Policy number: G0384

SUMMARY OF BENEFITS
ACS HEALTH IN EUROPE

First Euro Health Scheme

G0384

Underwritten by the Globe Partner association

Contractual document

This document is a translation of the terms and conditions of the summary of benefits written in French. Neither the Insurer, nor the Policyholder can be held responsible if any statement in this translation and any provision in the policy differ. In that case, the wording of the policy in French will prevail.

Pre-contractual information specific to distance selling

1. Policy no. G0384 has been taken out with the Insurer by the Policyholder, whose respective legal notices are set out in Section VI of this Summary of Benefits.

2. The authority responsible for regulating the Insurer is the *Autorité de Contrôle Prudentiel et de Résolution* (ACPR) - 4 place de Budapest, CS 92459, 75436 Paris Cedex 09, France.

3. The method for calculating premiums is set out in Section 5 ("Premiums") of this Summary of Benefits.

4. Membership lasts until 31 December following the policy start date. It is then renewed each year by tacit renewal on 1 January. The start dates and length of membership are defined in article 2.1 ("Start, duration and renewal of membership certificate and cancellation") of this Summary of Benefits.

5. The object of the policy, as mentioned in article 1 ("Object of the prospectus") is to guarantee Insured Parties the payment of benefits under the conditions defined in Section III ("Guarantees and benefits") of this Summary of Benefits.

6. Exclusions are set out in Section IV ("Excluded risks and benefits") of this Summary of Benefits.

7. In the case of distance selling, the policy provisions offered in the Summary of Benefits for policy no. G0384 are valid until the date indicated in the cover letter, enclosed with this Summary of Benefits.

8. In the case of distance selling, the policy no. G0384 may be taken out according to the method set out in article 4 ("Membership Conditions") of this Summary of Benefits as well as in the cover letter, enclosed with this Summary of Benefits.

9. The premium payment terms are set out in article 10 ("Amount and settlement of premiums") of this Summary of Benefits.

10. Fees relating to distance selling techniques used are payable by the Member. That is to say the cost incurred for sending letters and telephoning Insurer, the Policyholder and their service providers or for internet connections shall be paid by the Member and shall not be liable for any reimbursement.

11. A cancellation right exists and the procedure for exercising it and the address to which the cancellation notice should be sent are set out in article 2.3 ("Cancellation in the case of direct selling or distance selling") of this Summary of Benefits.

12. Pre-contractual and contractual relations between the Insurer, the Policyholder and the Member are governed by French law. The Insurer and the Policyholder undertake to use the French language during their pre-contractual and contractual relations. French courts shall have jurisdiction.

13. The procedures for assessing complaints are explained in article 3.3 ("Information – Complaints – Mediation") of this Summary of Benefits.

Contents

Section 1 – Object and basis of the Summary of benefits

1 – Object

The policy corresponding to this Summary of benefits is a group insurance policy taken out by the Policyholder with the Insurer. The policy is subscribed by the Globe Partner association with MFPREVOYANCE, the "Insurer", in the context of an underwriting delegation given to MGEN International Benefits.

It is covered by branch 2 Sickness defined in article R.321-1 of the French Insurance Code and is governed by both its stipulations and the provisions of the French Insurance code and applicable French legislation.

Its object is to provide cover to individual expatriate members of the Globe Partner association, and their Dependants, if any, residing in a European Economic Area country, including Overseas Communities (Barthelemy, Saint-Martin, Saint-Pierre-et-Miquelon, Wallis and Futuna), for reimbursement of medical expenses recognised by the World Health Organisation, in accordance with the "International classification of Health interventions" (ICHI) and this Summary of benefits.

2 – Effective date, duration, renewal of the membership certificate

2.1 Affiliation

The application to take out this policy is made via a standard membership form approved by the Insurer, completed, dated and signed by the insurance applicant.

The membership application form states Member's identity, elements required to determine coverage and calculate premium, and consent. **The** insurance applicant acknowledges that he/she is familiar with the Summary of Benefits.
The cover must be the same for the Member and his/her Spouse or any Beneficiaries covered by this policy, if applicable.

At the time the Member or a Beneficiary takes out the policy, the Member must pay an advance on the first premium. If a cancellation request is made, the premium shall be returned in full.

Membership of the policy is recorded in a membership certificate, particularly stating:

- The membership number,
- The membership start date,
- The Member's full name,
- The full names of any Beneficiaries,
- The coverage area,
- The type and amount of cover taken out,
- The premium amount and their payment terms.

Nevertheless, in light of the documents and information received, the Insurer, or its Delegate where relevant, may stipulate a revised price on a membership certificate compared with that initially stated on a membership form, or a specific exclusion. The insurance applicant may reject this price by informing the Insurer in writing within 30 days from the date of receipt of the proposal.

2.2 Start date and renewal

For the Member, the insurance takes effect on the date indicated on the membership certificate, for a period ending on 31 December of the same year.

It is then renewed by tacit agreement on 1 January for a period of one year, unless the Member cancels.

The Member may terminate his/her membership of the contract:

- on the annual expiry date of the contract set at 31 December by notifying his intention at least two (2) months before this date, i.e. by 31 October at the latest. Termination is effective on 31 December, at midnight, of the year in which it is notified.
- in application of the provisions of law no.2019-733 of 14 July 2019 amending article L. 221-10-2 of the French Mutual Code, which comes into force on 1 December 2020.

The Member may notify his or her request for termination under the conditions set out in article L.221-10-3 of the French Mutual Code, in the following ways, at the Member's discretion:

- either by simple letter or any other durable medium,
- or by a declaration made at the head office or at one of the Insurer's branches,
- or by an extrajudicial act,
- or, where the contract is taken out by a remote communication method, by the same method of communication,
- or by any other means provided for in the contract.

Membership may also end under one of the following conditions:

- In the event of non-payment of premiums by the Member,
- On the date on which the Insured Party ceases to be a Member of the Policyholder,
- In the event of cancellation of this group insurance policy,
- Following the dissolution of the Policyholder.

2.3 Cancellation in the case of direct selling or distance selling

The Policyholder undertakes to send the Member, who has acquired the status of Insured Party, information concerning the cancellation right in the case of direct selling or distance selling of the policy which is the object of this Summary of benefits.

In the case in of direct selling:

The provisions of article L. 112-9 of the French Insurance Code apply:

"Any natural person that has been subject to door to door selling at their home address or workplace, even at their request, and who signed within this framework an insurance proposal or contract for purposes not falling within the context of their commercial or professional activity, has the right to cancel the latter by registered mail with request for notification of receipt during a deadline of 14 consecutive calendar days, as of the date of the conclusion of the policy, without having to give reasons or bear penalties. (….) Once he/she becomes aware of an incident calling the contract coverage into play, the subscriber may no longer exercise this right of cancellation."

In the case of distance selling:

Distance selling provisions apply if the policy is concluded via one or more distance selling techniques, particularly sale via correspondence or via the internet.

In accordance with article L 112-2-1 of the French Insurance Code, a cancellation period of 14 calendar days applies in the case of distance selling. This period begins on the date the policy is concluded or from the date the applicant receives the policy conditions and information mentioned in article L.222-6 of the French Consumer Code (*if this is after the date the policy is concluded*).

The date of conclusion of the policy corresponds to the membership start date.

This cancellation right shall not apply if the policy is entirely executed by the two parties at the Member's explicit request before the Member exercises his/her cancellation right.

Cancellation procedure in the case of direct selling or distance selling

To exercise his/her cancellation right, the Member must send the Insurer, via **ACS,** 153 rue de l'Université, 75007 Paris, France, a letter by registered mail stating his/her desire to cancel his/her membership. The following template may be used:

"By this letter, I the undersigned ……. (full name and address) hereby cancel my membership of policy G0384 which I signed on …… in …… (place of membership) and ask for reimbursement of the payment I made, corresponding to the sum of € …. [amount in euros]. On …… (date and signature)."

Effects of cancellation (direct selling, distance selling or on receipt of the membership certificate)

The Insurer, via ACS, then reimburses the premiums paid within 30 calendar days from the date the registered mail is received. Membership is considered never to have existed and cover does not apply, from receipt by the Insurer, via ACS, of the cancellation letter sent via registered mail. After the period of thirty (30) days, the sum due accrues interest at the legal rate.

3 – Other provisions

3.1 Limitation period

The provisions relating to the limitation on actions resulting from the policy which is the object of this Summary of benefits are governed by articles L 114-1

to L.114-3 of the French Insurance Code reproduced below:

Article L.114-1 of the French Insurance Code:
All actions resulting from an insurance policy are limited to two years from the triggering event.
However, this period only runs:
1° In the event of any reticence, omission, or false or inaccurate declaration on the insured risk, from the date on which the insurer becomes aware of this,
2° In the event of a claim, from the date on which the parties become aware of it, if they can prove they were previously unaware of it.
When the cause of the action by the Insured Party against the Insurer is third-party recourse, the time limit for the limitation only begins on the date this third party initiates legal action against the Insured Party or has been compensated by the Insured Party.

Article L.114-2 of the French Insurance Code:
The limitation shall be interrupted by usual causes of interruption to the limitation on action and the selection of appraisers following a claim. The interruption to the limitation on action may also result from the sending of a letter by registered mail with proof of receipt sent by the Insurer to the Insured Party in relation to action regarding payment of the premium and by the Insured Party to the Insurer provider in relation to settlement of compensation.

Article L.114-3 of the French Insurance Code:
By way of exception to article 2254 of the French Civil Code, the parties to the insurance policy may not, even by mutual agreement, either amend the limitation period, or add reasons for suspending or interrupting it.

Notes: The ordinary causes for interrupting the limitation period are defined in articles 2240 et seq. of the French Civil Code. The ordinary causes for interrupting the limitation period stipulated in the French Civil Code are:
- **Recognition by the debtor of the right of the person against whom the time limitation was imposed (article 2240 the French Civil Code),**
- **Legal proceedings (articles 2241 to 2243 of the French Civil Code),**
- **Measures taken to preserve rights pursuant to the French Code of Civil Procedure or an order for enforced execution (article 2244 of the French Civil Code),**
- **A service of process made upon one a joint and several debtor or an order for enforced execution or recognition by the debtor of the right of the person against whom the time limitation was imposed (article 2245 of the French Civil Code),**
- **A service of process made upon the principal debtor or an acknowledgement for cases of time limitations applicable to guarantors (article 2246 of the French Civil Code).**

3.2 Subrogation

In accordance with the French Insurance Code, the Beneficiary of benefits subrogates the Insurer in order to undertake any recourse proceedings against any liable third party, within the limit of expenses incurred. In the event that subrogation, due to the Insured member, can no longer be exercised in favour of the Insurer, then the Insurer will be relieved of its obligations to the Insured member insofar as the subrogation could have been exercised.

3.3 Delegated management agreement

The operations relating to this policy delegated by the Insurer to ACS, 153 rue de l'Université, 75007 Paris, France, are set out in a delegated management agreement, particularly ACS's obligations towards the Insurer in terms of acceptance, declaration, transfer of premiums, management of healthcare benefits and establishment of statistics.

3.4 Data protection

According to the Data Protection Act of January 6th 1978, the personal data collection is necessary for the management of the insurance contract by the Insurer, its TPA, its service providers, its subcontractors or its reinsurers. The data processing is intended to: issue, manage and execute insurance contracts; the development of statistics and actuarial studies; the recourses, management of claims and litigation; the implementation of the legal and regulatory provisions in force, in particular, the fight against money laundering, the financing of terrorism and against fraud; operations related to customer management and business development. The recipients of these data are the duly authorized staff of the Insurer, its TPA, its service providers, its subcontractors or reinsurers and, if relevant, the social organizations of the persons involved, the insurance intermediaries.

These personal data may be transferred to service providers or subcontractors established in countries outside the European Union. These transfers may only concern countries recognized by the European Commission as having an adequate level of protection for personal data, or recipients with appropriate

safeguards. These data will be kept throughout the duration of the Contract, until the expiry of both the limitation periods and the deadlines provided by the storage obligations.

The Insured member has a right of access, rectification and erasure of his personal data, and when consent is necessary for processing, he/she has the right to withdraw it. Under regulatory conditions, the Insured member has the right to request the limitation of data processing, to oppose it, or request the portability of the data transmitted when it was necessary for the Contract or when its consent was required. The Insured also has the right to provide guidelines regarding the processing of personal data after his/her death. Any request for the exercise of his rights may be addressed to the DPD department by letter (CNP Assurances pour MFPrévoyance - Délégué à la Protection des Données, 62 rue Jeanne d'Arc - 75640 Paris Cedex 13, France) or email: (urgence.dpofs@MFPrévoyance.fr).

The Member has the right to lodge a complaint with the Commission Nationale Informatique et Libertés [CNIL] located at 3, Place de Fontenoy - TSA 80715 - 75334 Paris Cedex 07 - France; Tel: +33 (0) 1.53. 73.22.22.

3.5 Information – Complaints – Mediation

In the event of difficulties in the application of your contract, ACS is able to investigate all your requests and complaints. You can address your complaints to our dedicated complaints department, whose contact details are given below:

ACS, Service Réclamations, 153 rue de l'Université, 75007 PARIS, France - Email: recla@acs-ami.com.

ACS undertakes, from the date of sending your written complaint, to acknowledge receipt of your complaint within 10 days and to provide you with a response within a maximum of 2 months.

In any event, after this two-month period, and regardless of response you receive or in the absence of a response, you may appeal to the Insurance Obudsman, whose contact details are as follows: **LMA - TSA 50110 - 75441 PARIS CEDEX 09 France, www.mediation-assurance.org**.

The Ombudsman's opinion is not binding on the parties in dispute and they retain the right to bring proceedings before the competent court. The Ombudsman is not authorised to give an opinion on insurance admissibility conditions.

3.6 Penalties in case of false declarations

ANY INFORMATION SUPPLIED BY THE INSURED OR ONE OF THEIR BENEFICIARIES THAT IS INCORRECT, FALSIFIED, EXAGGERATED OR ANY FRAUDULENT ACTS ON THEIR PART SHALL BE THE DIRECT RESPONSIBILITY OF THE INSURED AND SHALL GIVE RISE TO :

- **THE NULLITY OF YOUR POLICY IN THE EVENT OF INTENTIONAL MISREPRESENTATION (ARTICLE L.113-8); PREMIUMS PAID ARE KEPT BY THE INSURER, WHO IS ENTITLED, AS A COMPENSATION, TO THE PAYMENT OF ALL PREMIUMS DUE; IN SUCH A CASE, THE INSURED WILL HAVE TO REIMBURSE ALL THE CLAIMS PAID BY THE INSURER UNDER THE CONTRACT;**
- **IF THE INTENTIONAL MISREPRESENTATION, DISCOVERED BEFORE ANY CLAIM, IS NOT ESTABLISHED, PREMIUM INCREASE OR TERMINATION OF THE POLICY (ARTICLE L.113-9);**
- **IF THE INTENTIONAL MISREPRESENTATION DISCOVERED AFTER THE CLAIM, IS NOT ESTABLISHED, DECREASE OF CLAIM ACCORDING TO THE RATIO BETWEEN THE PAID PREMIUM AND THE PREMIUM THAT SHOULD HAVE BEEN PAID IF THE INITIAL DECLARATION HAD BEEN CONSISTENT WITH THE REALITY (ARTICLE L.113- 9).**

3.7 Jurisdiction

French courts shall have jurisdiction. The language used in relation to this policy is French. This Summary of benefits is a non-contractual translation of the insurance policy.

Section 2 – Insured parties

4 – Members

Those who qualify are expatriate members of the AMI Association who are under 65 years of age. The membership does not exempt the Insured member from the affiliation to any social security scheme, whenever the latter is mandatory by local laws.

The Insured member must, when joining, complete and sign the application form including a medical questionnaire validated by the Insurer. A complementary medical examination may be requested by the Insurer.

5 – Registration conditions

The Insurer reserves the right to make acceptance

conditional upon the production of any additional information it considers necessary.

Waiting Periods do not apply if the Member can, at the time of Membership, provide evidence of valid equivalent insurance cover and an equivalent zone of coverage.

At the date of acceptance by the Insurer, the member and his/her dependents where appropriate, become the "Insured" and their membership is effective until 31st December of the current year. This acceptance is formalised by sending a **membership certificate**.

The Member undertakes to provide evidence of his/her declarations at any time by sending supporting documents corresponding to his/her situation.

6 – Cover start date – Waiting period

Once the policy relating to this Summary of benefits has taken effect, cover is effective for each Insured Member, and their beneficiaries where relevant, who acquire the status of Insured Parties on the following dates:

6.1. Insured person affiliated on the policy start date:

- From this date.

6.2 Insured person affiliated after the policy start date:

- On the date they join the category of insured person to be insured, as mentioned on the certificate of insurance.

6.3 Cover in favour of Beneficiaries of the Member defined in section 8 of this Summary of benefits start at the same time as those in favour of the principal Insured Party or, at a later date, when the parties concerned fulfil the required conditions.

6.4 Waiting periods

Coverage of costs by the Insurer shall come into force for each of the Beneficiaries accepted for the Insurance **after examination and acceptance of the medical questionnaire, except in relation to the following costs to which a Waiting Period is applied, beginning on the membership start date:**

- **dental prosthetics: 6 months**
- **vision care: 6 months**
- **childbirth and maternity: 10 months**

Waiting Periods do not apply:

- If the Member can, at the time of Membership, provide evidence of valid equivalent insurance cover, and
- In the event of interruption of coverage of less than one month between two memberships, or
- If the expenses to be covered are the result of an Accident, as defined in section 6 of this Summary of benefits, which occurred after the insurance acceptance date.

6.5 Territorial application scope of the cover

Medical expenses are reimbursable, under the conditions defined in this Summary of benefits, in one of the following zones:

Zone G: Countries of the European Economic Area (including Overseas Communities),
Zone H: Countries of the European Economic Area (including Overseas Communities) and the United Kingdom.

However, during a stay of less than seven (7) weeks in a country outside the zone of coverage mentioned above, only expenses arising from an Accident or an Illness of an urgent nature as defined below under Emergency provided that the treatment has been given by a doctor, generalist or specialist, or that the hospitalization was required as a direct cause of the emergency and that it took place within 24 hours, shall be reimbursed.

In other cases, on express approval by the Insurer.

6.6 Choice of formulas

The choice of formula is made by the Insured at the time of joining, between the following formulas: ***, **, *** and ****.** It cannot be modified until membership is renewed. In case of increase of benefits, the Insured must fulfil a new application form including a medical questionnaire (see. Art. 4 - Section 2).

7 – Cessation or suspension of cover

7.1 Except in the event of a deliberate reticence, omission or false or inaccurate declaration, once accepted the Insured Party may not be excluded from the Insurance against his/her wishes provided he/she is part of the category of person to be insured under the policy which is the object of this Summary of benefits, subject to application of the provisions of article L.141-3 of the French Insurance Code.

In any event, cover ceases:

7.1.1 For each Insured Party:

- **At the initiative of the Member in case of annual or infra-annual cancellation of his individual insurance contract,**
-
- **In the event of a false declaration in accordance with article 3.6,**
- **In the event of the death of the Insured member,**
- **As soon as the Insured member ceases to belong to the category of insured persons to which the policy applies,**
- **In the event of non-payment of premiums, in accordance with the provisions of the French Insurance Code,**
- **On the date on which the Member ceases to be a member of the Policyholder,**
- **In the event of liquidation proceedings in relation to the Insurer or to the Policyholder,**
- **At December 31 in the year of his/her 70th birthday,**

For Beneficiaries, on the date they no longer meet one of the conditions stipulated in article 8.

7.1.2 For all Insured persons:

On the effective termination date of the policy which is the object of this Summary of benefits, by the Policyholder or by the Insurer.

7.2 The cover in favour of the Beneficiaries cease (or are suspended) at the same time as those of the Insured Party. The cessation (or suspension) of cover, both for the Insured Party and his/her Beneficiaries, results in the termination of entitlement to services for all procedures and treatments which have occurred since the cessation date.

Section 3 – Cover and benefits

8 – Beneficiaries of cover

The healthcare expenses cover described in the policy which is the object of this prospectus applies to:

- either the Member only, or
- the Member and the Beneficiaries.

In this case, the following may be included on the policy:

- The Member's Spouse (or Civil Partner) designated by name (or, in the absence of a Spouse or Civil Partner and subject to providing a sworn declaration of having lived together for at least six months, a Common Law Spouse),

- and, providing they are dependent for tax purposes:

- The Member's children and those of his/her Spouse (or, in the absence of a Spouse, those of the Common Law Spouse or Civil Partner specified above) aged less than 21,
- The Member's children and, if living under the same roof, those of his/her Spouse (or, in the absence of a Spouse, those of the Common Law Spouse or Civil Partner specified above), aged 21 up until their 26th birthday, whilst in secondary or further education (paid employment is acceptable provided this does not exceed three months per year).
- Children regardless of age if they are physically or mentally disabled (evidence of disability and persistence must be provided to the Insurer) and meet the following cumulative conditions: not being employed or not collect their own resources due to their work, and to be dependant from the Insured.

Concerning children who are students, a school certificate is required at the time of subscription and at the start of each subsequent academic year.

In order to be considered Insured Parties, the Beneficiaries must be named on the membership certificate. The coverage shall be terminated for the beneficiaries as soon as they no longer fulfil the afore defined conditions and, in any case, at the same date as for the Insured Person.

In case of death of the Insured Person, the health benefits are maintained free of charge for all beneficiaries during one month.

The benefits are payable for medical care and hospitalisation occurring within the period during which the beneficiary belongs to the afore defined category.

9 – Benefits covered

9.1 Type of cover

9.1.1 The cover consists in reimbursing healthcare expenses incurred by the Insured from the first euro.

The treatment must be recognised by local medical authorities and provided by practitioners exercising within a field in which they are qualified (in line with legislative, regulatory and other requirements in respect of professional standards in the country

concerned).

If one of the Insured Party's beneficiaries is covered by the French Social Security scheme or equivalent, the benefits received from this organization shall be deducted from his/her benefits.

If the Spouse (or Common Law Spouse or Civil Partner) is an employee, the benefits paid by the Insurer shall be in addition to those from any Healthcare Costs scheme from which he/she may benefit personally.

9.1.2 It is stipulated that **in the event of hospitalisation,** costs in respect of the following shall be covered:

- Medical hospitalisation in a public or private establishment,
- Hospitalisation and surgery. Procedures carried out under general anaesthesia or in relation to trauma surgery and surgical procedures carried out under local anaesthesia are deemed to be surgical procedures,
- Related medical and paramedical costs provided in the context of hospitalisation,
- Transportation of the patient by ambulance.

Emergency local transportation by ambulance is covered, within the same country, in the event of hospitalization, between the patient's home or the site of the Accident and the closest hospital in the same country. It is also covered if the patient's condition requires his/her subsequent transfer from the first establishment to another closer establishment.

The Insurer's prior authorisation is required, via ACS, for any hospitalisation, except in the case of emergency hospitalisation as defined in Section 6.

9.1.3 In other cases, cover is defined in the table of benefits set out in annex 1.

9.2 Amount of benefits

The amount of benefits is determined for each expense item within a limit of what is considered reasonable and usual and according to the table of benefits set out in annex 1.

The "**reasonable and usual"** cost is the lowest amount between the cost requested by the service provider and the cost applicable in the same region for a similar service offered by service providers of an identical professional level. The "reasonable and usual" cost of a service varies depending on the type of treatment, the quality of the service and the equipment, and the place and country where the treatment is received. The Insurer reserves the right to limit reimbursement of healthcare costs and ancillary costs, as well as the duration of hospitalisation, to the amount generally applicable in the region where the patient is treated.
The unreasonable and unusual nature may therefore result in reimbursement being refused or the amount of the reimbursement being limited.

In all cases, the amount of benefits is limited to the difference between the actual costs incurred and the benefits payable by any organisation the insured party may be covered by.

9.3 Declaration of claims

In case of hospitalisation, the Insured can be covered in order to avoid him/her to advance the expenses, by calling +33 (0) 1 76 36 04 63 or e-mailing: hospitalizations@expatpa.com.

For all other expenses, the documents shall be sent to ExpaTPA – 142 rue de Rivoli – 75001 Paris - FRANCE – Phone : +33 (0) 1 76 36 04 63 / e-mail : acs@expatpa.com.

The declaration form must be accompanied by the supporting documents requested by the Insurer. No copies, photocopies or duplicates of invoices will be accepted.
However, in order to optimise the processing time of his/her claims, for all invoices up to **€500,** the Insured is recommended to submit his/her file (scanned supporting documents) on his/her **online personal account**. In this case, the Insured Party must retain the originals for 24 months from the date of treatment. During this period, the Insurer may ask to receive the originals, failing which the reimbursement paid may be challenged.

The Insurer, via ACS where relevant, reserves the right to ask any Insured Party to provide it with any information required to process its personal data and data relating to reimbursement requests. For this, the Insurer may require access to medical records with all the legal confidentiality obligations that entails.

IT IS STIPULATED THAT IF THE MEMBER FAILS TO RESPOND TO REQUESTS FOR ADDITIONAL DOCUMENTS AND/OR FAILS TO RETURN MANAGEMENT FORMS DULY COMPLETED, HIS/HER REQUEST SHALL BE PLACED ON HOLD UNLESS OTHERWISE AGREED BY THE INSURER.

ANY INFORMATION SUPPLIED BY AN INSURED PARTY

WHICH PROVES TO BE ERRONEOUS, FALSIFIED OR EXAGGERATED OR ANY FRAUDULENT ACTIONS OR DELIBERATE MISCONDUCT BY AN INSURED PARTY SHALL INCUR THE DIRECT LIABILITY OF THE INSURED PARTY AND REPAYMENT OF THE SUMS UNDULY PAID BY THE INSURER BASED ON THIS INCORRECT DATA.

9.4 Documents to be produced

- In case of hospitalization: invoices, fee notes
- In case of illness: detailed invoice, prescriptions
- In case of home birth: a copy of the birth certificate of the child.

The Insurer may request any other evidence to supplement the record.

In the event of Hospitalization, surgery, radiography or medical treatment, a medical certificate must be requested from us in advance. It should be returned to us after having been completed by the doctor of the Insured. Any failure to fulfil this obligation could result in a refund being refused.

10 - Prior Agreement – Limitation to actual expenses

10.1 Prior agreement

Reimbursement of expenses is subject to prior agreement by the Insurer, except in the event of a clear Emergency (see. Definitions), under the circumstances listed below:

- Hospitalization expenses,
- Childbirth Expenses,
- MRI,
- Rehabilitation following hospitalisation,
- Physiotherapy (after 10 sessions),
- Physical therapy,
- Physiotherapy, chiropractor, osteopath, homeopath and acupuncturist

Unless in case of an Emergency, each admission to a Hospital must be notified to the Insurer at least 15 days prior to the effective admission.

The approval of the Insurer shall be communicated within five (5) working days of receipt of the request.

In the event that the request for prior agreement has not been made and if, and only if, treatment then proves medically necessary, the Insurer shall reimburse 80% of hospital expenses invoiced based on a reasonable and usual rate and 50% of the amount for any other service of a similar kind which would have had to be reimbursed.

Prior agreement is not required in the event of an emergency as defined in this Summary of benefits. Nevertheless, the Insurer should be advised within 48 hours, or as soon as possible in the event of force majeure as defined by jurisprudence. Provisions relating to reasonable and customary costs in countries where the care is provided apply under all circumstances.

10.2 Limitation to actual costs

In accordance with article 9 of law no. 89-1009 of 31 December 1989 and decree no. 90-769 of 30 August 1990, reimbursement or compensation of costs incurred for an illness, childbirth or an accident may not exceed the costs remaining payable by the Insured Party following all types of reimbursement to which he/she is entitled.

In accordance with article 2, paragraph 1 of decree no. 90-769 of 30 August 1990 cover of the same kind taken out with several insurers shall be effective within the limit of each cover, irrespective of the date they were taken out. In this limit, the beneficiary of the Agreement may obtain additional payment by sending details of the reimbursements made by the other organization(s).

For application of the aforementioned arrangements, the limitation of expenses for which the Insured is still liable is determined by the Insurer for each of the treatments or expense items.

In case of undue payments: the beneficiary of the benefit commits to repay to the Insurer, as soon as possible, the undue claims. As a consequence, the Insurer can make compensation between these amounts and any other benefits due by the Insurer to the Insured.

Section 4 – Excluded risks and benefits

EXCLUDED RISKS

THE EXPENSES INCURRED ARE NOT PAID BY THE INSURER IF THEY RESULT FROM THE FOLLOWING:

1. **AN ILLNESS OR ACCIDENT DUE TO THE INTENTIONAL ACT OF THE INSURED PERSON,**

INTENTIONAL MUTILATION OR ATTEMPTED SUICIDE,

2. **THE CONSEQUENCES OF WAR, WHETHER CIVIL OR NOT, INSURRECTION, RIOT, ATTACK OR POPULAR UPRISING OR ACTS OF TERRORISM, UNLESS THE INSURED PARTY DOES NOT TAKE PART ACTIVELY IN THE EVENT,**
3. **ANY INTENTIONAL ACT THAT MIGHT LEAD TO THE APPLICATION OF THE CONTRACT COVER AND ANY CONSEQUENCES OF CRIMINAL PROCEEDINGS THAT MIGHT BE TAKEN AGAINST THE INSURED,**
4. **A CLAIM RESULTING DIRECTLY OR INDIRECTLY FROM A NUCLEAR REACTION.**

5. **THE INSURER RESERVES THE OPTION TO MODIFY THE COVER IN ONE OR MORE SPECIFIC TERRITORIES SUBJECT TO NOTIFYING THE SUBSCRIBER 15 DAYS IN ADVANCE.**

EXCLUDED BENEFITS

1. **THIS POLICY DOES NOT COVER:**
2. **TREATMENTS OUTSIDE THE GEOGRAPHIC ZONE OF COVERAGE, EXCEPT FOR CASES SPECIFIED IN THE SECTION ON THE 'TERRITORIAL APPLICATION SCOPE OF THE COVER',**
3. **ANY FORM OF EXPERIMENTAL OR UNSUPERVISED TREATMENT THAT DOES NOT FOLLOW COMMONLY ACCEPTED, CUSTOMARY OR CONVENTIONAL MEDICAL PRACTICE, UNLESS SPECIFIC CONSENT HAS BEEN GIVEN BY THE INSURER,**
4. **INCIDENTAL EXPENSES OR COMFORT EXPENSES IN THE CASE OF HOSPITALIZATION (TELEPHONE, TELEVISION, ETC.),**
5. **TREATMENTS FOR DRUG ADDICTION OR ALCOHOLISM,**
6. **EXPENDITURE INCURRED ON THE ACQUISITION OF AN ORGAN (BUT NOT THE ORGAN TRANSPLANT ITSELF),**
7. **ANY OPERATION OR TREATMENT RELATING TO A SEX CHANGE,**
8. **AESTHETIC TREATMENTS, AGE-REDUCING TREATMENTS, SLIMMING TREATMENTS,**
9. **THE CHECKS, EXAMINATIONS, TREATMENTS AND COMPLICATIONS ASSOCIATED WITH STERILITY, STERILIZATION, SEXUAL DYSFUNCTION, CONTRACEPTION INCLUDING THE INSERTION OR REMOVAL OF CONTRACEPTIVE DEVICES, THE VOLUNTARY TERMINATION OF PREGNANCY EXCEPT IN THE CASE OF A PREGNANCY TERMINATION THAT IS MEDICALLY NECESSARY AND COMPLIES WITH LOCAL LEGISLATION,**
10. **ANY ELECTIVE/VOLUNTARY SURGERY AND/OR PLASTIC/COSMETIC SURGERY,**
11. **SPA TREATMENTS,**
12. **MEDICAL EXPENSES ASSOCIATED WITH A STAY AT A THALASSOTHERAPY CENTRE OR FITNESS CENTRE, REST HOME OR RECOVERY HOME EVEN IF THIS STAY IS MEDICALLY PRESCRIBED,**
13. **MEDICAL EXPENSES RELATING TO A STAY IN A REST HOME OR CONVALESCENCE HOME, UNLESS THIS STAY FOLLOWS A HOSPITALIZATION OR SERIOUS SURGERY AS ASSESSED BY THE INSURER'S DOCTOR (TO THE EXCEPTION OF CENTERS FOR REHABILITATION IMMEDIATELY FOLLOWING HOSPITALIZATION),**
14. **OUTPATIENT CONSULTATIONS WITH REGARDS TO PSYCHOTHERAPY, PSYCHOANALYSIS AND PSYCHIATRY, AS WELL AS RELATED MEDICATION,**
15. **CONSULTATIONS, TREATMENTS AND COMPLICATIONS ASSOCIATED WITH THE LOSS OF OR IMPLANTATION OF HAIR UNLESS THE TREATMENT IS RELATED TO A HAIR LOSS CAUSED BY A SERIOUS ILLNESS,**
16. **TREATMENTS TO MODIFY THE REFRACTION OF AN EYE OR THE EYES (LASER EYE CORRECTION), INCLUDING REFRACTIVE KERATOTOMY (KR) AND PHOTOREFRACTIVE KERATOTOMY (KPR) UNLESS COVERED IN THE TABLE OF BENEFITS,**
17. **UNPRESCRIBED MEDICATION, AND COMMONLY USED NON-MEDICAL PRODUCTS SUCH AS MEDICAL ALCOHOL, ABSORBENT COTTON, SUNCREAMS, DENTAL HYGIENE PRODUCTS, DRESSINGS, SHAMPOOS ETC,**
18. **EXPENSES INCURRED BEFORE THE START DATE AND AFTER THE END OF COVER,**
19. **EXPENSES INCURRED DURING WAITING PERIODS.**

Section 5 – Premiums

11 – Premium calculation and payment

11.1 Premium payment

Premiums are paid by the Insured, according to his age and that of his/her beneficiaries. Age is calculated by

difference between birth year and year of admission. This amount shall be revised at the effective annual renewal date on 1 January of each year according to the age.

Premiums are paid in advance in euros **annually, bi-annually, quarterly, or monthly** by the Insured to the Policyholder according to the procedure defined in the membership form. The amount of premium excludes taxes. All taxes and costs resulting from applicable legislation are added to the amount of the premium and are integrally paid by the Insured.

11.2 Annual revision and indexation of premiums

Premiums may be revised each 1st January according to the technical results of the contract, medical questionnaires, demographic changes, regulation, social security parameters.

When a new pricing is established by the Insurer, it shall be sent to the Policyholder four (4) months before the planned renewal date. **The Policyholder must inform the Insured member three (3) months before this pricing comes into force.**

In the event of disagreement, the **Insured member** may ask for its membership certificate to be cancelled by sending a letter sent by registered mail **within two (2) months from notification by the Policyholder.** Cancellation shall be effective from the first day of the month following receipt of the letter sent by registered mail by the Insurer.

11.3 Non-payment of premiums

In the event of non-payment of the premium or a fraction of the premium, in accordance with article L.141-3 of the French Insurance Code, a letter sent by registered mail shall be sent to the Member of the policy which is the object of this Summary of benefits at least ten (10) days after the renewal date, informing him/her that at the end of a period of forty (40) days after the date of the later, non-payment of the premium shall result in cancellation of the policy which is the object of this Summary of benefits, without further notice.

Section 6 – Definitions

The terms and expressions used in this Summary of benefits have the following meanings:

Accident: any unintentional bodily injury caused to the Insured, arising from abrupt, sudden and unexpected action with an external cause, to the exclusion of an acute or chronic Illness.

Member: refers to the Insured party of the Policyholder who took out the policy, which is the object of this Summary of benefits, and pays its premium.

Formal Hospital Admission:

(i) For stays of at least 24 hours, Formal Hospital Admission is the formal acceptance by a hospital or other inpatient health care facility of a patient who is to be provided with a room, board as well as continuous nursing service in the hospital in which the patient resides at least overnight.

(ii) For stays of less than 24 hours in case of Surgical Procedures, Formal Hospital Admission is the formal document indicating that the patient is provided with nursing services and a bed, despite the fact that s/he does not stay overnight.

(iii) For stays of less than 24 hours in case of non-Surgical Procedures, Formal Hospital Admission is the formal document indicating that the patient has entered the hospital for less than 24 hours for chemotherapy, radiotherapy or dialyses treatment for less than 24 hours. The patient enters for Treatment and leaves after treatment.

Insured member: is the party in respect of which the risk is insured. For the policy which is the object of this Summary of benefits, this refers to the Insured member and, where relevant, his/her Beneficiaries designated in the policy.

Beneficiary: the insured person to whom the benefits paid by the Insurer in respect of this policy are due in the event of occurrence of the risk.

Insurer: is the insurance organisation covering the insured risk. This is **MFPrévoyance** (French limited company with a Board of Directors and a Supervisory Board, governed by the French Insurance Code, with share capital of €81,773,850, registered on the PARIS Trade and Companies register (RCS) under number 507 648 053. Registered office: 62 Rue Jeanne d'Arc – 75640 Paris Cedex 13, France) in respect of the policy which is the object of this Summary of benefits.

Policyholder is the legal entity which signs the policy which is the object of the Summary of benefits, for the benefit of its Members. This is the Globe Partner association, governed by the law of July 1st 1901, registered office: 153 rue de l'Université, 75007 Paris, France, registration number (SIRET): 497 959 437 000

11.

Medical auxiliaries: nurses, carers and other state-registered medical personnel.

Common Law Spouse: is a person of a different gender or the same gender living as a couple with the Member as part of a de facto union characterised by living together in a stable and continuous relationship (article 515-8 of the French Civil Code).

Spouse: is the person married to the Insured Party, who is not separated or divorced according to a judgement with the status of res judicata. This is a legally registered union between two people of the same gender or different genders. In this policy, a Civil Partner or Common Law Spouse is treated as a Spouse.

Waiting period: period during which the Insured Party is not entitled to certain benefits.

Third Party Administrator: legal entity entrusted by the Insurer, for a limited, potentially renewable time, to carry out legal actions, services or specific activities on its behalf to contribute to the fulfilment of its responsibilities. In the framework of the policy which is the object of this Summary of benefits, this means **ACS**, 153 rue de l'Université, 75007 Paris, France.

Childbirth expenses: medical expenses (**including a private room**) incurred for vaginal childbirth. Any complication, including caesarean if medically required, shall be covered by the "hospitalisation" cover.

Expenses for the parent accompanying a child aged under 16: cost of a hospital room for a parent during the hospitalisation of an insured child. If a hospital bed is not available, the Insurer shall cover the cost of an equivalent room within the limits of the amounts indicated. Other expenses such as meals, telephone calls and newspapers are not covered.

Excess: expenses payable by the Insured Party, to be deducted from the reimbursable amount.

Hospital/Duly authorised institution: refers to an institution such as a medical or surgical hospital legally approved in the country where it is located, placed under the permanent control of a resident physician. Rest homes and care homes, spas, health centres and fitness centres are not considered to be hospitals.

Hospitalization refers to:

(i) a stay for at least 24 hours for medical treatments or *Surgical Procedures* in a public or private *Hospital* due to an *Accident* or *Illness*, provided that the insured receives a *Formal Hospital Admission*. In such a case are covered:

- *Surgical Procedures* and corresponding accommodation costs,
- medical and paramedical expenses provided in the context of hospitalization, and
- the transportation of the patient between the patient's home or the site of the *Accident* and the closest hospital located in the same country.

(ii) a stay of less than 24 hours, provided that the insured receives a *Formal Hospital Admission*, in case of:

- Surgical Procedures,
- fibrescopy, colonoscopy, endoscopy, and
- chemotherapy, radiotherapy or dialyse treatments.

Stays of less than 24 hours for emergency rooms visits which do not result in *Surgical Procedures* are deemed to be outpatient treatments and are not reimbursed as hospitalization expenses.

Surgical procedures: acts carried out under general or local anaesthesia or the reaching of an organ to be treated after an incision are deemed to be surgical procedures.

Prescription glasses and contact lenses: coverage for one eye examination per insurance year by an optometrist or ophthalmologist and contact lenses or glasses to correct sight.

Prescribed medication: refers to medication whose sale and use is legally subject to prescription by a physician. Products able to be bought without a medical prescription are not included in this definition and are not eligible for reimbursement.

PACS: is the person linked to the Insured member by a civil union, in force (article 515-5 of the French Civil Code).

Orthodontics: use of devices to correct a malocclusion and ensure teeth function and align correctly.

Limitation period is the period beyond which a party's rights may no longer be invoked.

Country of origin: is considered to be the country of origin indicated on the Beneficiary's passport and/or the country declared as the country of origin on the membership form.

Home country/ domicile: means the Insured's main and usual place of residence outside of his/her country of origin.

Medical prosthesis: hearing aid, phonation aid (electronic larynx), wheelchair and personal mobility aid, artificial limb, ostomy product, hernia support, abdominal bandage, elastic support stockings or orthopaedic sole and any other medically prescribed apparatus.

Dental prosthesis: prosthetic treatments, including crowns, inlays, onlays, reconstruction or repairs using adhesive, bridges and implants, and all the necessary and ancillary treatments, when the dental coverage is included.

Dental treatment: includes an annual dental check-up, simple fillings linked to cavities or root-canal work.

Emergency: Term used in the event of an accident or the appearance of an illness requiring immediate medical measures and treatment of the Member. Only medical treatment given by a doctor, generalist or specialist or hospitalization occurring within twenty-four hours of the direct cause of the emergency shall be considered conditions necessary for reimbursement.

For the Formula « * », the Emergency treatments are limited to the Hospitalisation benefits.

Table of benefits 1st € annexed to the Summary of benefits

Level of cover	*	**	***	****
Maximum limit per beneficiary per calendar year	**€ 500 000**	**€ 1 000 000**	**€ 1 500 000**	**€ 2 000 000**
HOSPITALIZATION (prior consent)				
Medical hospitalisation	100% of actual expenses	100% of actual expenses	100% of actual expenses	100% of actual expenses
Inpatient medical treatment	100% of actual expenses	100% of actual expenses	100% of actual expenses	100% of actual expenses
"Forfait hospitalier" (daily hospital fee)	100% of actual expenses	100% of actual expenses	100% of actual expenses	100% of actual expenses
Psychiatry	Not covered	Not covered	100% of actual expenses max. €3 000 / year	100% of actual expenses max. € 5 000/ year
Additional fee for Private Room (standard category only)	50 €/day max 21 days of hospitalisation	75 €/ day max 21 jours/hospitalisation	€100 / day max 21 days of hospitalization	150 €/day max 21 days of hospitalization
Accompanying bed for Hospitalization of a child under 16 years	100% of actual expenses limited to €25/day max 21 days of hospitalization	100% of actual expenses limited to €35/day max 21 days of hospitalization	100% of actual expenses limited to €45/day max 21 days of hospitalization	100% of actual expenses max. €60 /day max 21 days of hospitalization
Local transportation by ambulance (medically justified)	100% of actual expenses	100% of actual expenses	100% of actual expenses	100% of actual expenses
Emergency dental plastic surgery following an Accident occurred during the insurance period	100% of actual expenses	100% of actual expenses	100% of actual expenses	100% of actual expenses
Outpatient care before and following hospitalization (up to 30 days before and 90 days following Hospitalization)	100% of actual expenses limited to €1000/year	Included in « Routine medical expenses » below		
Childbirth (including private room)	Not covered	Not covered	100% of actual expenses limited to € 4 000 / year	100% of actual expenses limited to € 6 000 / year
Medically assisted procreation	Not covered	Not covered	Not covered	100% of actual expenses max €300 / attempt max 3 attempts lifetime max.
ROUTINE MEDICAL EXPENSES				
Physician fees and home visits (excluding dentists)	Not covered	90% of actual expenses max €40 for a Generalist max € 60 for a Specialist	100% of actual expenses max €60 for a Generalist max € 90 for a Specialist	100% actual expenses max €100 for a Generalist max €150 for a Specialist
Paramedical fees (nurses, physiotherapists, speech therapists, orthoptists, podiatrists)		90% of actual expenses	100% of actual expenses	100% of actual expenses
Laboratory tests		90 % of actual expenses	100 % of actual expenses	100 % of actual expenses
MRI (X-rays, medical imaging)		90 % of actual expenses	100 % of actual expenses	100 % of actual expenses
Prescription drugs		90 % of actual expenses	100 % of actual expenses	100 % of actual expenses
alternative medicine (acupuncture, chiropractic, homeopathy, psychotherapy)		Not covered	100 % of actual expenses max €30 per session max 5 sessions /year	100 % of actual expenses max €50 per session max 10 sessions /year
OTHER PROSTHESES				

Prosthetic appliances, Artificial Limbs and Hearing Aids Maximum limit	Not covered	90 % of actual expenses max. € 300 / an	100% of actual expenses max. € 600 / an	100 % of actual expenses max. € 1 000 / an
PREVENTIVE MEDICINE				
Inoculations, antimalarial and preventive prescription drugs (if mandatory or recommended)	Not covered	Not covered	100% of actual expenses	100 % of actual expenses
Complete health check-ups (pre-expatriation check-up included)		Not covered	Not covered	100 % of actual expenses max. € 300 / year (1 check-up every 3 years)
VISION CARE				
Eyeglass lenses, Frames, Contact lenses (including disposal lenses if medically prescribed)	Not covered	Not covered	100% of actual expenses max. € 300 / year	100 % of actual expenses max. € 500 / year
Laser eye surgery (myopia-, hypermetropia- and astigmatism correction)	Not covered	Not covered	Not covered	100 % of actual expenses max. € 300 / year
DENTAL CARE				
Maximum limit per beneficiary per calendar year			**Max €1 500 / year**	**Max €2 500 / year**
Dentist fees & dental care (preventive and surgical treatment), including gingivectomy)	Not covered	Not covered	100% of actual expenses	100% of actual expenses
Bone grafts, periodontology	Not covered	Not covered	Not covered	Not covered
Orthodontics (If treatment started before 16 years)	Not covered	Not covered	100 % of actual expenses Max. €800 / year	100 % of actual expenses Max. €1 200 / year
Dental prosthesis	Not covered	Not covered	100 % of actual expenses max. € 400 / tooth and max. 3 teeth/ year	100 % of actual expenses max. €500 / tooth and max. 4 teeth/ year
Dental implants	Not covered	Not covered	Not covered	

Annex – Privacy notice ACS

Protecting data and the privacy of insured members is a top priority. This privacy notice explains how and what type of personal data will be collected, why it is collected and to whom it is shared or disclosed. Please read this notice carefully.

Processing of personal data

The information collected by ACS, insurance broker, simplified joint-stock company registered under number 317 218 188 RCS Paris, and located at 153, rue de l'Université – 75007 Paris, France, either directly from you or via your insurance intermediary, is subject to data processing for the sole purpose of:

- preparing, concluding, managing and executing your quote or contract (study of needs, underwriting, calculation and collect of premium, preparation of endorsements, claims management, treatment of complaints if any…),
- enforcing regulations related to anti-money laundering and terrorist financing prevention, fight against fraud,
- elaborating statistical and actuarial studies,
- redistributing risks via reinsurance or coinsurance.

The processing of such data is carried out in compliance with the requirements applying to the collection, processing, recording, organization, purpose limitation and data minimization, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transfer, dissemination, security of personal data.

The recipients of such data are, within the limits of their relevant assignments and according to applicable purposes, the insurers, reinsurers, insurance intermediaries (your direct broker, if applicable), and eventually their subcontractors, which intervene in the context of the execution or the management of your contract, third party administrators, the mediator if a case is submitted to him/her, authorities legally authorized to manage your complaints, Tracfin for the fight against terrorism and anti-money laundering. Your data may also be transmitted to any person benefiting from the contract (subscriber, insured, member, and beneficiary of the contract).

You expressly accept the collection and processing of data concerning your health. This information is necessary for the execution and the management of your contract and your benefits, which is the sole purpose of the processing, and made in accordance with the regulations of medical confidentiality. This information is exclusively intended for the medical advisors of ACS, its departments in charge of managing your benefits, its third-party administrators and assistance providers if applicable, as well as for the insurers and reinsurers of your contract.

Transfer of personal data :

In addition, we inform you that your personal data, or that of other parties concerned by or benefiting from the contract, may be transferred outside the European Union if necessary for the performance of your contract.

The sole purpose of such transfers is to allow the performance of insurance and assistance claims, and only the data necessary for the achievement of this purpose are transferred.

The recipients or categories of recipients authorized to receive the data are the accredited staff of the medical administrators ans assistance companies as well as of the insurers, where appropriate.

These transfers are made according to the regulations relating to the protection of personal data applicable in the European Union.

Your rights :

In accordance with the French data protection law n° 78-17 of January 6 1978 as amended in 2004 and 2018 and to

EU regulation 2016/679 of April 27th 2016, you have the right to Access, Rectify, Erase, and to the Portability of, any data concerning yourself, as well as the rights to the Restriction of and to Object to the processing of your personal data, which you can pursue by writing to our Data Protection Officer: dpo@acs-ami.com or by postal mail to « ACS, To the attention of the DPO, 153, rue de l'Université, 75007 Paris, France » (together with a copy of an official ID).

You may send a complaint:

- On the CNIL website by filling out the online form.
- By postal mail writing to CNIL - 3 Place de Fontenoy - TSA 80715 - 75334 PARIS CEDEX 07 FRANCE

Regarding your health data, these rights may also be exercised by writing to the ACS Medical Consultant (ACS, To the attention of the Medical Consultant, 153, rue de l'Université, 75007 Paris, France) together with of a copy of an official ID.

Data retention Duration :

Personal data will be retained in accordance with applicable laws and regulations, and specifically as follows :

Documents	**Data Retention Duration**
Proposal, quotations	3 years
Individual Enrollment Forms	• 5 years from the date of the termination of contract(if no claim) • 5 years from the date of the termination of the insurance coverage
Contributions and premiums	5 years
Healthcare claims (illness/ accident medical expenses)	3 years from the date the claim is closed
Claims files in the event of Death, Total and Irreversible Loss of Autonomy, Incapacity, Disability	• if the benefit has been paid: 10 years from the last date of payment • if the benefit has not been paid in totality or partially to the beneficiary(ies) in the event of death of the Insured: 30 years from the date of the recognition of the death of the Insured by the company • if the benefit could not be paid in total or partial due to the disappearance of absence of the Insured: 30 years from the date of recognition by the company of the determination of the disappearance or absence of the Insured
Permanent Partial Disability Due to Illness (PPDI)- Permanent Partial Disability Due to Accident Disability (PPDA)	• if the benefit has been paid: 10 years from the last date of payment • if not paid: 30 years

MFPrévoyance, Limited company with a board of directors and a supervisory board,
with capital of 81 773 850 euros, registered by the French insurance code,
RCS 507 648 053 PARIS, Head office : 62 rue Jeanne d'Arc - 75640 Paris Cedex 13, France