Supplementary Health Insurance Contract

BCVR – 8672

For

AFILIATYS members

Coordonated policy as of 01/01/2015

The present contract is valid as from 1 January 2010 for the members of ASBL Afiliatys and their coinsured affiliated to the Supplementary Health Insurance Contract BCVR 8672 expiring on 31 December 2009, as well as new subscribers who will be affiliated under the terms and conditions provided for in this document and its annexes. The insurance contract therefore keeps the same contract number assigned by the insurance company.

It is concluded between

AFILIATYS ASBL
Rue de la Science 29
1049 Brussels

Hereafter the policyholder

And

ALLIANZ BENELUX s.a.
Rue de Laeken 35
1000 Brussels

Hereafter the insurer

And

CIGNA INTERNATIONAL HEALTH SERVICES BVBA
Plantin en Moretuslei 299
2140 Antwerp

Hereafter the broker/administrator

Definitions

1. Accident A sudden event that harms the physical integrity of the insured person and one of the causes of which is external to the victim's organism.

2. Insured person The Afiliatys member and/or his/her spouse and family who individually adhere to the Group Contract 'Supplementary Health Insurance' that is the object of this contract. Upon his/her affiliation, the insured person receives an insurance certificate issued by the broker.

3. Orthopaedic device Device designed to correct deformities of the body.

4. Main insured The main insured is the person (active or retired) linked to the policyholder through affiliation that is current on the subscription date of the present contract.

5. Co-insured The co-insured is the family member of the main insured who also benefits from the group insurance.

6. Group Health Insurance Contract The health insurance contract concluded between ASBL AFILIATYS and the insurer, through Cigna. The insurance consists of the present general terms and conditions, the special terms and conditions, as well as the possible annexes.

7. Broker Cigna International Health Services BVBA

8. Insurer Allianz Benelux s.a. Insurance company, authorised under code number 0097 for practising the branches 'Life' and 'Non Life' (R.D. of 04.07.1979 – M.B. of 14.07.1979. R.D. of 19.05.1995 – M.B. of 16.06.1995) – R.C.B. 574 – B.C.E. Company number 0403.258.197

9. Hospital The institution legally recognised, approved and identified as a hospital where scientifically tested diagnostic and therapeutic means are used, with the exception of:

- closed psychiatric institutions;
- temporary residential homes for psychiatric patients and sheltered housing;
- special needs schools;
- institutions only destined for the housing of the elderly, convalescent patients or children and health spas;
- retirement homes and retirement/nursing homes, even if they are integrated in a hospital institution.

10. Official and other agent This definition also covers retired staff members who were active within the Institutions.

11. Healthcare costs Insofar as they give rise to legal entitlement, whether prescribed or provided by a physician, and are incurred during hospitalisation:

- cost of stay in a hospital;
- costs related to a medical or paramedical act;
- purchase of prescribed medication for the insured by a physician;
- costs of prostheses or orthopaedic devices;
- the medical equipment.

12. Outpatient healthcare costs The costs provided for under the last points of definition 11 above, insofar as they are not incurred during hospitalisation.

13. Medically necessary costs All medical and paramedical acts that are appropriate and in direct relation to the diagnostic posed by the physician; all prescriptions made for personal comfort and convenience are therefore excluded.

14. Deductible Share of the reimbursable costs that remain at the insured person's expense, as specified in article 7 of the present contract.

15. Hospitalisation The stay for at least one night in a hospital, insofar as the condition of the patient requires it, and with a view to administering curative treatment within the shortest possible period.

16. One day Clinic The 'One Day Clinic' formula is considered as hospitalisation, insofar as it is an institution recognised as a day-hospital and actual use is made of the operating theatre, of the plaster room or of a hospital bed.

17. Infirmity Congenital or accidental condition of an individual who does not enjoy or only imperfectly enjoys one of his/her physical or mental functions.

18. Legally foreseen reimbursement A first reimbursement, legally foreseen in the Staff Regulations of the officials and other agents of the European Community, has been made in favour of the insured person by the Joint Sickness Insurance Scheme (= JSIS) or any other national or international social security scheme. Reimbursement by the broker in case of a system other than the JSIS is regulated by the same conditions that are applicable to the reimbursement resulting from the JSIS (by analogy). If prior agreement is required by the JSIS, Cigna will take on this responsibility in case reimbursement is provided for by a national or international social security scheme.

19. Sickness Any non-accidental alteration of the insured person's health, showing objective symptoms that make it possible to establish a diagnosis as well as the appropriate therapeutic treatment according to recognised medical standards.

20. Medication Any product sold exclusively in pharmacies, prescribed by a physician and registered as such with the Minister entrusted with this matter.

21. Policyholder ASBL AFILIATYS, who subscribes the group contract with the insurer and the broker.

22. Prosthesis Device that replaces a limb or organ entirely or in part, and that is attached to the body of the insured person.

23. JSIS Joint Sickness Insurance Scheme applicable to officials and other agents of the European Union.

24. Claim Any event entitling to the benefits of the present insurance contract.

25. Staff Regulations Staff Regulations of the officials and other agents of the European Union.

26. Terrorism A clandestinely organised action or threat of action for ideological, political, ethnic or religious purposes, carried out by an individual or a group and perpetrated on individuals or destroying wholly or partially

the economic value of a tangible or intangible good, either to impress the public, to create a climate of insecurity or to pressure the authorities, or to hinder the movement or the normal functioning of a service or enterprise (Belgian Act of 01.04.2007. M.B. 15.05.2007).

Object of the contract

The aim of the contract is to offer health insurance that is supplementary to the cover the insured/coinsured persons enjoy under the Joint Sickness Insurance Scheme of the European Institutions as defined by the JSIS, for medical expenses incurred by the beneficiary as a result of illness, an accident or maternity or childbirth expenses, within the maximum intervention limits on the part of the insurer, also specified in the contract.

The contract is therefore not designed to insure an unlimited cover of the expenses incurred by the insured person, but is a supplementary intervention with respect to a series of expenses described and guaranteed by his/her health insurance scheme.

The Insurer as well as the broker/administrator commit to an exclusive collaboration with the policy holder in the frame of the cover complementary to the one the main insured/co-insured with the Joint Sickness Insurance Scheme of the European Institutions.

Article 1 - The contract

The aim of this group health insurance contract is to define the insurance conditions and the limitations of a supplementary reimbursement of healthcare costs that are medically necessary and granted by the insurer at the benefit of the individual insured persons having claimed such costs. The reimbursement of healthcare costs intervenes on the condition there is a legally foreseen reimbursement. This supplementary cover concerns all the healthcare costs related to any deterioration of health that is medically diagnosed, whatever its cause, whether accidental or otherwise.

As an exception to the second paragraph of this article, the healthcare costs resulting from an accident or occupational disease suffered by an official or other agent of the European Union institutions and entitling them to full reimbursement according to the articles 72 and 73 of the Staff Regulations of the officials and other agents of the European Union, are excluded from the current cover.

Article 2 - Inception – Duration of the contract – Cancellation

2.1. The present supplementary health insurance contract is valid from 1 January 2010 for a period of 5 years, until 31 December 2014. The contract is renewed for the period from 1 January 2015 up to 31 December 2019. After this date, the contract will be tacitly renewed for 5 years, unless one of the parties (insurer or policyholder) decides to cancel the contract at the latest 1 year before the expiration of the policy by sending a registered letter to the other party, the postmark being legally valid. The principal expiry date is set at 1 January.

2.2. On 1 January 2010, the insurer will guarantee the continuation of the insurance, without renewal formalities, for the persons already insured on 31 December 2009 through Cigna by contract BCVR 8672, under the following modalities:

- The person insured under the ‘Major Risks’ contract is automatically covered by the ‘Hospi Safe Plan’ under the present contract;
- The person insured under the ‘Comprehensive Formula’ of the contract previously subscribed to is automatically covered by the ‘Hospi Safe Plus Plan’ of the present contract.

2.3. Exceptionally, from 1 January 2010 until 30 April 2010, and from 1 January 2015 up to 30 April 2015, any person meeting the conditions of article 3, who is not yet affiliated to the BCVR 8672 contract managed by Cigna, will be able to request his/her affiliation, without medical formalities, for one of the two options provided for in the present contract.

According to the same principle, the person insured under the formula 'Major Risks' on 31 December 2009 will be able to subscribe, without medical formalities, to the Hospi Safe Plus Plan provided for by the present contract, until 30 April 2010. Likewise, the person under the plan "Hospi Safe" on 31.12.2014 will be able to subscribe, without medical formalities, to the plan "Hospi Safe Plus" provided for by the present contract, and this up to 30.04.2015. After this date, the provisions of article 8 below will be applicable.

2.4 Once the cancellation of the group insurance contract by one of the parties has become effective, it implies extinction of the cover. The costs linked with the claims incurred before the cancellation date will be settled by the insurer according to the terms and conditions of article 5 of this contract. This is the date the medical services (outpatient expenses) are provided or the hospitalisation date.

2.5 Once the cancellation of the contract has become effective, the insurer will offer each insured person who is interested the possibility to continue the insurance individually, without subscription formalities and without additional waiting periods.
The insured person can exercise his/her right to continuity in accordance with the provisions of article 21 below.

Article 3 - Request for affiliation

3.1. Can be affiliated to the present contract as main insured person: the members of Afiliatys, provided that they are covered by the Joint Sickness Insurance Scheme of the European Institutions or by an equivalent cover:

- the officials and other agents of the European Union institutions, agencies and other bodies who are active in or have held a statutory position within one of those organisms;
- the active members of staff of the EIB, of Eurocontrol, of the European University Institute of Florence, of the European Schools, and of any organism with a Community vocation created by an act of a European Union institution.

3.2. Can be affiliated to the present contract as co-insured person:

- the spouse of the main insured person;
- their children or other dependent person (including adopted children), up to the age of 26;
- the beneficiaries of a survivor's pension (widow, widower, orphan) after the decease of one of the persons who subscribed the present contract as main insured; provided that they can prove that the first part of their medical expenses is settled by the JSIS or their national or international social security system.

The settlement modalities and limits by the present contract of co-insured persons applicable to the different categories below are those applied by the JSIS system.

3.3. The main insured person who requests affiliation for his/her family members must do so for his/her family as a whole, unless there is an alternative supplementary insurance.

Article 4 - Conditions of affiliation

Without prejudice to the provisions of article 2.3 above, affiliation to the present contract will be subject to the following conditions:

a. The main insured must be a member of ASBL AFILIATYS, the policyholder. For the persons mentioned under article 3.2, however, only justification of AFILIATYS membership of one of the persons mentioned under article 3.1 is required.

b. Affiliation of the persons mentioned under article 3.1 or of the other dependents mentioned under article 3.2 must be requested at the latest six (6) months prior to the effective retirement date under the legal retirement system to which the main insured person belongs.

Affiliation of spouses is done in the name of one of the persons mentioned under article 3.1 who is already affiliated, and insofar as the affiliation request is made at the latest six (6) months prior to the effective retirement date of the main insured person under the legal retirement system to which the latter belongs. This affiliation is possible even in the event the main insured person were to be refused his/her personal affiliation on medical grounds. The cover of spouses cannot start before the effective date of the cover of the persons mentioned under point 3.1 above. If affiliation of the person mentioned under article 3.1 is refused on medical grounds, the cover of spouses starts on the first day following the month in which affiliation is accepted.

c. Affiliation of dependent children (article 3.2) is done in the name of one of the persons mentioned under article 3.1 or 3.2 already affiliated. This affiliation is possible even in the event the main insured person were to be refused his/her personal affiliation on medical grounds. The cover of dependent children cannot start before the effective date of the cover of the persons mentioned under point 3.1 above. If affiliation of the person mentioned under article 3.1 is refused on medical grounds, the cover of dependent children starts on the first day following the month in which affiliation is accepted.

d. The affiliation form should be filed together with a medical questionnaire, duly completed by the person to be insured. On the basis of this questionnaire, the medical consultant of the insurer can request a medical examination of the person concerned and be notified of its results.

The medical examination costs are at the insured person’s expense.

The insurer reserves the right to reject an affiliation request on the basis of the medical information provided.

Affiliation is done without medical formalities for all persons mentioned under article 3.1 and 3.2 provided that their affiliation request is filed within 13 months following the start of employment (the probation period is included in this period) of the person mentioned under article 3.1. This is confirmed under oath in the affiliation request.

The insured person will attach to his/her affiliation form a copy of his/her AFILIATYS membership card or indicate the AFILIATYS member number, or join a copy of his/her request for membership with AFILIATYS.

Once the person is accepted for insurance, s/he has to communicate the member number of AFILIATYS to the broker/administrator for the affiliation procedure to be completed.

e. Newborn babies are automatically insured from birth, without medical questionnaire, provided that:
- the mother or father is already insured;
- the affiliation request is filed within 3 months after birth.

Article 5 - Inception, suspension and termination of the cover

5.1 For each person who has filed a request for affiliation, the cover starts on the first day of the month following the approval of the request by the insurer. A new request for affiliation is subject to approval by the medical consultant.

5.2 If the insured person cancels his/her affiliation by registered mail, the cover will end on the first day of the month following receipt of the cancellation letter.

5.3 The insured persons who, on the basis of section 3 of chapter 4 of Annex 10 of the Regulations, have a supplementary cover for the duration of their secondment to a Third Party Country, can request the suspension of their rights and obligations under the present contract. To this end, a premium suspension request must be filed with Cigna by the insured/co-insured person, establishing the date on which the payments will stop. The person concerned will also have to inform the broker of the date on which the insurance is resumed under the present contract, after a suspension of his/her cover as mentioned above.

Article 6 - Payment of the premiums

The premiums are payable in advance by the main insured and/or the co-insured, according to the following schedule:
- Hospi Safe Plan: annually, on 1 January;
- Hospi Safe Plus Plan: quarterly (01/01, 01/04, 01/07, 01/10).

The broker will collect the premiums by direct debit, credit card payment or payment request. If the premium is not paid within three (3) months after the expiry date, notwithstanding the broker’s reminders, the cover of the insurance will stop immediately and permanently.

Article 7 - Benefits and methods of reimbursement

The insurance covers the healthcare costs that are medically necessary, on the condition that they have been reimbursed first by the JSIS, even though the intervention of this scheme is limited to the one foreseen in article 72 § 4 of the Staff Regulations.
For co-insured persons who do not benefit from the JSIS, the reimbursements borne by the insurer may not exceed the difference between the claimed costs and the reimbursement as foreseen by the JSIS according to the Staff Regulations, in case the person concerned would have enjoyed the benefits of this scheme.

In case the JSIS modifies the amounts of its intervention with respect to the tariffs applicable on 1 January 2010, the supplementary reimbursements borne by the insurer will be adjusted accordingly. If a prior agreement is required by the JSIS, Cigna will take on this responsibility in the case of reimbursements provided for by a national or international social security scheme.

7.1. Formulas and benefits

7.1.1. Basic supplementary health insurance: Hospi Safe Plan

The Hospi Safe Plan covers the reimbursement of the following healthcare costs:

- the healthcare costs during hospitalisation comprising at least one night and the costs of surgical interventions as insured by the JSIS (such as the costs of the stay, the costs of medical and paramedical benefits, the surgeon's fees, the costs of anaesthetics, the operating theatre, the plaster room, bandages, medical imaging, ...) ;

- the surgical interventions foreseen in the appendices of the JSIS may also be executed in One Day Clinic, which is then equivalent to hospitalisation for at least one night;

- the ambulant healthcare costs (visits by the practitioner, medication on prescription, ...) are reimbursed if they are directly related to the cause of the hospitalisation and claimed within two months

- preceding the hospitalisation or six months following the hospitalisation and as described in the JSIS;

- the costs of transport that is medically necessary and directly related to the hospitalisation;

- the post-surgical stays in rehabilitation and functional re-education that are medically necessary, within six months following the covered hospitalisation.

- The expenses of the emergency room of a hospital are reimbursable only when they are linked to a hospitalization as described above and when they are incurred within 2 months before and 6 months after the hospitalization.

- For expenses incurred as of 01.01.2015: All medical expenses during pregnancy (on the basis of a medical certificate attesting of the pregnancy), after reimbursement by the JSIS.

7.1.2. Comprehensive supplementary health insurance: Hospi Safe Plus Plan

(Optional cover Dental, Vision, Hearing, Orthopaedic devices, Medical fees for various treatments for which the JSIS provides a maximum number of sessions)

This formula is more comprehensive and covers, in addition to the basic formula described under point 7.1.1, the outpatient healthcare costs described below, outside the hospitalisation and outside the pre- and post-hospitalisation period:

The Hospi Safe Plus Plan also covers the costs related to:

a) Expenses reimbursable in complement to the JSIS:

- Medical consultations and visits and prescribed pharmaceutical products;

- dental care (examples: orthodontics, prostheses and dental materials, bridges, crowns and implants);

- miscellaneous treatments listed in chapter 8, point 2 of the general implementation provisions concerning the reimbursement of medical costs of the JSIS;

- healthcare and medication related to an eye illness, glasses and spectacles, contact lenses and eyeball implants;

- healthcare and devices directly related to hearing;

- orthopaedic devices (such as: orthopaedic shoes, elastic socks for varicose veins, artificial limbs and their segments, crutches, wheelchairs and similar auxiliary appliances).

b) Expenses without intervention of the JSIS

- Speech therapy for non-medical reasons (on the basis of a settlement note of the JSIS stating the refusal of the expenses by the JSIS and a copy of the original invoice). This cover is limited to children up to age 12 (included).

- Pharmaceutical products in the frame of prevention beyond the limit of the JSIS (on the basis of a settlement note of the JSIS stating the refusal of the expenses by the JSIS and a copy of the original invoice).

- Dietary treatment or programme (on the basis of the original invoice).

- Subscription to a sports association or facility or swimming pool (on the basis of the original invoice), on the condition that the subscription counts at least 6 months or 26 sessions.

7.2. Methods of reimbursement

7.2.1. Supplementary health insurance: Hospi Safe Plan

For all healthcare costs described under point 7.1.1., the supplementary reimbursement borne by the insurer equals 100% of the difference between the incurred expenses and the reimbursement previously obtained from:

- the Joint Sickness Insurance Scheme of the European Union (JSIS) and/or any private insurance; and, if necessary, after deduction of:
- the reimbursements of costs received or which the beneficiary can claim under another medical insurance, legal or statutory (see article 72 § 4 of the Staff Regulations) and/or
- the reimbursements obtained as a supplement at the expense of the JSIS under article 72 § 3 of the Staff Regulations.

The supplementary reimbursement rate borne by the insurer for post-surgical stays in rehabilitation and functional re-education cannot exceed 20% of the expenses incurred.

7.2.2. Supplementary health insurance: Hospi Safe Plus Plan

For all healthcare costs described under point 7.1.2. (a), the supplementary reimbursement borne by the insurer equals **80%** of the difference between the incurred expenses and the reimbursement previously obtained pursuant to the provisions listed under point 7.2.1. The supplementary reimbursement rate borne by the insurer for the

various treatments listed under chapter 8, point 2 of the general provisions for implementation concerning the reimbursement of medical expenses cannot exceed 20% of the expenses incurred.

For the medical consultations and visits and prescribed pharmaceutical products, the maximum reimbursement amounts to 1.250 EUR per person per calendar year, with a deductible per calendar year in function of the age of the insured person on January 1st of the year of:

- 0 EUR for children up to 18 year (included)
- 50 EUR for persons between 19 and 60 years (included)
- 100 EUR for persons as of 61 years

Are not considered as reimbursable expenses:

- the cost of a spectacle frame for a total amount (after reimbursement under the JSIS) exceeding 200.00 EUR (this amount is the intervention limit of the Hospi Safe Plus Plan);

- dental costs (dental care, orthodontics, dental prostheses) for a total amount per calendar year (after reimbursement under JSIS) exceeding:

  800.00 EUR for the first year and second year;
  1.600.00 EUR the third year;
  2.400.00 EUR the fourth year;
  3.200.00 EUR as from the fifth year.

These amounts are the intervention limits of the Hospi Safe Plus Plan.

For the expenses described under point 7.1.2. (b), the reimbursement rate is defined as follows:

- Speech therapy for non-medical reasons: reimbursement of 80% of the invoice with a maximum of 30 sessions per person per calendar year and 1.250 EUR per person per calendar year

- Pharmaceutical products in the frame of prevention beyond the limit of the JSIS: reimbursement of 80% of the invoice

- Dietary treatment or programme: reimbursement of 20% of the invoice with a maximum of 50 EUR per person per calendar year

- Subscription to a sports association or facility or swimming pool: reimbursement of 20% of the invoice with a maximum of 50 EUR per person per calendar year.

7.3. Special reimbursement under the JSIS

If the insured person receives special reimbursement under article 72 § 3 of the Staff Regulations and article 24 of the regulation applicable to the cover of the risk of illness for the European Union officials, the insured person must inform the insurer about it through Cigna. The amount of the special reimbursement granted by the JSIS to the insured person must be retroceded to the insurer according to the methods to be agreed upon between the parties.

Article 8 - Change of formula

Without prejudice to the provisions of article 2.3, the cover extension from a Hospi Safe Plan to a Hospi Safe Plus Plan is only possible in so far as the request us submitted at least six (6) months prior to the effective retirement date under the legal retirement system to which the main insured person belongs, and under reservation of an orthopantonogram, on the basis of which the insurer reserves the right to request further information before accepting or refusing the extended cover. The costs of a medical examination are at the expense of the insured person. The insurer, Cigna and the medical consultant appointed by the insurer will treat the information obtained as a result of the implementation of the agreement with absolute secrecy.

Article 9 – Exclusions

1. Are not covered by the supplementary health insurance:

- The healthcare costs related to an accident or an occupational disease suffered by an official or other agent of the European Union, which give rise to full reimbursement according to the articles 72 and 73 of the Staff Regulations of officials of the European Communities.
- The healthcare costs for hospitalisation, the cause of which is the object of exclusion on the basis of the medical formalities.
- The healthcare costs for hospitalisation that is already ongoing on the affiliation date of the insured person.
- For the insured who were affiliated to the present contract with medical formalities, the healthcare costs for hospitalisation related to an infirmity and/or illness that existed at the time of affiliation of the insured and that had already manifested itself through objective symptoms that could be diagnosed. However, the cover is acquired if, during the year following affiliation, the insured was not hospitalised for or did not have any medical treatment related to the pre-existing cause.
- The healthcare costs for any form of sterilisation, its consequences and results.
- For aesthetic treatment and care.
- The nursing costs for home care, except special care given under medical prescription (e.g. injections, change of dressings, etc.) and limited to the covered risks.
- The costs of spa treatments, except for post-surgical rehabilitation and functional reeducation as provided for under article 7.1.1.
- The performances as a result of damages caused by acts of terrorism are covered under the terms and within the limits and time spans provided for by the Act of 1 April 2007 (M.B. 15 May 2007) concerning insurance against damages caused by terrorism, it being understood that Allianz Benelux s.a. as a member of TRIOP asbl, association constituted as implementation of the provisions of this Act.
- The contract does not cover claims resulting from damages caused by weapons or devices designed to explode as a result of a modification of the structure of the atomic nucleus.

2. The following benefits are never covered:

- resulting from an act of war, i.e. directly or indirectly resulting from an offensive or defensive action by a power at war or any other event of a military nature;
- resulting from uprisings, civil unrest, any acts of collective violence of political, ideological or social inspiration, whether or not accompanied by rebellion against the authorities or any instituted powers, if the insured person took part actively and willingly;
- resulting from taking part intentionally in a crime or offense;
- resulting from attempted suicide;

- caused intentionally by the insured or by the beneficiary or resulting from any obviously reckless act, except in the case of rescuing people or goods;
- resulting from alcoholism or drug use, as well as illnesses or accidents and their consequences suffered by the insured when he is inebriated or under the influence of alcohol, narcotics, hallucinogens or other drugs or those caused by the abuse of medication, provided that a causal link is proven between these states and the treatment;
- resulting from any fact or succession of facts having a single origin, if this fact or these facts originate or result from the radioactive, toxic, explosive or other dangerous properties of nuclear combustibles, radioactive products or waste, as well as the damages resulting directly or indirectly from any source of ionising radiation.

Article 10 - Payment of the insured benefits

The settlement of benefits is made within maximum a fortnight after Cigna receives the 'Claim for reimbursement of medical expenses' duly filled in together with the original settlement note issued by the JSIS.

The statement will be in the possession of Cigna at the latest 18 months after the date on which the statement was drawn up. The 'Claim for reimbursement of medical expenses' is provided by Cigna online, on a website of the broker dedicated to the management of the present contract. A settlement note can be drawn up electronically or on paper, as the insured persons chooses, in accordance with the insured benefits, and the supplementary amounts are then paid into the bank account mentioned by the insured person without delay. On the broker's website, the insured person will have access to his/her secure personal archive of reimbursed benefits.

Article 11 - Premiums

11.1. Premiums

The annual premiums are fixed by the insurer and are attached to the present contract for each of the age classes that are covered by the contract. The annual premium remains constant (except in the event of indexation or modifications resulting from articles 11.2 and 11.3 below) for the whole affiliation period of the insured in a specific class.
The premiums are those in force on 1 January 2010. They are expressed in EUR (€). The annual premiums are adjusted to each category on 1 January of the year during which the insured person will reach the next category (19, 36, 51, 61 and 68 years of age, respectively).

11.2. Indexation of the premium

The premiums defined under point 11.1 will vary each year in function of the Harmonised Consumer Price Index, health sector, recorded on 1 July of each year and published by Eurostat (EUR 27). They are implemented as from 1 January each year.

The insurer will notify this variation of the premium to the broker Cigna, who will inform the policyholder and the insured/co-insured persons before 1 September and will amend the premiums claimed from the insured on 1 January of the following year. The insurer will also notify any modification of the reference index that would be applied for the indexation of the premium.

Upon notification, the policyholder can terminate the agreement within three months following notification by the insurer. In the present contract, the indexation of the premiums will take place for the first time on 1 January 2011 on the basis of the aforementioned consumer price index recorded on 1 July 2010.

11.3. Modification of the premium

In the event of contractual, legal or regulatory amendments in matters of social security, changes to the JSIS or amendments of the Belgian laws on hospitals or any other legal or regulatory change that has a significant impact on the cost or scope of the benefits covered, the insurer reserves the right to change the insurance terms and conditions as from the end of the financial year during which the aforementioned changes occurred, after having informed the policyholder with a minimum prior notice of six months.

Without prejudice to the provisions of article 2 of the present terms and conditions, the premium mentioned in article 11 can be revised by the insurer on the annual expiry date of the agreement on the basis of the annual assessment of the management results as provided for by article 12. The insurer will notify the policyholder and the insurance of the proposed amendment broker by registered mail, at the latest 9 months prior to the annual expiry date of the agreement. Upon each notification, and in the event of disagreement about the new proposal, the policyholder can terminate the agreement within three months as from the date of notification by the insurer.

11.4 Premium waiver or reduction for children from 0 to 1 year

In the formula Hospi Safe, children of 0 to 1 year (included) are exempted of premium payment.
In the formula Hospi Safe Plus, children of 0 to 1 year (included) receive a yearly premium reduction of 100 EUR, or 25 EUR per quarter.

Article 12 - Administration of the contract – Results – Account of receipts and expenditure

Every year, at the latest by 28 February, the insurer will send the policyholder and the broker an account of receipts and expenditure of the previous insurance period, according to the schedule below.
The broker will add a report resulting from the administration of the present contract. Should the case arise, a proposal about the proposed premiums for the next insurance period will be attached to the assessment document, pursuant to article 11.3 above.

12.1. Receipts

- the premiums due (excluding taxes) during the previous insurance period;
- the estimated amount foreseen as reserved for claims and IBNR on 1 January of the previous insurance period for claims not made at the start of the previous insurance period.

12.2. Expenditure

- the benefits paid during the previous insurance period;
- the estimated amount set up as reserve for claims and IBNR on 31 December of the previous insurance period, for claims not made at the end of the previous insurance period;
- administration costs.

12.3. Assessment and information to the insured parties

On the basis of the analysis of the figures and evolution prospects of the contract, the policyholder will assess, together with the insurer, the possible revision modalities of the premiums and/or benefits.
Information about the proposed premiums for the next insurance period will be sent to the insured/co-insured parties by the broker by 1 October of the current insurance period at the latest, together with a management appraisal for the 3 previous insurance periods in the present contract.

Article 13 - Omission and fraud

Upon affiliation it is compulsory for the insured person to declare exactly all circumstances he/she is aware of and that he/she should reasonably consider as being constituent for the insurer to evaluate the risk.

In case of intentional omission or inaccuracy at the time of affiliation or when applying the provisions of article 7.3 above, the insurer has the right to be released from his commitments towards the insured person (deciding either on the cancellation of the affiliation request and the proposed benefits, or the cancellation of the insured benefits).
In case of fraud noted by the insurer, the benefits are ended immediately and the insurer is no longer bound by his contractual obligations with respect to the insured/co-insured party. Any fraud or attempt to fraud towards the insurer will result not only in cancellation of the insurance contract with the fraudster, but also in criminal prosecution under article 496 of the Belgian Criminal Code.

Article 14 - Territorial validity of the insurance

The present contract is valid worldwide. However, outside the European Economic Area, the healthcare costs will be reimbursed up to a maximum amount corresponding to the amount reimbursed for each expense by the JSIS, with an overall maximum amount per insured party of 25,000 EUR per insured and per calendar year as supplementary reimbursement.

Article 15 – Litigation

The law applying to the present contract is the Belgian law.

All disputes arising out of or in connection with the interpretation or application of this Agreement and that have not been settled in mutual agreement or through the intervention of AFILIATYS shall be finally settled under the CEPANI Rules of Arbitration by a single arbitrator, in case the two parties agree with her/his appointment. Failing the appointment of a single aribtrator, each party shall designate an aritrator and the two arbitrators shall then designate a third arbitrator.

Failing the appointment of an arbitrator by one of the two parties, or failing an agreement between the arbitrators designated by each party upon the identity of the third arbitrator, the appointment shall be made, at the request of the party first asking, by the President of the Court of First Instance of Brussels.

The parties exclude explicitly any action to annul the decision of the arbitration.

The arbitration shall be conducted in the French language.

Each party will bear half the expenses of the arbitration.

In agreement with the insured person and the Insurer, any dispute of medical nature that has not been settled in mutual agreement between the doctor of the insured person and the medical consultant of the Insurer, can be submitted to a third medical expert designated in mutual agreement by the two before mentioned doctors to be settled definitively.

Failing the appointment of this medical expert, the appointment shall be made, at the request of the party first asking, by the President of the Court of First Instance of Brussels.

Lodging of complaints:

Any complaint regarding the execution of the agreement should be lodged with :
- Ombudsman van de Verzekeringen, de Meeüsplantsoen, 35, 1000 Brussel, fax: 02/547.59.75, info@ombudsman.as, or
- department complaints of the insurance company Allianz Benelux n.v., Lakensestraat,35, , 1000 Brussel, fax : 02/214.61.71, klachten@allianz.be,

without prejudice to the insured person's possibility to take legal action as described in the present article.

Within the framework of the present contract, and with respect to its members, AFILIATYS has a role as adviser as regards negotiation, general information, advice for certain affiliations, as well as conciliation in the event of litigation.

Article 16 - Expiration of the cover

Except in the event of expiry of the group policy, under article 2 above, the present contracts ceases to be effective with respect to the insured/co-insured party:

- in case of non-payment of the premium, in spite of summons to pay within a fortnight sent by the broker by registered mail with acknowledgement of receipt, according to article 6;
- in case of omission or fraud according to article 13 above;
- in case of cancellation by the insured/co-insured. This cancellation should be notified to Cigna, as provided for by article 5;
- upon termination of the functions of the persons listed under article 3.1. However, the cover can be continued in the event the insured persons or their co-insured are still beneficiaries of the JSIS after they cease to have their functions within the Institution.
- at the moment the insured reaches the age of 26, except if he/she is still a dependent of the persons listed under articles 3.1 and 3.2 because of their studies or their health.

Article 17 – Currency

The premiums and insured benefits are payable in EUR.

Article 18 – Mandates

The insurer gives power of attorney to Cigna to collect all annual premiums or prorated premiums from affiliates and to issue and sign the insurance certificates and to settle claims.

Article 19 - Protection of the privacy and the rights of the registered persons

The personal data conveyed to Cigna will exclusively be used for the following purposes: evaluation of the insured risks, management of the commercial relation, management and execution of the insurance contract and of the claims insured by the contract. Only for these purposes, they can be transferred, if necessary, to a reinsurer or to an expert. Any person justifying his/her identity has the right to consult the data contained in the file concerning himself/herself.
To exercise this right, the person concerned should send a dated and signed request to the following department:

Protection of Privacy, Cigna International Health Services,
Plantin & Moretuslei 299
B 2140 Antwerp.

To this request a copy of the ID card of the applicant will be added and the request will mention the name and address of the physician to whom our medical consultant can communicate the possible medical information. Moreover, the affiliate has the right to obtain, free of charge, the correction or deletion of his/her data if they are inaccurate, and refuse the processing of this information for direct marketing purposes, mentioning this expressly next to his/her signature on the present document. In order to ensure the quick processing of the contract and the claims, and only for this purpose, the insured hereby gives his/her consent for the processing of the data concerning his/her health by the Medical Department.

Article 20 - Subrogation of the insurer

Due to the fact that the cover of the health insurance group contract is due, or in the event the insurer has already implemented the contract, the insurer is subrogated in the rights that can belong to the policyholder or the insured against all third parties responsible for an accident or illness. The policyholder and/or insured cannot waive totally or partly the recourse in favour of any third party without the written consent of the insurer. The policyholder and/or insured must provide the insurer with all information necessary in order to enable the insurer to exercise his right of recourse with respect to third parties (a/o pursuant to article 7.3).

Article 21 - Termination of the group contract and continuation as individual insurance

21.1 The policyholder or, in the event of bankruptcy or liquidation, the administrator or liquidator of the policyholder, will inform the main insured person within thirty days following the loss of the group insurance cover, of the exact moment of this loss and the possibility to carry on the contract individually.

21.2 The possibility to continue the healthcare insurance individually will be conditional upon the implementation of the nomenclature of Belgian social security and on the condition that the applicant policyholder and the insured persons have their main residence in Belgium. The insurer will propose a contract on the basis of the rates, terms

and conditions applicable for hospitalisation insurances for individuals, sold at the time when the insured exercises his/her right to continue the contract.

21.3 The modalities for carrying on the contract individually by the main insured and/or co-insured persons are not part of the present insurance contract.

Article 22 – Special Provisions

22.1 The policy does not provide coverage related to business, including but not limited to this insurance and the fulfilment of any obligation thereunder, to the extent it would violate any applicable sanction law or regulations of the United nations and/or the European Union and/or any other applicable national economic or trade sanction law or regulations.

22.2 - Notifications
Any change of domicile must be notified to the insurance company within 30 days. Notifications to the party insuring or the insured will be validly made to the last address communicated to the insurance company.

All notifications on behalf of the insurance company must be made to the registered office.
All notifications from one party to the other will be deemed to have been made on the date of posting, which appears on the postmark.

22.3 Terrorism
The benefits payable under this insurance agreement for claims caused by terrorism are guaranteed in the context of and pursuant to the conditions and limitations laid down by the 1 April 2007 Law regarding the insurance for damage caused by terrorism, as Allianz Benelux s.a. is a member of TRIP vzw, the legal person established in accordance with the provisions of that law.

* * * *

The present supplementary health insurance contract is drawn up in threefold and signed for acceptance by AFILIATYS asbl in the name and on account of all members affiliated to the present contract and by the insurer. A copy is destined for the archives of the policyholder AFILIATYS asbl, a copy for the insurer's archives and a copy for the archives of the broker Cigna. The present contract was originally drawn up in French and it will be the version that will be valid before the courts. Thus agreed and executed between parties to be implemented in good faith. Drawn up in Brussels on September 10th, 2009.

Accepted by the policyholder
ASBL AFILIATYS

Accepted by the insurer
ALLIANZ BENELUX S.A.

Accepted by the broker/administrator
Cigna International Health Services SPRL

Premiums applicable on 1 January 2015

Age	Hospi Safe premium due per year	Hospi Safe Plus premium due per quarter
0-1	0 €	91,55 €
2-18	64,76 €	116,55 €
19-35	77,70 €	142,46 €
36-50	116,55 €	213,68 €
51-60	155,41 €	284,92 €
61-67	194,26 €	352,91 €
+67	259,01 €	472,69 €