Cigna®

ASSOCIATION INTERNATIONALE DES ANCIENS DES COMMUNAUTÉS EUROPÉENNES ASBL

(International Association of Former Officials of the European Communities)

Collective/Individual Accident Insurance Policy
n° 719.757.143

IGO Health Benefits

1. General Conditions (G.C.)

Article 1 – Risks covered

Under the General Conditions (G.C.) and Special Conditions (S.C.) which follow, the policy covers any accidents that the insured parties might suffer in any part of the world during the course of their private lives.

Subject to the provisions of Art. 2, an accident is considered as any unexpected event that harms the physical or psychological integrity of the insured party, of which the cause or one of the causes is outside the victim's body.

The following are also considered as accidents:

- Poisoning, including food poisoning;
- The consequences of animal bites or insect stings;
- Distortions, tears or ruptures in muscles or tendons resulting from physical effort;
- A therapeutic incident following an error committed by the medical team;
- The unexplained disappearance of the insured party if, when one year has elapsed and after the circumstances of the disappearance have been investigated, the insured party is presumed dead unless it cannot be presumed that his/her death was caused accidentally.

Article 2 – Risks excluded

a) Illnesses (including professional illnesses) cannot be considered as accidents, either in themselves or in their consequences.

b) Suicide or attempted suicide.

c) Accidents resulting from war or events of the same nature.

d) Accidents resulting from:
   - Voluntary participation in brawls;
   - Acts generally accepted to be reckless;
   - Inebriation or the use of narcotics not prescribed by a doctor, except by error;
   - The practice of:
      § Motor sports in competition or training;
      § The following aeronautical or aerial sports: Parachuting, gliding, flying in a microlight, ballooning, delta-planing, paragliding and bungee-jumping;
      § Combat and defence sports, with the exception of the following: Judo, Aikido, Tai-Chi-Chuan and fencing;
   - Wall-climbing or rock-climbing or mountain-climbing along unmarked paths, except in case of necessity;
   - Yachting/pleasure sailing, except within five miles of the coast, or unless the vessel and its crew are certified for sailing on the open seas.

e) No benefits will be paid to beneficiaries who intentionally provoked the death of the insured party.

f) Damage resulting from the use of explosives or nuclear energy that comes under the application of the Paris Convention ratified by the Belgian State on 3 August 1966, as well as the additional conventions concluded subsequently to that date.

Article 3 – Age limit for affiliation

Those persons who have not entered a declaration of affiliation before the date of their 80th birthday may no longer be insured.

Article 4 – Benefits

The benefits provided under the policy will be paid under the following conditions:

a) In case of death

In case of death, the capital assured will be paid to the beneficiary/beneficiaries designated by the insured party or, in the absence of such designation, to the persons designated below:

- The spouse and direct descendents of the insured party, in accordance with the provisions of the law on succession applicable to the insured party; however, the amount to be paid to the spouse may not be less than 25% of the capital sum;

- In the absence of persons in the category mentioned above, the parents or grandparents, in accordance with the provisions of the law on succession applicable to the insured party;

- In the absence of persons from either of the two categories mentioned above, the legal heirs in ranking order, in accordance with the provisions of the law on succession applicable to the insured party.

Any sums already paid to the insured party for the same accident for permanent disability will be deducted from that capital sum.

b) In case of permanent invalidity

Total or partial permanent invalidity is measured by the effect on physical-psychological integrity (EPPI) as laid down by the European scale of assessment of effects on a person's physical and psychological integrity (in the latest edition published at the time of consolidation), though this may not exceed 100%.
All or some of the capital assured will be paid to the insured party in accordance with the European scale and its rules of application. The indemnities due for cases of death and permanent invalidity may not be cumulated.

Injuries to limbs or organs that were already infirm will only be compensated according to the difference in their condition before and after the accident.

Assessment of the injuries to healthy limbs or organs damaged by the accident must take into account the condition of infirmity of other limbs or organs unaffected by the accident insofar as those limbs or organs function in synergy with those damaged by the accident. In this case, the compensation will cover the total or partial loss of function. Compensation for the partial loss of function will be determined in accordance with the Gabrielli formula[*].

Practical utilisation modalities of the European scale for assessing permanent invalidity

Principles

The assessing physician quantifies the degrees of invalidity, effects on the person's physical and/or psychological integrity that can be confirmed medically and are therefore measurable, by referring to the latest edition of the European scale published at the time of consolidation [when the injuries are confirmed definitive].

Certain types of after-effects (for example, ophthalmological, ENT, stomatological, etc.) require recourse to a specialist in the field in question. The assessing physician must find in the report of the expert he consulted all the technical data and all the elements for consideration that would enable him to pronounce on the cause and qualification of the after-effects.
Whatever the function envisaged (walking, hearing, sight, etc.), when a prosthesis, orthesis or technical aid supplied to the patient improves the functional problems presented, the latter will be assessed taking account of the benefit provided.

The assessing physician will explicitly mention at the time of his consolidation examination the medical charges that might still need to be covered subsequently to the date of consolidation.

[*] i = (V1 - V2) / 1*100
i = invalidity to be agreed for the accident, taking account of the state of infirmity of the synergetic organ unaffected by the accident
V1 = remaining validity before the accident
V2 = remaining validity after the accident

Definitions

For the application of the European scale, permanent invalidity is defined as follows:

> The definitive reduction of the person's physical and/or psychological potential that can be confirmed or explained medically, to which are added the pain and psychological repercussions that the doctor knows are normally associated with the after-effects, as well as the consequences for a person's daily life that are customarily and objectively associated with that after-effects.

The level of invalidity is:

> The extent, up to a theoretical maximum of 100%, of the difficulty encountered by any person for whom the after-effects have been thus quantified in carrying out the customary gestures and actions of daily life.

General matters

The levels proposed by the scale relate to the individual considered as a whole. Thus, a level does not quantify the deficiency of a function or an organ if the integrity thereof is rated 0%.

The levels concern after-effects considered separately.
Total loss of function is placed in the same category as the anatomical loss of the limb or organ in question.
Situations that have not been described are assessed by comparison and analogy with situations of after-effects that have been described and quantified.

Imperative nature of the scale

The European scale is obligatorily applicable. It is restrictive if it sets a predetermined level; if it provides for a range of levels, the assessor cannot go beyond the minimum or maximum.

Partial anatomical and/or functional after-effects must be assessed in relation to the deficiency observed, taking account of the levels in the scale of total loss in cases where the scale does not specify precise levels.

The utilisation modalities for certain chapters of the scale (e.g. for calculating the synergy of the fingers on one hand) are also obligatorily applicable. For a left-handed person, the levels relating to the upper right limb are applied to the left limb, and vice-versa.

Multiple after-effects

In the case of multiple side-effects from the same accident, calculating the overall level is done by simple addition,

- Without exceeding the level of the total loss of the limb or organ in the case of multiple injuries to that limb or organ;
- Without exceeding 100%.

In the case of successive and synergetic after-effects, the Gabrielli rule applies (see above).

Prior condition

A prior condition is defined as a condition proven to have had a clinical expression and having been perceptible in the person's daily life before the accident in question.

Prior condition or one of predisposition

A latent prior condition, without perceptible clinical expression or repercussion on the person's daily life, is placed in the same category as a pathological predisposition or susceptibility.

c) Medical expenses

Expenses relating to medical treatment following the accident will be paid by the insurers in accordance with the provisions appearing in the Special Conditions (S.C.).

2. Special Conditions (S.C.)

Article 1 – Cancellation of the General Conditions by the Special Conditions

The G.C. will be modified by the S.C. to the extent that they conflict with the latter.

Article 2 – Description of the risk

a) The present policy is taken out by: The *Association Internationale des Anciens des Communautés européennes*, an International Association referred to as the "Policyholder" for the benefit of the persons designated in Art. 3 of the S.C., hereinafter referred to as the "Insured Parties".

b) The insurers declare that they are sufficiently aware of the risk and absolve the Policyholder from having to provide more detailed information in this respect.

c) If essential changes are made to the nature of the professions of the insured persons or if they engage in professions not included in the insurance policy, the Insured Parties must make a declaration thereof to the insurers.

Article 3 – Persons insured

The following persons have the option of being insured under the conditions of the present policy:

a) Any person whose principal occupation was with one of the Institutions or Organs of the European Union and who benefits as such from an indemnity or a pension.

b) The spouses of the persons mentioned in Art. 3a) of the S.C., subject to the following conditions:
   - The person mentioned in Art. 3a) of the S.C. must have taken out the insurance policy him/herself in order that his/her spouse can also be affiliated;
   - The spouse must be insured according to the same formula for assured capital (Art. 6) as the person mentioned in Art. 3a) of the S.C., unless the last paragraph of Art. 4 of the S.C. is applicable;
   - The spouse must be covered by the *Régime Commun d'Assurance Maladie* [Joint Sickness Insurance Scheme] or a National Social Security Scheme.

c) The surviving spouses of civil servants and the surviving spouses of persons mentioned in Art. 3a) of the S.C. who benefit as such from a pension.

The persons mentioned in Art. 3) may remain insured during the interval of time between, on the one hand, the end of the period during which they drew a prepension and, on the other hand, the start of their pension. The amounts of the premium and the cover will then be calculated on the basis of the prepension of the insured person during the twelve months immediately preceding the receipt of their pension.

Article 4 – Start and end of cover

The persons mentioned in Art. 3 who were declared to the insurers through Cigna are insured as from 00:00 hours on the day after the said declaration.

When the declaration is made in the first fifteen days of the month, the premium will be due from the 1st of that month. When the declaration is made in the second fifteen days of the month, the premium will only be due from the 1st of the following month.

The benefits provided under the present policy are guaranteed to the Insured Parties without age limit.

They cease to be granted to those Insured Parties who so wish, on condition that such is declared to the insurers, through Cigna, it being understood that retirement takes place from the 1st of the month following the request for cessation.

After the Insured Party's 75th birthday, cover will be limited to the benefits guaranteed according to formula A.

If the person mentioned in Art. 3a) of the S.C. and the person mentioned in Art. 3b) of the S.C. are insured, cover will be limited to the benefits guaranteed according to formula A for both Insured Parties from the 75th birthday of the person mentioned in Art. 3a) of the S.C. if the latter is older than the person mentioned in Art. 3b) of the S.C.

However, if the person mentioned in Art. 3b) of the S.C. is older than the person mentioned in Art. 3a) of the S.C., cover will be limited to the benefits guaranteed according to formula A for the person mentioned in Art. 3b) of the S.C. when the latter reaches his/her 75th birthday. On the other hand, the person mentioned in Art. 3a) of the S.C. may remain insured for another formula up to his/her 75th birthday.

Article 5 – Method of affiliation to the insurance policy

In order to be insured, the interested party must enter a declaration of affiliation with the insurers through Cigna which includes the following information:

- The date of the declaration;
- The identity of the Insured Party;
- The date of birth of the Insured Party;
- His/her capacity (indicate whether affiliating on the basis of Art. 3a), 3b) or 3c) of the S.C.);
- The formula for assured capital chosen from among the options offered by Art. 6 of the S.C.;
- The beneficiary/beneficiaries in case of death.

The Insured Party may, during the course of the insurance policy, opt for one of the other assured capital formulae mentioned in Art. 6 of the S.C.

To this end, the Insured Party must enter a new declaration of affiliation and indicate the new formula selected, although the new cover may only take effect at the start of the following insurance year of the policy, which is set at the first of July of each year.

Article 6 – Cover

When making the declaration of affiliation mentioned in Art. 5 of the S.C., the Insured Party can choose between three formulae for assured capital:

Formula A
- Capital on death, equal to 2.3 times the Insured Party's allowance or annual pension;
- Capital on invalidity, equal to 4 times the Insured Party's allowance or annual pension;

Formula B
- Capital on death, equal to 3.5 times the Insured Party's allowance or annual pension;
- Capital on invalidity, equal to 6 times the Insured Party's allowance or annual pension;

Formula C

- Capital on death, equal to 5 times the Insured Party's allowance or annual pension;
- Capital on invalidity, equal to 8 times the Insured Party's allowance or annual pension.

Depending on the formula selected by the Insured Party, the benefits guaranteed by the present policy are as follows:

a) In case of death
Payment of a capital sum equal to 2.3, 3.5 or 5 times the allowance or annual pension of the Insured Party.

b) In case of total permanent invalidity
Payment of a capital sum equal to 4, 6 or 8 times the allowance or annual pension of the Insured Party.

c) In case of partial permanent invalidity
Payment of a capital sum equal to 4, 6 or 8 times the Insured Party's allowance or annual pension multiplied by the percentage of permanent invalidity attributed in application of the scale set out in Art. 4b) of the S.C.

d) Additional allowance
On the advice of the independent medical consultant or the conclusions of the medical commission described in Art. 15 of the S.C., an allowance in addition to partial permanent invalidity will be granted to the Insured Party for aesthetic prejudice, sexual prejudice (apart from reproduction), exceptional pain not objectified but medically plausible, disruption of the leisure activities specific to the Insured Party.

That allowance will be determined in accordance with the assessment matrix for special prejudices appearing in the table below:

Qualitative scale	Very slight	Slight	Moderate	Average	Quite serious	Serious	Very serious
Quantitative scale	1	2	3	4	5	6	7
Rate for additional allowance	0.5%	1%	1.5%	2%	2.5%	4%	7%

Cases of permanent invalidity equal to or less than 5% do not give entitlement to payment of a capital sum for those who opted for the formula with an excess of 5%. If in these cases permanent invalidity is greater than 5%, the capital sum is determined according to the following table:

Degree of invalidity	**Benefits**
From 0 to 5%	None
6%	1.5%
7%	3.0%
8%	4.5%
9%	6.0%
10%	7.5%
11%	9.0%
12%	10.5%
13%	12.0%
14%	13.5%
15%, 16%, 17%, etc.	15%, 16%, 17%, etc.
Up to 100%	Up to 100%

For those who opted for the formula with no excess, the capital sum is determined according to the percentage of invalidity.

In a case where the degree of invalidity is represented by a decimal number, the percentage of the corresponding benefits is established proportionally.

e) For the calculation of the benefits described in points a, b and c of the present article, account will be taken of the allowance or basic pension of the twelve months immediately preceding the accident and for which the contribution has been paid. For person insured for less than one year, the calculation will proceed by extrapolation to complete the twelve months. For the Insured Parties mentioned in Art. 3b) of the S.C., the allowance or basic pension of the Insured Party mentioned in Art. 3) of the S.C. will be taken into consideration.

f) Medical expenses

Payment for medical expenses, medications, hospitalisation, surgery, prostheses (without amortisation due to wear and tear), radiography, physiotherapy, clinical treatment and transportation, as well as any similar expenses necessitated by the accident.

However, if the independent medical consultant considers certain expenses to be abnormally high or ineffectual, he may reduce them to an amount considered to be reasonable or, as the case may be, refuse to refund them.

However, it is understood that the present insurance cover will only come into effect after exhaustion of the indemnities that the Insured Party would receive under the *Régime Commun d'Assurance Maladie* of the European Communities and/or a National Social Security Scheme.

Since the insurance for these expenses is a Property Insurance, and pursuant to the legal provisions of public order on this matter, the insurers will only be liable to refund these expenses if no other Insurance does so.

Article 7 – Premiums

a) The premium is expressed in the form of a percentage of the annual allowances or basic pensions. The premium for insurance of the spouse mentioned in Art. 3b) of the S.C. is calculated on the allowance or basic pension of the person mentioned in Art. 3a) of the S.C.

The rates of premium are as follows:

1. Formula WITHOUT excess

Formula for capital assured (Art. 6 of the S.C.)	**Assured on the basis of**	
	Art. 3a) and 3b)	**Art. 3c)**
Formula A	0.55%	0.61%
Formula B	0.80%	0.87%
Formula C	1.06%	1.17%

In addition to the monthly premium thus calculated, a sum equal to 9.25% thereof is due for taxes.

2. Formula WITH excess of 5%

Formula for capital assured (Art. 6 of the S.C.)	Assured on the basis of	
	Art. 3a) and 3b)	Art. 3c)
Formula A	0.47%	0.52%
Formula B	0.68%	0.75%
Formula C	0.91%	1.01%

In addition to the monthly premium thus calculated, a sum equal to 9.25% thereof is due for taxes and charges.

b) The insurers will collect the premium each month on the due date. Each collective premium payment is accompanied by a list showing the insured persons, their registration number and the amount of the premium collected.

Article 8 – Settlement of indemnities

In the case of permanent invalidity, the indemnity is payable to the Insured Party. In the case of death, the capital sum is payable to the beneficiaries in the order indicated in Art. 4 of the G.C. The signature of a receipt absolves the insurers completely of any further liability towards the signatory.

Article 9 – Exemption from making certain declarations

a) Exemption from declaring the other "individual" insurances
The Insured Parties are exempt from declaring to the insurers the other insurances they have taken out themselves.

b) Exemption from declaring infirmities and illnesses
The Insured Party is exempt from declaring to the insurers any infirmities or illnesses that might afflict him subsequently. He/she is and shall remain insured automatically by the present policy. However, it is understood that if an illness, infirmity or pathological condition were to cause an accident or exacerbate its consequences, the insurers will only be liable for compensation for the consequences that the accident would probably have had without the presence of that illness, infirmity or pathological condition.

c) Exemption from declaring benign accidents
The Insured Parties are exempt from submitting to the insurers a medical certificate for accidents he judges to be benign. In these cases, the indemnity is limited to the reimbursement of medical expenses (see article 6, f of the C.P.). It is understood that the insurers may not be then held liable if the Insured Party

deteriorates subsequently as the result of an undeclared accident. Should this happen a medical file will then be composed and evaluated by an independent medical consultant, who can call the Insured for a medical evaluation. It is thus always in the interest of the Insured to inform the insurers as soon as possible of any deterioration of the consequences of the accident compared to his initial evaluation.

Article 10 – Errors and deadlines

a) Errors, omissions, inaccuracies
   Any inaccurate declaration, any reluctance, error or omission on the part of the policyholder and/or the Insured Party may not result in forfeiture if it was committed in good faith. With regard to declarations of allowances or pensions, they will simply result in an adjustment of the premium with the actual amounts, except in cases of bad faith.

b) Delay or omission of a formality
   If the omission of a procedure to be completed by a particular deadline were to incur forfeiture, this would not happen if it is proven that the delay was the result of force majeure and that the omission was rectified as soon as possible.

Article 11 – Statutory limitation

The period of statutory limitation is three years.

a) Its starting point – distinct for each claim relating to the reimbursement of the various benefits paid to the Insured Party or his/her beneficiaries – is set at the date of introduction of each medically justified request detailing its amount made by the Insured Party or his/her beneficiaries for the purposes of settling the financial entitlements concerned in that request.

b) If the accident causes permanent invalidity, the provision by the Insured Party or his/her beneficiaries of the attending physician's report regarding the level of permanent invalidity confirmed by the latter will count as a request within the meaning of the preceding paragraph.

c) In a case where the initial level of permanent partial invalidity deteriorates after the Insured Party's claim had been settled – that deterioration being related to the cause of the event that gave rise to the initial permanent partial invalidity – a new period of limitation would start either from the new claim within the meaning of Art. 11a) of the S.C., or from the provision of the new medical certificate within the meaning of Art. 11b) of the S.C. However, the insurers will not consider a claim for further compensation for such a deterioration in the initial level of permanent partial invalidity, which is introduced after three years have elapsed from the date of the previous decision confirming a cure or specifying the initial level of permanent partial invalidity following the first consolidation of the injuries.

Article 12 – Subrogation

The insurers are subrogated in all the Insured Party's rights to legal recourse that he/she might have against the third party responsible for the damage. They are also subrogated in the rights and actions that the Insured Party might benefit from in application of Art. 29-*bis* of the Belgian law on compulsory insurance for motor vehicles.

Article 13 – Obligations in case of an accident

Except for a case of force majeure, the Insured Party must declare any accident of which he/she was a victim to Cigna within fifteen working days following the date on which the accident occurred.

That declaration must indicate in detail the place, date and time, the causes and the circumstances of the accident, as well as the names of any witnesses.

A medical certificate must be appended thereto, except if the declaration is limited to the reimbursement of medical expenses in the case the accident is considered benign (see article 9c of the C.P.).

If this is not done within thirty days, no indemnity shall be due.

The stipulations above relating to the deadlines of fifteen and thirty days mentioned above shall be applied subject to the provisions of Articles 9 and 10b) of the S.C.

In the case of an accident, the Insured Party or his/her beneficiaries must immediately and at their own expense seek the care of a doctor and all useful measures for the recovery of the Insured Party must be taken; the insurers shall not be liable for any deterioration due to a delay in seeking medical treatment or failure to obey the instructions of the doctors during treatment.

The Insured Party must, on pain of forfeiture, submit to an examination by the independent medical consultant in a case where the Insurers identify a risk of permanent invalidity as a consequence of a declared accident. In that case, the Insured Party undertakes to provide Cigna, at the expense and request of the insurers, with a report from the attending physicians whom he/she authorises give the independent medical consultant any information they may require, both with regard to the injuries and to any current or previous illnesses or infirmities.

The Insured Party or his/her beneficiaries must provide proof or presumptions making it possible to establish reasonably that the death, infirmity or temporary incapacity is the direct and exclusive result of an accident covered by the present policy.

In the case of death, the insurers are authorised to have an autopsy carried out if the proof or presumptions at their disposal do not make it possible to establish reasonably the cause of death.

Deliberately falsified declarations made by the Insured Party or his/her beneficiaries regarding the accident or its consequences shall authorise the insurers to refuse to pay any compensation whatsoever.

Article 14 – Settlement of benefits in case of permanent invalidity

The level of permanent invalidity will be determined after consolidation of the Injured Party's injuries. To this end, the Insured Party must provide a medical report confirming consolidation of his/her condition and indicating the nature of the injuries.

Based on the aforementioned medical report, an independent medical consultant is entrusted with examining the Insured Party. The insurers will send the Insured Party through Cigna a settlement proposal or his/her beneficiaries, as the case may be, accompanied by the report of the independent medical consultant, by the following deadlines:

1) The insurers will do their best to send the settlement proposal by one month from the date of their doctor's examination, which must take place without unjustifiable delay.

2) If, when this period has elapsed, the insurers are not in a position to send the settlement proposal, they will inform the Insured Party or his/her beneficiaries of the reason for this through Cigna (e.g., awaiting the results of the further information requested by the independent medical consultant from other specialist doctors; awaiting the report to be drawn up by the judicial authorities requested by the insurers, etc.) and the deadline will be extended by one month.

3) If the insurers see that they will not be in a position to send the settlement proposal before the new deadline has elapsed, they will propose to Cigna to open a consultation procedure in order to determine how to proceed with handling the matter and what new deadline should be set, which should not exceed 2 months. Cigna undertakes to keep the Insured Party or his/her beneficiaries informed about developments in his/her case.

The assured capital will be paid upon receipt by Cigna of the settlement proposal countersigned by the Insured Party, in accordance with the instructions given by the latter in this regard.

In case of disagreement by the Insured Party or his/her beneficiaries, as the case may be, with the settlement proposal, that disagreement must be notified to the insurers through Cigna.

Article 15 – Procedures opened in case of disagreement with the insurers' position regarding medical matters

In case of disagreement with the insurers' position on medical matters, each party may choose in particular one of the three following procedures:

1. Medical commission

- Each party may request the setting-up of a medical commission, which will be done within sixty days starting from the date when the third doctor is appointed.

  That medical commission will be composed of three doctors:
  1) The first doctor appointed by the Insured Party or his/her beneficiaries;
  2) The second doctor appointed by the insurers;
  3) The third doctor appointed by mutual agreement of the two first doctors.

  Failing agreement on the appointment of the third doctor within two months of the appointment of the first doctor, the third doctor will automatically be appointed by the Presiding Judge of the European Court of Justice, at the initiative of one of the parties.

  Once it has completed its work, the medical commission – on the basis of all the documents, reports and certificates present by the insurers and the Insured Party or his/her beneficiaries, as the case may be – will set out its findings on the degree of invalidity caused to the Insured Party in a report addressed to the insurers, Cigna and to the Insured Party or his/her beneficiaries.

Based on those findings, the insurers will draw up a settlement proposal which they will send to the Insured Party or his/her beneficiaries.

- The costs of the medical commission's work will be paid by:

  a) The insurers, if the medical commission's findings do not accord with the insurers' settlement proposal, notified in accordance with the provisions of Art. 14 above;

  b) The insurers and the Insured Party, if the medical commission's findings accord with the insurers' settlement proposal, notified in accordance with the provisions of Art. 14 above;

  The costs will then be shared in such a way that the Insured Party pays for the fees and disbursements of the doctor he/she has chosen and half the fees and disbursements of the third doctor, the remainder being paid by the insurers. The costs of any transportation with a first-class railway ticket or economy-class airline ticket will be refunded by the insurers.

2. Opinion of a single medical assessor

- Each party may request the consultation of a single medical assessor within a period of thirty days from the date of the settlement proposal. That medical assessor will be appointed by mutual agreement between the doctor appointed by the insurers and the doctor appointed by the Insured Party.

  Failing agreement on the appointment of the single medical assessor within two months of the request being made, the single medical assessor will automatically be appointed by the Presiding Judge of the European Court of Justice, at the initiative of one of the parties.

  The opinion issued by the single medical assessor based on the documents, reports and certificates presented by the insurers and the Insured Party will be sent to the insurers, Cigna and to the Insured Party or his/her beneficiaries.

  Based on that opinion, the insurers will draw up a settlement proposal which they will send to the Insured Party or his/her beneficiaries.
  If the single assessor considers it necessary, he may examine the Insured Party before issuing his opinion.

- If the opinion of the single medical expert accords with the settlement proposal of the insurers, the Insured Party or his/her beneficiaries will pay for the fees and disbursements incurred by the consultation. In the opposite case, those expenses will be paid by the insurers.

3. Courts

Each party may take the matter to court. The courts of Brussels alone shall have jurisdiction.

Article 16 – Procedures opened in case of a legal dispute

Disputes of a legal nature – such as, for example, a disagreement with the position of the insurers concerning recognition of the accidental origin of an event – will be laid before the courts. The courts of Brussels alone shall have jurisdiction.

However, if he/she prefers, the Insured Party may go to arbitration.

The provisions of part six, Arbitration, of the Belgian Judicial Code will apply.

The arbitration procedure requires an arbitration agreement to be drawn up between the Insured Party or his/her beneficiaries and the insurers.

The amicable composition clause is excluded.

The arbitration tribunal will be composed of one or three arbitrators. If the parties to the arbitration agreement do not agree as the person of the single arbitrator, each of them will designate one arbitrator and both the arbitrators thus designated will go on to appoint an additional arbitrator, who will preside over the arbitration tribunal.

If one of the parties fails to designate his arbitrator within one month of the demand made to this end by the other party, by registered letter, or if both the first arbitrators fail to agree on the choice of a third one, the appointment will be made by the Presiding Judge of the European Court of Justice, at the request of the first party to take action.

The arbitration tribunal will give its judgement by an absolute majority of votes within three months of the acceptance of its mission by the single arbitrator or by the chairman of the tribunal.

The tribunal will also rule on the costs and fees for its intervention. If a majority of votes cannot be reached, the chairman will have the casting vote.

Article 17 – Payments to be made by the insurers

Payment of the sums due to the Insured Party or his/her beneficiaries must be made by the insurers without unjustifiable delay, starting from the date of receipt by Cigna of the settlement proposal mentioned in Art. 14 or Art. 15 of the S.C. as the case may be, countersigned by the Insured Party or his/her beneficiaries.

If the level of permanent partial invalidity specified in the disputed settlement proposal is equal to or greater than 20%, the insurers will pay the capital sum resulting from the application of the invalidity level appearing in the initial settlement proposal.

If on the other hand the level of permanent partial invalidity is less than 20%, payment of the capital sum will be suspended until completion of the procedures described in Art. 15 of the S.C.

Article 18 – Advance on the invalidity capital

If after medical treatment has ceased the degree of permanent invalidity cannot still be specified definitively, the findings of the independent medical consultant mentioned in Art. 14 of the S.C. or, as the case may be, the findings of the medical commission mentioned in Art. 15 must state the latest date by which the Insured Party must be re-examined.

If the degree of permanent invalidity is considered to be at least 20%, a provisional indemnity proportionate to that undisputed fraction of the level of permanent invalidity will be offered to the Insured Party. That indemnity will be deducted from the final payments.

Article 19 – Medical deterioration

The Insured Party may enter a request for recognition of a deterioration of his/her injuries or permanent invalidity by the deadline stated in Art. 11 of the S.C., accompanied by a report from his/her attending physician.

That deterioration will be covered if its existence is recognised by the independent medical consultant or by the doctors of the medical commission or by the Courts.

Article 20 – Duration and cancellation

The present policy, replacing the “Individual Collective” policy taken out by the policyholder on 1 July 1983 (bearing the same policy number), will take effect on 1 July 2013 for a period of 24 months.

Thereafter, it will be renewed tacitly from year to year.

The present policy may be cancelled by registered letter posted at least six months before its expiry date. The policy may be validly cancelled by the policyholder through Cigna.

Article 21 – Powers of attorney

The insurers grant power of attorney to Cigna, designated brokers, to collect all the monthly or proportional premiums.
With regard to the management and settlement of claims, it is expressly agreed that this will be done through Cigna, Plantin en Moretuslei 299, 2140 Antwerp (Belgium).

The present insurance policy, drawn up in triplicate, is signed for acceptance by the representatives of the *Association Internationale des Anciens des Communautés européennes* and the insurers.

Cigna

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