEFINITION

Accident: Any physical injury, not intended by the member or the dependent, resulting from sudden action with an external cause. In accordance with Article 1315 of the French Civil Code, it is the responsibility of the beneficiaries to provide evidence of the accident and the direct relationship of cause and effect between the accident and the death.
Basic social security scheme: Any social security scheme in force in the country of expatriation or the Caisse des Français à l'étranger – CFE.
Certificate of enrollment: Document issued to each member confirming their enrollment in the plan and specifying, in particular, the benefits and level of coverage selected, the effective date and the premiums.
Contracting association: ASFE: Legal entity which provides the plan to its members and agrees to fulfill the corresponding obligations.
FOC: French Overseas Communities (Saint Pierre and Miquelon, Wallis and Futuna, Saint-Barthélemy and Saint-Martin).
FODR: French Overseas Departments and Regions (Guadeloupe, Guyana, Martinique, Reunion and Mayotte).
Hospitalization: A stay in a hospital (public or private) for medical or surgical treatment of an illness, accident or maternity. Home hospitalization is an alternative to conventional hospitalization and allows the patient to be cared for in their own home.
Illness: Any deterioration in the state of health certified by a competent medical authority.
Member: Member of the contracting organization requesting enrollment in this plan and meeting the conditions set out in Article 12.

• GEOGRAPHICAL LIMITS

Coverage applies in the country of destination located anywhere in the world as well as in France and in the FODRs and FOCs. However, coverage also applies for periods of not more than 60 consecutive days between two stays in the country of destination during international trips out of the country of destination (in a private capacity).

It is specified that, based on events (war or civil war, insurrection, etc.) which may occur there and, in any event, in accordance with the designation of countries at risk issued by the French Ministry of Foreign Affairs, enrollment in the plan may be excluded for certain countries to which travel is strongly discouraged by the ministry (red zone) or subject to prior acceptance by the insurer if travel to that country is discouraged by the ministry unless for compelling reasons (orange zone).

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

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

• LANGUAGE OF THE PLAN

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

• CURRENCY OF THE PLAN

The currency of the plan is the euro. However, MSH INTERNATIONAL gives members the option of using the US dollar for their membership, both for the premiums and the benefits.
The currency selected by the member is shown on the certificate of enrollment. For the insurer, the premiums and benefits are in all cases payable in euros.
A particular reference number, as described in paragraph below, is assigned to the plan according to whether the membership operates in euros or dollars.

IMPORTANT

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

• REFERENCE NUMBERS USED IN THE PLAN

The plan uses the following reference numbers:

1. **Membership in euros:**
   - n° 509 / 863693 in all cases, other than those where Short-Term Disability benefit and / or Long- Term Disability benefit have been purchased by the member,
   - n° 509 / 863694 where Short-Term Disability benefit and / or Long-Term Disability benefit have been purchased by the member.

2. **Membership in dollars:**
   - n° 509 / 863693 / 10 in all cases, other than those where Short-Term Disability benefit and / or Long-Term Disability benefit have been purchased by the member,
   - n° 509 / 863694 / 10 where Short-Term Disability benefit and / or Long-Term Disability benefit have been purchased by the member.

2.2 / BENEFITS

PREAMBLE – INSTRUCTIONS TO MEMBERS FOR CLAIMING BENEFITS

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

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

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

ARTICLE 4 – DEATH OF THE MEMBER

• DEFINITION AND AMOUNT OF THE BENEFIT

The purpose of this benefit is to pay a lump sum in the event of the death of the member to the designated beneficiaries listed in paragraph below. This payment is subject to the provisions of paragraph with the amount being equal to 100% of the selected lump sum.
The member is free to choose the amount of the lump sum.
The amount of the insured lump sum to be selected can be between:
- in euros: €25,000 and €1,000,000, in multiples of €25,000,
- in dollars: $30,000 and $1,200,000, in multiples of $30,000.

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

• EXCLUSIONS FROM COVERAGE

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

• ADISTRIBUTION OF DEATH BENEFIT

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

If the member does not want the insured lump sum to be allocated according to the above clause, or if, during the life of the plan, he or she wants to designate one or more other beneficiaries, he / she should designate the beneficiary or beneficiaries of his / her choice and inform the insurer. This designation may be carried out by private deed or certified document.
To avoid any risk of duplication of names and to make it easier to locate the designated beneficiaries, the member should provide, for each beneficiary, details which will allow them to be accurately identified, including their surname, first names and date and place of birth.
Any designation or change in designation which is not brought to the attention of the insurer is non-binding.

IMPORTANT

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

With the member's agreement, any designation of beneficiary may be subject to acceptance, after a period of at least 30 days following the effective date of membership of the plan, if the designation is made free of charge.
While the member is alive, this acceptance must be formalized either by an endorsement signed by the insurer, the member and the beneficiary or by a private deed or certified document signed by the member and the beneficiary.
Acceptance is only binding on the insurer if they have been notified in writing. Proof of such notification falls upon the person claiming the benefit.

IMPORTANT

It is specified that the designation in favor of a specific beneficiary becomes irrevocable if it is accepted by them under the above conditions.

A private deed is a document, which can be freely drafted, drawn up by one of the parties and signed by all participants. There must be as many originals as there are participants. The private deed may or may not be registered with the tax department. A certified document is a document drawn up by a public official and signed before them by all parties.
The entitlement of beneficiaries to the insured lump sum is subject to them surviving for two days following the death of the member.

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

Except in cases of force majeure, the death must be declared to the insurer within six months of its occurrence, by sending them the supporting documents required for settlement, including:
- an extract of the death certificate,
- a medical certificate, to be sent to the insurer's medical advisor under confidential cover, indicating the date of death and specifying if it was a natural or accidental death or a death resulting from an event excluded under the plan,
- any document proving identity and / or marital status,

- where appropriate, any documents specifying the cause and circumstances of the accident resulting in the death.

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

Payment of the lump sum is made to the designated beneficiary or beneficiaries within fifteen days of the date of receipt of the supporting documents by the insurer.

If there is more than one beneficiary:

- the lump sum is allocated as specified by the member or, in the absence of any specific instructions, shared equally between beneficiaries of the same class,
- the lump sum will not be distributed by the insurer but a single payment will be made subject to a receipt being signed jointly by the parties or their legal representative.

ARTICLE 5 – PERMANENT TOTAL DISABILITY OF THE MEMBER

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

• DEFINITION AND AMOUNT OF THE BENEFIT

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

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

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

• EXCLUDED RISKS

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

Furthermore, other than in application of Article L2.-8 of the French Insurance Code, and subject to the exclusions listed above, the benefit applies to the consequences of medical conditions or disabilities which occurred before the date of signature of the application for coverage under the plan if they were declared on the application form and were not subject to a specific exclusion of which the member was notified by registered mail.

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

FORMALITIES TO BE COMPLETED

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

- a detailed certificate from the treating doctor indicating the nature of the illness or accident, to be sent to the insurer's medical advisor under confidential cover,
- any evidence establishing the need for third party assistance such as the notification of the award, if any, by Social Security of a disability allowance requiring third party assistance,
- any document proving identity and / or marital status,
- where appropriate, any documents specifying the cause and circumstances of the accident which caused the permanent and total disability.

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

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

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

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

PAYMENT OF THE LUMP SUM

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

In the event of the member's death before the lump sum is paid, a lump sum will be paid to the designated beneficiaries as defined under Article 4.

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

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

• DEFINITION AND AMOUNT OF THE BENEFIT

The purpose of this benefit is to pay the beneficiary or beneficiaries specified under Article 4, if the member dies following an accident as defined under Article 2 and subject to the provisions of paragraph below, an additional lump sum the amount of which is equal to 100% of the death benefit provided for under Article 4.

The benefit is payable on condition that the death occurs no later than twelve months after the accident. In accordance with Article 1315 of the French Civil Code, it is the responsibility of the beneficiaries to provide evidence of the accident and the direct relationship of cause and effect between the accident and the death.

• EXCLUSIONS FROM COVERAGE

The benefit is not payable in the following cases:

- **illness, even if it is the result of an accident,**
- **accidents caused intentionally by the member or resulting either from suicide or intentional self-inflicted injuries or the use of narcotics or psychotropic drugs without a medical prescription,**
- **accidents resulting from the member being under the influence of alcohol as defined by a blood alcohol concentration equal to or above that set by the French highway code to characterize the offense of drunk driving,**
- **air navigation accidents unless the member is aboard an aircraft with a valid certificate of airworthiness and flown by a pilot in possession of a non-expired permit and license. The pilot may be the member him / herself.**
- **accidents caused by:**
  - **matches, races, bets and sporting competitions (unless the member is participating as an amateur),**
  - **motor racing**
  - **nuclear disintegration,**
  - **scuba diving,**
  - **bungee jumping,**
  - **air sports whether or not they require the use of a motorized vehicle (shows, conventions, adventure racing, aerobatics or flying competitions, records or record attempts, preparatory and acceptance trials, parachute jumps not carried out for safety reasons, hang gliding, paragliding, microlighting etc.)**
- **accidents caused by civil or foreign war, insurrection, riots or brawls regardless of where the events take place and who the protagonists are unless the member does not take an active part or is called upon to carry out a servicing or surveillance assignment for the purpose of ensuring the security of persons and goods,**
- **accidents caused by a war involving France.**

• PAYMENT OF THE BENEFIT

FORMALITIES TO BE COMPLETED IN THE EVENT OF A CLAIM

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

DISTRIBUTION OF THE LUMP SUM

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

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

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

• DEFINITION AND AMOUNT OF THE BENEFIT

The purpose of the benefit is to provide, subject to the provisions of paragraph B. below, a lump sum to the member in the event of illness or accident causing bodily infirmity which affects them in their professional activity or their private life.
The member is free to choose the amount of the lump sum, **up to the level of the death lump sum selected by them.**
The amount of the insured lump sum to be selected can be between:
- in euros: €25,000 and €1,000,000, in multiples of €25,000,
- in dollars: $30,000 and $1,200,000, in multiples of $30,000.

The amount selected by the member is shown on the certificate of enrollment.
The amount of the lump sum due for cases of total infirmity (equal to 100%), as determined by the insurer's doctor, is set at 100% of the selected lump sum. If the infirmity is partial, the amount of the lump sum paid is proportional to the degree of infirmity.
No lump sum is due for cases of infirmity of less than 33% .

The age and profession of the member are never taken into account.
The degree of infirmity is determined by the insurer's doctor on the date of recovery from the accident or stabilization of the illness.
Determining the degree of infirmity: The degree of infirmity used in the application of the insurance contract is determined by medical expertise (joint opinion of the member's treating doctor and the insurer's medical examiner and, if necessary, by a third doctor acting as arbitrator as described below), depending on the degree of functional incapacity of the member. Functional, physical or mental incapacity is assessed independently of any consideration of resources or profession, with reference to the scale of incapacity in common law published in the French medical journal, Concours Médical.

IMPORTANT

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

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

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

FORMALITIES TO BE COMPLETED
The member must declare the illness or accident to the insurer as soon as possible with the declaration including details of the gravity, causes and circumstances of the illness or accident. The member must also:
- send the insurer's medical advisor a certificate from the doctor who was called to provide first aid describing the precise nature of their current condition, injuries and their consequences. This declaration should be sent under confidential cover,
- where applicable, send any documents required to establish the fact and extent of the accident,
- agree to be examined by the insurer's doctor.

The insurer reserves the right to request any additional documents they deem necessary.
Any fraud, concealment or false declaration on the part of the member with the purpose of misleading the insurer with respect to the circumstances or consequences of the illness or accident will lead to loss of entitlement to the benefit.

RECOGNITION BY THE INSURER OF THE STATE OF INFIRMITY
The insurer has the express right to assess, recognize or monitor the state of infirmity of the member. For this purpose, the insurer's doctors, agents or representatives must be able to visit the member, who agrees to meet with them and provide them with an honest account of his or her condition. They may also invite the member to attend an appointment.
If the member does not agree to the visits and / or medical examinations, the insurer is automatically authorized by law to suspend payment of the benefit.
In the event of a disagreement between the member's doctor and that of the insurer regarding the state of infirmity, the member and the insurer may together choose a third doctor in order to reach a majority decision and, if they cannot agree on the choice of doctor, the appointment will made by the Tribunal de Grande Instance of Paris. Arbitration fees are shared equally between the member and the insurer. **Members agree to submit to the jurisdiction of the Paris courts and waive the right to any proceedings in any other country.**

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

• COMPENSATION FROM THE PERSON OR PERSONS WHO CAUSED THE ACCIDENT
The member retains the full amount of any compensation obtained from the persons responsible for the accident.

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

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

• DEFINITION OF THE BENEFIT

DEFINITION OF THE BENEFIT

Temporary total incapacity to work is a state of temporary incapacity **following an illness or accident** affecting the member in their professional activity or in their private life and which makes it totally physically or mentally impossible for them to perform any professional activity whatsoever. This state must be medically diagnosed and recognized by the insurer.
Permanent total or partial disability is a disability **following an illness or accident** making it totally or partially physically or mentally impossible for the member to carry out their normal professional activities or any professional activities providing the same level of income as before the period of sick leave following an illness or accident.

PURPOSE OF THE BENEFIT

The purpose of this benefit is to provide an allowance in the event of a period of sick leave by the member (a daily allowance in case of temporary total incapacity to work or an annual pension in case of permanent total or partial disability) following an illness or accident.
Three options hereafter referred to as Standard Disability Benefit, Short-Term Disability Benefit and Long-Term Disability Benefit, are available to the member in respect of this benefit. Options 2 and 3 may be purchased together (see definitions below).
The option or options selected by the member are shown on the certificate of enrollment.
Sick leave benefits are paid to the member, provided he or she is recognized by the insurer as suffering from temporary total incapacity to work or permanent total or partial disability as defined in paragraph above and subject to the provisions set out in paragraph below.
The state of temporary total incapacity to work or permanent total or partial disability is determined by the insurer's medical advisor independently of the rulings of any Social Security scheme to which the member may belong.

CONDITIONS GOVERNING THE AWARD OF BENEFITS

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

• AMOUNT OF BENEFITS

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

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

AMOUNT OF THE BENEFIT:

The member is free to choose the amount of the daily allowance, up to the limit of one thousandth of the selected death lump sum.
The amount of the daily allowance to be selected can be between:
- in euros: €25 and €500 per day, in multiples of €25,
- in dollars: $30 and $600 per day, in multiples of $30,

up to the limit of one thousandth of the selected death lump sum.
However, if the amount of the selected death lump sum is less than or equal to €250,000 or $300,000, the amount of the daily allowance selected by the member may exceed one thousandth of the death lump sum and may be increased by €25 or $30 per day.
The amount of the daily allowance selected by the member is shown on the certificate of enrollment.
The monthly amount of the permanent total disability pension (for disabilities greater than or equal to 66%) is equal to that of the daily allowance multiplied by 30 to provide a monthly amount.
The amount of the daily allowance selected by the member is shown on the certificate of enrollment.
Furthermore, it is specified that the daily allowance paid cannot, under any circumstances, exceed 70% of the average daily professional income earned by the member during the 12 calendar months preceding the period of sick leave taken into consideration.

Temporary total incapacity to work:

When the insurer recognizes the member to be in a state of temporary total incapacity to work, the member is paid a daily allowance from the expiration of a period of total and continuous sick leave from work (known as the "waiting period") of 30 days, 60 days or 90 days as chosen by the member and shown on the certificate of enrollment.
The amount of temporary total incapacity benefit paid by the insurer is set at 100% of the selected daily allowance, limited in all cases to **70% of the average daily professional income earned by the member during the 12 calendar months preceding the period of sick leave taken into consideration.**

1. **Terms of payment of the benefit**: The daily allowance, which is acquired on a daily basis for as long as the member is in a state of temporary total incapacity to work, is payable to the member monthly in arrears until the date of recovery from the accident or stabilization of the illness and for a maximum period of no more than 24 months.

2 **Cessation of payment of the daily allowance**: Payment of the daily allowance ends in all cases:
- when the member returns to work or is found to be medically fit to return to work, even on a part-time basis,
- from the day on which the member is recognized to be in a state of permanent disability with the provisions of paragraph B.1.2 below being applicable on that date,
- on the date on which the member receives their retirement pension from Social Security, including for reasons of unfitness for work, and no later than the day on which the member reaches the age of 70,
- and no later than the end of the maximum period of 24 months mentioned above.

Permanent disability

Determining the degree of disability "n": The degree of disability "n" is determined by medical expertise (joint opinion of the member's treating doctor and the insurer's medical examiner and, if necessary, by a third doctor acting as arbitrator as described below), and with reference to the scales of functional and occupational incapacity shown below. The degree of disability is determined independently of the rulings of the member's Social Security scheme on the date of recovery from the accident or stabilization of the illness and at the latest on expiration of the maximum benefits period of 24 months specified in respect of Temporary total incapacity benefit.
Functional, physical or mental incapacity is assessed independently of any professional considerations, with reference to the scale of incapacity in common law published in the French medical journal, Concours Médical. Occupational incapacity is assessed on the basis of the degree and nature of the incapacity in relation to the insured's occupation, with consideration given to the manner in which the occupation was performed prior to the illness or accident, the normal conditions for performing the occupation and their remaining capacity to perform the occupation.

IMPORTANT

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

The following table shows the rating obtained for various degrees of incapacity both functional and occupational. **To be eligible for a permanent disability pension the rating must be at least 40% .**

DOI*	DEGREE OF FUNCTIONAL INCAPACITY								
	20	30	40	50	60	70	80	90	100
10	–	–	–	–	–	–	40.00	43.27	46.42
20	–	–	–	–	41.60	46.10	50.40	54.51	58.48
30	–	–	–	42.17	47.62	52.78	57.69	62.40	66.94
40	–	–	40.00	46.42	52.42	58.09	63.50	68.68	73.68
50	–	–	43.09	50.00	56.46	62.57	68.40	73.99	79.37
60	–	–	45.79	53.13	60.00	66.49	72.69	78.62	84.34
70	–	–	48.20	55.93	63.16	70.00	76.52	82.79	88.79
80	–	41.60	50.40	58.48	66.04	73.19	80.00	86.54	92.83
90	–	43.27	52.42	60.82	68.68	76.12	83.20	90.00	96.55
100	–	44.81	54.29	63.00	71.14	78.84	86.18	93.22	100.00

** DOI = Degree of Occupational Incapacity*

In the event of a disagreement between the member's doctor and that of the insurer regarding the rate of permanent disability, the member and the insurer may together choose a third doctor in order to reach a majority decision and, if they cannot agree on the choice of doctor, the appointment will made by the Tribunal de Grande Instance of Paris. Arbitration fees are shared equally between the member and the insurer. **Members agree to submit to the jurisdiction of the Paris courts and waive the right to any proceedings in any other country.**
In any event, payment of the benefit may be terminated if there is an improvement in the health of the insured.

1 **Amount of the permanent disability pension**: If the degree of disability "n" determined by the insurer is greater than or equal to 66% , the disability is deemed to be total. A pension is then paid, the monthly amount of which is equal to 30 times the amount of the selected daily allowance. This amount is limited in all cases to **70% of the average daily professional income earned by the member during the 12 calendar months preceding the period of sick leave taken into consideration.**
If the degree of disability "n" determined by the insurer is between 40% and 66% , the disability is deemed to be partial. A reduced pension is then paid, the amount of which is based on the pension paid by the insurer in the event of total disability with the application of a coefficient of n / 66.

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

2 **Terms of payment of the benefit**: The pension is paid from the date on which the disability is recognized by the insurer but no earlier than the end of the maximum benefit period of 24 months in respect of the temporary total disability benefit specified above.
The amount of the pension may be reviewed if there is a change in the disability status.
The pension is payable to the member quarterly in arrears, for the entire duration of the disability.

3 **Cessation of payment of the pension**: Payment of the pension ceases in all cases:
- when the member returns to work or is found to be medically fit to return to work, even on a part-time basis,
- and, at the latest, on the date on which the member receives their retirement pension from Social Security, including for reasons of unfitness for work and, at the latest, on the day on which the member reaches the age of 70.

OPTION 2: SHORT-TERM DISABILITY BENEFIT

If the insurer recognizes the member to be in a state of temporary total incapacity to work, the member will be paid a daily allowance from:
- the 7th day of total and continuous absence from work due to illness,
- the 1st day of absence from work due to hospitalization,
- the 1st day of absence from work due to an accident.

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

1 **Terms of payment of the benefit**: The daily allowance, which is acquired on a daily basis for as long as the member is in a state of temporary total incapacity to work, is payable to the member monthly in arrears until the date of recovery from the accident or stabilization of the illness and, at the latest, for a maximum duration which the member is free to choose and which is shown on the certificate of enrollment of **30, 60 or 180 days**.

2 **Cessation of payment of the daily allowance**: Payment of the daily allowance ends in all cases:
- when the member returns to work or is found to be medically fit to return to work, even on a part-time basis,
- from the day on which the member is recognized to be in a state of permanent disability,
- on the date on which the member receives their retirement pension from Social Security, including for reasons of unfitness for work, and at the latest on the day on which the member reaches the age of 70,
- and, at the latest, at the end of the maximum period selected by the member and shown on the certificate of enrollment (unless the member has also taken out option 3 below).

OPTION 3: LONG-TERM DISABILITY BENEFIT

If the insurer recognizes the member to be in a state of temporary total incapacity to work, the member is paid a daily allowance from the expiration of a period of total and continuous sick leave from work (known as the "waiting period") of **30 days, 60 days or 180 days** as chosen by the member and shown on the certificate of enrollment.
The amount of the daily allowance is set at 70% of the average daily professional income earned by the member during the 12 calendar months preceding the period of sick leave taken into consideration. This allowance may not exceed €500/$600.

1 **Terms of payment of the benefit**: The daily allowance, which is acquired on a daily basis for as long as the member is in a state of temporary total incapacity to work, is payable to the member monthly in arrears until the date of recovery from the accident or stabilization of the illness and, at the latest, until the 1,095th day of the period of sick leave.

2 **Cessation of payment of the daily allowance**: Payment of the daily allowance ends in all cases:
- when the member returns to work or is found to be medically fit to return to work, even on a part-time basis,
- from the day on which the member is recognized to be in a state of permanent disability,
- on the date on which the member receives their retirement pension from Social Security, including for reasons of unfitness, for work and, at the latest, on the day on which the member reaches the age of 70,
- and, at the latest, at the end of the period of 1,095 days specified above.

• PROVISIONS COMMON TO ALL SICK LEAVE BENEFITS

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

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

PROVISION SPECIFIC TO MATERNITY OR PATERNITY

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

RETURN TO WORK FOR LESS THAN 90 DAYS

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

CUMULATIVE BENEFITS

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

EXCLUSIONS FROM COVERAGE

Benefits are not payable in the following cases:

- **accidents or illnesses caused intentionally by the member or resulting from either a suicide attempt or intentional self-inflicted injuries or the use of narcotics or psychotropic drugs without a medical prescription,**
- **accidents or illnesses caused by civil or foreign war, insurrection, riots or brawls regardless of where the events take place and who the protagonists are unless the member does not take an active part or is called upon to carry out a servicing or surveillance assignment for the purpose of ensuring the security of persons and goods,**
- **accidents or illnesses caused by a war involving France,**
- **accidents resulting from the member being under the influence of alcohol as defined by a blood alcohol concentration equal to or above that set by the French highway code to characterize the offense of drunk driving,**
- **air navigation accidents unless the member is aboard an aircraft with a valid certificate of airworthiness and flown by a pilot in possession of a non-expired permit and license. The pilot may be the member him / herself.**
- **accidents caused by:**
  - **matches, races, bets and sporting competitions (unless the member is participating as an amateur),**
  - **motor racing**
  - **nuclear disintegration,**
  - **scuba diving,**
  - **bungee jumping,**
  - **air sports whether or not they require the use of a motorized vehicle (shows, conventions, adventure racing, aerobatics or flying competitions, records or record attempts, preparatory and acceptance trials, parachute jumps not carried out for safety reasons, hang gliding, paragliding, microlighting etc.)**
- **accidents caused by civil or foreign war, insurrection, riots or brawls regardless of where the events take place and who the protagonists are unless the member does not take an active part or is called upon to carry out a servicing or surveillance assignment for the purpose of ensuring the security of persons and goods,**
- **accidents caused by a war involving France.**

Furthermore, unless Articles L2.-8 and L2.-9 of the French Insurance Code are enforced, and subject to the exclusions listed above, the benefits apply to the consequences of medical conditions or disabilities which occurred before the date of signature of the application for coverage under the plan if they were declared on the application and were not subject to a specific exclusion of which the member was notified by registered mail.
In addition, sick leave benefits are not paid during periods of statutory maternity or paternity leave.

• PAYMENT OF THE BENEFIT

FORMALITIES TO BE COMPLETED IN THE EVENT OF A CLAIM

The declaration of sick leave must be made by the member who is required to send it to the insurer within the following timescales:

- **if the duration of the waiting period is less than 90 days: within three months of the start of the period of sick leave,**
- **if the duration of the waiting period is equal to or greater than 90 days: within 30 days of the expiration of the waiting period.**

No payments will be made for the period prior to the declaration if the sick leave is not declared within these timescales.
The declaration must be accompanied by:

- a medical certificate to be sent under confidential cover to the insurer's medical advisor stating the start date of the period of sick leave and the nature of the illness or accident, the date of the first medical diagnosis and the expected duration of absence from work,
- proof of professional income over the last 12 months prior to the period of sick leave,
- any document proving identity,
- and, where applicable:
  - a confidential medical certificate using the form supplied by the insurer duly completed by the treating doctor,
  - if the member is covered by a Social Security scheme: proof of payment of cash benefits

from this scheme.
The insurer reserves the right to request any additional supporting documents they consider necessary for the payment of benefits.
No benefits will be paid until the required supporting documents are sent to the insurer.
If the member returns to work, the insurer must be informed as soon as possible.

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

The insurer has the express right to assess, recognize or monitor the state of incapacity or disability of the member. For this purpose, the insurer's doctors, agents or representatives must be able to visit the member, who agrees to meet with them and provide them with an honest account of his or her condition. They may also invite the member to attend an appointment.
If the member does not agree to the visits and / or medical examinations, the insurer is automatically authorized by law to suspend payment of the benefits.

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

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

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

ARTICLE 9 – BENEFITS SCHEDULE

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

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

Lump sum chosen by the member for total infirmity (equal to 100%), with reference to the scale of functional incapacity under common law published in the French medical journal, Concours médical:
If the infirmity is partial, the amount of the lump sum is proportional to the degree of infirmity (benefits are payable for infirmities equal to or greater than 33%)</td><td colspan="3">From €25,000 to €1,000,000 in multiples of €25,000,
or from $30,000 to $1,200,000 in multiples of $30,000
up to the level of the selected death lump sum (all causes)</td></tr>
<tr><td rowspan="2">Total sick leave from work by the member – Article 8
3 benefits options are available to the member:</td><td rowspan="2">STANDARD SICK LEAVE BENEFIT (Daily allowance and disability pension)</td><td>SHORT-TERM DISABILITY BENEFIT</td><td>LONG-TERM DISABILITY BENEFIT</td></tr>
<tr><td colspan="2">These 2 options can be purchased together.</td></tr>
<tr><td>Waiting period dependent on the options selected by the member:</td><td>As selected by the member: 30, 60 or 90 days</td><td>6 days
(except in case of hospitalization or accident: benefit paid from the 1st day of sick leave)</td><td>As selected by the member: 30, 60 or 180 days</td></tr>
<tr><td>Amount of the Daily allowance (or pension) dependent on the option selected by the member:</td><td>As selected by the member:
-from €25 to €500 per day in multiples of €25,
-from $30 to $600 in multiples of $30, limited to one thousandth of the selected death lump sum (with the option of increasing the amount of the allowance by €25 / $30 per day if the selected death lump sum is equal to or less than €250,000 / $300,000)
Maximum amount of benefit: 70% of the member's professional income.</td><td>70% of the member's professional income</td><td>70% of the member's professional income</td></tr>
<tr><td>Maximum duration of benefit, dependent on the option selected by the member:</td><td>24 months of daily allowance then payment of a disability pension until the date on which the retirement pension is paid and at the latest at age 70</td><td>As selected by the member: 30, 60 or 180 days</td><td>Until the 1,095th day of the period of sick leave</td></tr>
</table>

2.3 / OPERATION OF THE PLAN

ARTICLE 10 – LEGAL FRAMEWORK

This group insurance plan with optional membership is governed by French law and the French Insurance Code, in particular by Articles L141-1 and following. The plan falls within the scope of branch 2 (Healthcare) and branch 20 (Life-Death) of Article R321-1 of the French Insurance Code. The plan consists of these general conditions and the Certificate of enrollment. Coverage under the plan is based on the declarations made by the member.
The group insurance plan is in French. MSH INTERNATIONAL may make an English version available to the member. In case of disagreement on the interpretation of the benefits provided under this plan, only the French version of this plan will be taken into consideration. Translations of the contractual documents which make up the plan are made available to Members purely for information purposes and only the French language version is binding.

• LIMITATION PERIOD

In accordance with Article L2.-1 of the French Insurance Code, all legal actions arising from an insurance contract are barred two years from the event that gave rise to them. This limit is increased to ten years for Death benefits. However, this time limit runs:

- **in the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only from the date on which the insurer became aware of it,**
- **in the event of a loss, only from the date on which the relevant parties became aware of it, if they can prove they were unaware of such facts until then.**

In accordance with Article L2.-2 of the French Insurance Code, the limitation period is interrupted by one of the ordinary causes of interruption. These are listed under Articles 2240 and following of the French Civil Code and include the following cases:

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

The limitation period is also interrupted by:

- **the appointment of experts in response to a claim for benefits,**
- **the dispatch of a registered letter with proof of delivery sent by the insurer to the member regarding action for payment of the premium and by the member or the beneficiary to the insurer regarding payment of the benefit.**

• CANCELATION

The member may reverse their decision to enroll in the plan by registered mail with proof of delivery within a period of 30 calendar days from the date on which their Certificate of enrollment is sent out.
This cancelation should be worded as follows:
'I, the undersigned ..... declare my express wish to cancel my membership of the life & disability plan n° XXX / XXXXXX and request a refund of the premium paid under the terms and conditions defined under Article L132-5-1 of the French Insurance Code.'
By canceling their membership, all amounts paid by the member are refunded within a maximum period of 30 calendar days from the date of receipt of the registered letter by the insurer.

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

The contract concluded between the association and the insurer takes effect on July 1, 2015 for an initial period ending December 31st of the year during which it took effect.
It is automatically renewed on January 1st of each year for successive periods of one year unless terminated by either party by registered mail sent two months before each renewal date.

The plan may be amended, while it is in force, with effect from the 1st day of the calendar month, by mutual agreement between the insurer and the contracting association. If any amendments are agreed between the contracting association and the insurer, the insurer will issue an endorsement to the plan. In this case, the member will receive prior notification, under the conditions of Article 16, of the changes made to their rights and obligations under the plan.

ARTICLE 12 – ENROLLMENT OF MEMBERS OF THE CONTRACTING ASSOCIATION

• ENROLLMENT

Enrollment in the plan is open to any member of the contracting association who applies for membership of the plan, provided:
- they are aged 18 or over and under the age of 71,

- they are living abroad outside their country of nationality (the country in which they usually reside), in a private or professional capacity.

• CONDITIONS OF ENROLLMENT

To enroll in the plan, the member of the above-mentioned contracting association must complete and sign the enrollment form provided by the insurer and a health questionnaire.
Depending on the age of the applicant and the level of coverage being taken out, a medical visit with a doctor approved by the insurer and / or additional information or medical examinations may be required further to a review of this questionnaire.
The insurer will cover the cost of these formalities up to a maximum amount of €368 including taxes.
If the medical information provided does not allow the applicant to be accepted under the standard conditions of the insurance, the insurer reserves the right to reject the application or grant coverage subject to the exclusion of certain risks or payment of an additional premium.
Any non-disclosure or intentional misrepresentation invalidates membership in accordance with Article L2.-8 of the French Insurance Code.
If the applicant is accepted subject to special conditions, they will be notified of this by registered mail.
The person who is accepted for membership of the plan is hereafter referred to as the "member".
Membership is formalized by the issuing of a Certificate of enrollment in the plan which includes:
- the reference number and effective date of membership,
- the currency used,
- the benefits and level of coverage selected,
- the premium rate.

ARTICLE 13 – EFFECTIVE DATE OF MEMBERSHIP AND BENEFITS

• EFFECTIVE DATE, DURATION AND RENEWAL OF MEMBERSHIP

Membership takes effect on the date shown on the certificate of enrollment and at the earliest on the date of notification of acceptance by the insurer.
Subject to the provisions of Article 20:
- membership runs for a period of 12 months,
- **it is then renewed automatically on each anniversary for successive periods of one year unless terminated by registered mail at least two months prior to each renewal date.**

It ends if terminated in accordance with the provisions set out above and under Article 20.

• EFFECTIVE DATE OF BENEFITS

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

ARTICLE 14 – MAKING CHANGES TO BENEFITS

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

• DOWNGRADE OF SELECTED BENEFITS

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

• UPGRADE OF SELECTED BENEFITS

If the member wishes to upgrade their benefits, they should complete a new enrollment form and submit to the medical formalities specified in Article 12 above. The member must also make the request no later than two months before the annual renewal date of their membership of the plan.
The insurer reserves the right to refuse an upgrade of benefits or to accept it subject to restrictions or the payment of an additional premium. However, the member remains covered under the conditions which were in place prior to their request.
If accepted by the insurer, the new, upgraded benefits will take effect from the annual renewal date of membership of the plan, subject to notification of acceptance from the insurer. The member remains covered by the previous benefits until that date.

• PURCHASING NEW OPTIONAL BENEFITS

A member wishing to purchase new optional benefits should complete a new enrollment form and submit to the medical formalities specified in Article 12 above.
The insurer reserves the right to refuse the benefits or to accept them subject to restrictions or the payment of an additional premium.
If accepted by the insurer, the new benefits will take effect from the date of notification of acceptance by the insurer and, at the latest, on expiration of a waiting period of 6 months in respect of sick leave benefits

ARTICLE 15 – CESSATION OF MEMBERSHIP AND BENEFITS

• CESSATION OF MEMBERSHIP

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

- on the anniversary date of the year in which they request cessation of their membership of the plan, **provided the termination is notified to the insurer by registered mail at least two months before this date,**
- on the last day of the calendar quarter in which they cease to be members of the association, ASFE. ASFE must notify the insurer of this within a period of one month,
- on the last day of the calendar quarter during which the member returns permanently to their country of origin. The member must notify the insurer of this at least one month before their return date,
- on the last day of the calendar quarter in which their premiums are not paid subject to the provisions of Article 20 below,
- on the date on which they receive their Social Security old-age pension, including for reasons of unfitness for work and, at the latest, on the last day of the calendar quarter during which they reach the age of 71,
- on the date of termination of membership by the insurer. This is only possible in the first two years of membership,
- on the date of termination of the plan. However, a person who has been a member of the plan for two years or more at the date of its termination may apply for continuation of benefits until they receive their Social Security old-age pension, subject to the payment of the premium set by the insurer.

• CESSATION OF BENEFITS

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

In addition:

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

ARTICLE 16 – INFORMATION TO MEMBERS

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

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

ARTICLE 17 – COMPLAINTS – MEDIATION – DATA PROTECTION AND FREEDOM OF INFORMATION

• COMPLAINTS - MEDIATION

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

- by mail: Service des relations avec les consommateurs Groupama Gan Vie - Immeuble Michelet 4-8 Cours Michelet - 92082 LA DEFENSE CEDEX – FRANCE - Tel. 01 70 96 62 68
- by email: src-collectives@ggvie.fr

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

- by mail: Groupama Gan Vie – Service Réclamations - 160 avenue Charles de Gaulle - TSA 41269 - 91246 Morangis Cedex, France
- by email: service.reclamations@ggvie.fr

In both cases, the insurer agrees to acknowledge receipt of the complaint within a period of no more than 10 working days. It will be processed within 2 months at the most. If this is not the case, the complainant will be informed.

Finally, and without prejudice to their right to take legal action if necessary, the member may apply to the insurer's ombudsman by writing to the following address:

Médiateur de Groupama Gan Vie - 5-7 rue du Centre - 93199 Noisy-le-Grand Cedex – France.

Details of complaint-handling procedures are available to the member from their usual advisor and in the 'Legal notices' section of the website www.gan-eurocourtage.fr.

• DATA PROTECTION AND FREEDOM OF INFORMATION

PROTECTION OF PERSONAL DATA

The personal data of members is processed in accordance with the French law on Data Protection and Freedom of Information of January 6, 1978 amended. The processing of this data is necessary for the management of their membership and benefits. With the exception of health-related data, it is intended for their usual advisor, the insurer and their agents, service providers and subcontractors and for the reinsurers as well as professional and administrative bodies with respect to legal obligations. This data can also be used for the purposes of the assessment and acceptance of risks, internal control (portfolio monitoring) and in the context of legal provisions, notably with respect to combating money laundering and the

financing of terrorism. As part of the campaign against insurance fraud, the member's personal data may be passed on to professional bodies involved in combatting fraud as well as to licensed investigators.
The member, having provided proof of identity, has the right to access, rectify, remove and object to this data free of charge by mailing a letter to the insurer:
Groupama Gan Vie - Direction des Affaires Générales - Correspondant Informatique et Libertés 4-8 Cours Michelet - 92082 La Défense Cedex, France

COLLECTION AND PROCESSING OF HEALTH-RELATED DATA

The member expressly accepts the collection and processing of health-related data. This data is required for the management of the benefits and is processed in compliance with medical confidentiality. It is intended for the exclusive use of the insurer's medical advisor and their medical department, or for internal or external authorized persons (including medical experts). The member has the right to access, rectify, remove and object to data relating to them by mailing a letter, together with a photocopy of ID, to the insurer's medical advisor.

RECORDING OF TELEPHONE CALLS

The member may be required to contact the insurer by telephone for all types of inquiries. The insurer will inform them that their calls may be recorded to ensure the proper implementation of their benefits and, more generally, to improve quality of service. These recordings are intended only for the departments of the insurer who handled that particular call. If the member has been recorded and wants to listen to the recording of a conversation, they can make the request by mailing a letter to the insurer at the above address. They will be provided with copies of the recording or a transcript of the content of the conversation free of charge, within the time limits set for storage of these recordings.

TRANSFER OF INFORMATION OUTSIDE THE EUROPEAN UNION

With respect to the implementation of the plan and benefits and in compliance with the stated purposes, personal data relating to members may be transferred to countries within the European Union or outside the European Union. Members are informed of this by means of these provisions and expressly authorize it.

ARTICLE 18 – MISREPRESENTATION

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

2.4 / PREMIUM

ARTICLE 19 – ARBITRATION

All disputes regarding this plan will be resolved by arbitration. Each party appoints an arbitrator and the two arbitrators together appoint a third. If one of the parties fails to appoint their arbitrator within one month of notification by either party of the implementation of the arbitration clause, or if both arbitrators fail to agree on the appointment within the same timescale, the appointment will be made by the president of the Tribunal de Grande Instance, in summary proceedings, as instructed by the first party to act.
Arbitrators are not required to follow usual procedure and their decision will be final: the arbitration ruling is final and binding and must be delivered within a period of six months from the setting up of the arbitration tribunal. The parties also submit to the decision of the arbitrators with respect to arbitration costs.
This exclusion cannot impede, where applicable, the payment of benefits acquired in return for premiums or contributions previously paid by the insured.

ARTICLE 20 – PREMIUM

• SETTING AND PAYING THE PREMIUM

Benefits provided under the plan are subject to a premium expressed in euros or dollars, set according to the member's age (age is determined by the difference in years on January 1st of each year), the benefits selected and their amount.
The amount of the premium is shown on the certificate of enrollment.
Premiums are adjusted by the insurer on January 1st of each year, based on the claims experience recorded over the previous year.
Any taxes or charges which may become applicable to the plan, the recovery of which is not prohibited, are charged to the member and payable at the same time as the premium.

• PAYMENT

PAYMENT OF THE PREMIUM BY THE MEMBER

Premiums are payable to the contracting association monthly, quarterly, bi-annually or annually in advance, in euros and dollars.

If a member joins the plan during a payment period (month, quarter, half-year or year), the premium is calculated on a pro rata basis.
If membership is terminated, the membership and benefits are maintained until the end of the period covered by the last premium to be paid.

NON-PAYMENT OF PREMIUM

In accordance with the provisions of Article L2.-3 of the French Insurance Code, any premium due remains payable and may be recovered by any legal means.
In accordance with the provisions of Article L141-3 of the French Insurance Code, the contracting association must, at the earliest, ten days after the due date of the unpaid premium, send the member a registered letter of formal notice. By mutual agreement between the insurer and the contracting association, it is agreed that the contracting association authorizes the insurer to prepare and send out this letter.
The letter will state that, at the end of a period of 40 days of dispatch of this letter, the member is barred from the insurance plan due to non-payment of the premium. The member remains liable for the full premium until the date of their removal from the plan.

ARTICLE 21 - EXEMPTION OF PREMIUM PAYMENT – CONTINUATION OF COVERAGE IN THE EVENT OF SICK LEAVE

In the event of total sick leave from work by the member following an illness or accident occurring before the date of their 70th birthday, the member and their dependents covered under the plan will continue to benefit from the coverage purchased as per the plan's terms and conditions, without having to pay the premium, from the first day of the calendar month following the month during which the following occurred:
- payment of the benefits provided under the "standard" Sick leave benefit and throughout the entire duration of the payment if you have purchased the "standard" sick leave benefit (Option 1 – article 8 above);
- the 91st day of total and continuous absence from work, if the above does not apply.

These provisions only apply in the event of sick leave resulting from an illness or accident occurring after the effective date of your membership of the plan.

• DETERMINING THE BENEFIT

You will be considered as being in a total and continuous absence from work if we have recognized you to be in a state of temporary total incapacity to work or permanent total disability as defined in article 8 above.

• DECLARING AND PROVIDING PROOF OF THE SICK LEAVE

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

• RECOGNITION AND MONITORING OF THE STATE OF INCAPACITY OR DISABILITY

We reserve the express right to assess, recognize and monitor your state of incapacity or disability. To this end, the provisions of article 8 above apply to this coverage.

• EXCLUDED RISKS

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

• DURATION AND CESSATION OF CONTINUATION OF COVERAGE

Continuation of coverage is granted for as long as the sick leave qualifying for the exemption is in effect. It will end as soon as you return to work or if a medical authority certifies that you can resume a professional activity, regardless of the nature of this activity. Furthermore, continuation of coverage will cease at the latest on the date on which you start receiving a basic old-age pension (including due to inability to work) and, in all cases, on the day you reach the age of 70. It will also end in the event of the plan's termination.

Insurer's legal information: Groupama Gan Vie, a French 'société anonyme' with a capital of 1,371,100,605 euros – RCS Paris 340 427 616 - APE 6511 Z Head office: 8-10 rue d'Astorg - 75383 PARIS Cedex 08 – France - Tel: 01.44.56.77.77. Company regulated by the French Insurance Code and subject to the Prudential Supervisory Authority (ACP) - 61 rue Taitbout - 75009 Paris
The insurance products distributed by brokers under the Gan Eurocourtage brand are Groupama Gan Vie products.
www.gan-eurocourtage.fr – contact-collectives@gan.fr

YOUR CONTACTS

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GAP-VA012017

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SIACI SAINT HONORE GROUP

09.10.2017