General Terms and Conditions

Personal Accident Insurance 2016

(PO 2016 ENG)

SUMMARY:

This guide lists a number of topics. Not all the topics covered in these General Terms and Conditions are listed in this guide. In specific cases, other provisions of these General Terms and Conditions may also be relevant.

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Terms that are in *italics* in these General Terms and Conditions are defined in Article 3. (Definitions).

Article 1. Ranking

Any (special) clauses and/or provisions included in the *policy* that conflict with these General Terms and Conditions shall always take precedence over these General Terms and Conditions.

Article 2. Obligations of *underwriters* pursuant to (sanctions) laws and regulations

2.1. Compliance with sanctions laws and regulations

If the *insurer* and/or the *underwriters* on the basis of national, supranational or international sanctions laws or regulations are prohibited to provide cover or make payments or pay benefits, this insurance shall not provide any cover.

2.2. Reservation of cover and right to premature termination in connection with FISH and CDD checks

2.2.1. Based on laws and regulations, *underwriters* have a number of obligations in respect of integrity, including carrying out a CDD investigation (CDD stands for Customer Due Diligence, or "know your customer"). Furthermore, *underwriters* must conduct sound underwriting policy. In connection with these obligations, the data of the *policyholder*, the *insured*, the *beneficiary* and other interested parties are checked at different times. The objectives of these checks are compliance with (sanctions) laws and regulations, fraud prevention and risk management. Within this context, *underwriters* use various public sanctions lists and the database of the CIS Foundation in The Hague through the FISH (Fraud Information System Holland) application and Compliancy Check.

2.2.2. If (periodic) checks show that the *policyholder*, *insured*, *beneficiary* or other interested party is included in the aforementioned databases at that time, the insurance may be terminated prematurely, as further set out in Article 16 of these General Terms and Conditions.

2.2.3. The checks shall also be carried out when a claim is made under this insurance. If the *policyholder*, *insured*, *beneficiary* or other interested party at that time is included in the aforementioned public sanction lists or in the aforementioned database, there is no right to cover.

Article 3. Definitions

Within the scope of this insurance contract, the following terms shall be understood to solely have the meanings stated thereafter, unless explicitly stated otherwise in the *policy*.

3.1. Underwriters

W.A. Hienfeld B.V. acting as an authorised agent on behalf of - and for the account and risk of - the *insurer*.

3.2. Incapacity for work

Incapacity for work of the *insured* for perform the work, connected with the occupation specified in the *policy*. (Where in these General Terms and Conditions reference is made to "incapacitated", this shall be construed as reference to the condition of *incapacity for work*).

3.3. Beneficiary

The (legal) person designated on the *policy* or by notice in writing to receive the benefit.

3.4. Permanent disablement

Permanent full or partial loss or loss of function of any organ or part of the body. (Where in these General Terms and Conditions reference is made to "permanently disabled", this shall be construed as reference to the condition of *permanent disablement*).

3.5. Spouse/partner

1. The spouse or the registered partner of the *insured*, or in the absence thereof,
2. the person who has entered into a notarial cohabitation contract with the *insured* or, in the absence thereof,
3. the person who has been living at the same address with the *insured* for more than 6 months and runs a joint household (if they are not related to each other, not married and not registered as partners).

3.6. Event

An occurrence that results in one *accident* or a series of *accidents*.

3.7. Costs of medical treatment

Costs:
- fees of the attending physician (not being a dentist);
- incurred for dressings and medicines prescribed by a physician;
- of treatment and nursing in a *hospital*;
- for ambulance transport;
- of purchase of prostheses, a wheelchair or a guide dog which have become necessary as a result of the covered *accident*.

3.8. Child
The unmarried, legitimate child of the *insured*, younger than 27 years, living in the home of the *insured* or residing elsewhere due to study.

3.9. Acts of war
Armed conflict, civil war, insurrection, civil commotions, riots and mutiny, as defined in the text which has been laid down by the Union of Insurers (Verbond van Verzekeraars) at the registry of the District Court in The Hague on 2 November 1981 under number 136/1981 or any replacement hereof.

3.10. Accident
A sudden, unintended, immediate violent impact from outside on the body of the *insured*, which is the direct and exclusive cause of bodily injury that can be assessed in a medically objective manner.

3.11. Death
Death as evidenced by a death certificate.

3.12. Policy
A certificate signed by *underwriters*, which demonstrates the existence of the insurance contract with the *policyholder*. The *policy* may also include special clauses and/or provisions. The General Terms and Conditions also form part of the insurance contract.

3.13. Premium
The amount the *policyholder* must pay under this insurance contract, where a distinction is made between:
- **initial premium**: the (first instalment of the) *premium* the *policyholder* must pay upon entering into this insurance contract or in connection with an interim change of this insurance contract;
- **subsequent premium**: the *premium* the *policyholder* must pay upon renewal of this insurance contract.

3.14. Costs of dental treatment
Costs:
- the fees of dentists or physicians for dental treatment including non-removable dentures, such as crowns, false teeth, etc.;
- of medicines for dental treatment prescribed by the dentist or physician;
- of X-rays for dental treatment made by or as prescribed by a dentist or physician.

3.15. Insurer
The insurance company and/or risk carrier as specified in the *policy*.

3.16. Insured
The person whose life or health this insurance contract relates to.

3.17. Policyholder
The contracting party of the *insurer*.

3.18. Suicide
Suicide is defined as death of the *insured* caused by self-directed harm. *Suicide* does not refer to: euthanasia performed by a qualified physician.

3.19. Hospital
An institution where medical treatment takes place. It must comply with the following criteria:
- having diagnostic and surgical facilities, and;
- a constant presence of nursing staff, and;
- permanent supervision by physicians.

A *hospital* is not held to mean: nursing homes, rest homes, homes for the elderly, psychiatric institutions, sanatoriums, rehabilitation centres or clinics for the treatment of alcohol or drug dependency.

Article 4. Definition of the cover - general provisions

4.1. Territorial limits
The insurance provides worldwide cover.
Please note: if the *policy* includes *acts of war*, a different cover applies to *acts of war*; in that case, see Article 5.1.

4.2. Which cover applies when?
It is apparent from the *policy* that there is cover for one or several of the following categories:
A. *death* as a result of a covered *accident*;
B. *permanent disablement* as a result of a covered *accident*;
C. *incapacity for work* as a result of a covered *accident*;
D. *costs of medical* and/or *dental treatment* as a result of a covered *accident*.

4.3. Scope of the cover
4.3.1. If the *insured* has died as a result of a covered *accident* - if included in the *policy* - the sum insured for *death* specified in the policy shall be paid to the *beneficiary* or *beneficiaries*.
4.3.2. If the *insured* suffers (a degree of) *permanent disablement* as a result of a covered *accident* - if included in the *policy* - an amount not exceeding the sum insured for *death* specified in the *policy* shall be paid. The extent of the payment partly depends on the degree of permanent loss or loss of function of the part of the body or the organ; see also Article 11.2. of these General Terms and Conditions.
4.3.3. If the *insured* has become incapacitated as a result of a covered *accident* - if included in the *policy* - up to a maximum of the sum insured for *incapacity for work* specified in the *policy* paid per day. The extent of the payment depends on the duration and the degree of *incapacity for work*; see also Article 11.3. of these General Terms and Conditions.
4.3.4. If, as a result of an *accident* within the meaning of the *policy*, there is a need for *medical treatment* and/or *dental treatment*, the costs for this will be reimbursed, with a maximum of the sums insured for *medical* and/or *dental treatment* specified in the *policy*; see also Article 11.4. of these General Terms and Conditions.
4.3.5. The total benefit under this *policy* shall never exceed the maximum sum specified in the *policy*.

Article 5. Definition of the cover - additional provisions

5.1. *Acts of war*

5.1.1. During (temporary) stay abroad (any country with the exception of the Netherlands and the country in which the *insured* is domiciled at the moment) this insurance shall also cover *accidents* the *insured* was involved in outside the Netherlands as a result of:
- *Acts of war*;
- hijacking, looting, acts of sabotage or terror, or deprivation of liberty connected with *acts of war*;
- unlawful deprivation of liberty. The cover ends after 180 days from the moment of deprivation of liberty. In any case the cover ends at the moment when the *insured* has arrived at the destination, as determined when regaining his or her liberty.

5.1.2. The following *accidents* are not covered if the *insured* has suffered these as a result of:
- taking part in one of the 6 forms of *acts of war* or hijacking, looting, sabotage or acts of terrorism or deprivation of liberty in connection with *acts of war*, other than to protect his/her own life or that of any fellow sufferers;
- the *insured* violating the law through a private act or omission;
- an armed conflict between (a member of) NATO and/or the ASEAN and/or the PRC.

5.2. Double payment

5.2.1. If the *insured* is involved in a covered *accident* as a result of fire in a dwelling or as passenger in a public means of transport (with the exception of aircraft or vessels) and the *insured* dies or becomes 100% *permanently disabled* as a result of such *accident*, the sum insured for *death* or for *permanent disablement* will be doubled.

5.2.2. **Please note:** this provision shall not apply
- to supplementary cover and/or reimbursements;
- if there is an *act of war*;
- if it is apparent from the *policy* that a cumulative scale is applicable;
- if the total amount payable for *death* or *permanent disablement*, without the application of this provision, exceeds € 500,000.00.

5.2.3. If, by applying this provision, the payment were to exceed € 500,000.00, a maximum amount of € 500,000.00 will be paid.

Article 6. Additional cover

Additional cover for the *insured*

6.1. Plastic surgery

6.1.1. If the *insured* requires plastic surgery as a result of a covered *accident*, the costs for plastic surgery will be reimbursed to the *insured*, with a maximum of 10% of the sum insured for *permanent disablement*. If 10% of the sum insured is higher than € 5,000.00, the maximum amount of € 5,000.00 per *accident* will be reimbursed to the *insured*.

6.1.2. Such compensation is only provided if:
- the treatment is prescribed and carried out by a qualified physician;
- treatment occurs within a period of 730 days from the day of the *accident*;
- the *insured* has taken out health insurance in the Netherlands;
- the costs cannot be recovered from a liable third party.

The costs will be reimbursed only after it has been established that these conditions have been met.

6.1.3. The concurrence regulation set out in Article 16.4. applies to this provision.

6.1.4. Costs that fall under the statutory deductible of the basic health insurance will not be reimbursed.

6.1.5. If the *insured* is entitled to a benefit for *costs of medical treatment* under this insurance, the benefit of the additional coverage referred to in the provision will be reduced by the benefit for *costs of medical treatment*.

Article 7. Extensions of the concept of '*accident*'

In addition to the concept of *accident* as set out in Article 3.10., the following will also be regarded as or covered as an *accident*:

7.1. Acute poisoning by medicines

Acute poisoning by medicines obtained on physician's prescription, provided that the *insured* followed the dose prescribed by the physician.

7.2. Infection after involuntary fall

Infection from germs or an allergic reaction as a direct result of an involuntary fall into water or into any other substance as a direct result of (an attempt to) rescue a human being, an animal or goods from the water or another substance.

7.3. Infections

Infection resulting from cowpox, anthrax, foot-and-mouth disease, sarcoptes scabiae, trichophytia, and Bang's disease.

7.4. Swallowing substances

The acute and involuntary swallowing or inhaling of harmful substances, gases or vapours. Harmful substances, gases or vapours do not include: viruses or bacterial germs.

7.5. Complications

Complications or aggravation of the accident injury directly and exclusively resulting from necessary medical treatment of a covered *accident* the *insured* was previously involved in.

7.6. *Accident* resulting from rescue or self-defence

An *accident*:
- occurring during lawful self-defence, rescue (or attempt thereat) of persons, animals or goods;
- occurring during activities of emergency services or activities as a member of the voluntary (company) fire brigade, company emergency response team or reserve police.

7.7. *Accident* due to illness

An *accident* due to illness, ailment or infirmity of the *insured*.

7.8. Incorrect medical treatment following a covered *accident*

Any incorrect medical treatment directly related to a covered *accident* the *insured* was previously involved in;

7.9. Exhaustion and suchlike
Exhaustion, starvation, dehydration, sunburn and any other physical injury directly resulting from deprivation or any disaster.

7.10. Asphyxiation and suchlike
Asphyxiation, drowning, hypothermia, sunstroke, heat stroke or being overcome by heat, sprain, dislocation, strained and/or torn muscles or tendons.

7.11. Wound infection or septicaemia
Infection of a wound or septicaemia as a direct result of a covered *accident*.

Article 8. Exclusions and sanctions

8.1. Exclusions

8.1.1. **Allergic reactions**
Allergic reactions, in so far as they are not the result of a covered *accident*, do not fall under this insurance.

8.1.2. **Atomic nuclear reactions**
No right to a benefit exists for *accidents* caused by an atomic nuclear reaction. 'Atomic reaction' is defined as: any nuclear reaction during which energy is released, such as nuclear fusion, nuclear fission, artificial and natural radioactivity, radioactive radiation.

8.1.3. **Operating a motorcycle**
No right to a benefit exists in the case of an *accident* the *insured* was involved in during the operation of or being a passenger on a motorcycle or moped or scooter, if the head of the *insured* at the moment of the *accident* was not properly protected by a crash helmet that meets legal requirements or if the person operating the motorcycle was not in possession of a valid driving licence or certificate.

8.1.4. **Foreign armed forces**
No right to a benefit exists in the case of an *accident* that occurred whilst performing work, in the broadest sense, in the service of a foreign armed force or a government service to be put on a par with this.

8.1.5. **Consumption of alcohol and similar substances**
No right to a benefit exists in the case of an *accident* in which the *insured* at the time of the *accident* was under the influence of alcohol with a blood alcohol level of 0.8 permille or higher, or the breath alcohol level was 350 micrograms or higher, or in which the *insured* was under the influence of other intoxicants, stimulants or similar substances, which shall at least include soft and hard drugs.

8.1.6. **(Dangerous) sports**
No right to a benefit exists for *accidents* the *insured* was involved in whilst participating in: bungy-jumping, paragliding, parachute jumping and all related sports. Furthermore, no right to a benefit exists in the case of an *accident* the *insured* was involved in as a professional athlete.

8.1.7. **Crime**
No right to a benefit exists in case of *accidents* in connection with committing or taking part in a crime or an attempt thereat by the *insured*. This includes participation in fights, with the exception of the provisions in Article 7.6. (*accident* resulting from rescue or self-defence).

8.1.8. ***Acts of war***
No right to a benefit exists in case of *accidents* the *insured* has been involved in an *act of war* situation, unless the *accident* took place within 14 days after the *act of war* broke out in a country, not including the Netherlands, or the country where the *insured* was living at the time of the *accident* and which took the *insured* by surprise, or unless *acts of war* is covered in the *policy*.

8.1.9. ***Accident* in/with aircraft**
No right to a benefit exists if the *insured* is involved in an *accident*:
- as a crew member of an aircraft;
- as passenger in an aircraft if the pilot is not in possession of the licence required for the aircraft in question, or
- as an amateur glider pilot, if the *insured* is not in possession of a valid licence.

8.1.10. **Incorrect medical treatment without *accident***
The consequences of incorrect medical treatment that is not related to a covered *accident* the *insured* was involved in do not fall under the cover of this insurance.

8.1.11. **Deliberate intent**
No right to a benefit exists in case of deliberate or reckless conduct by or with the approval or through provocation of the *policyholder*, the *insured* or the *beneficiary* or any party interested in the insurance. Deliberate or reckless conduct shall also include: (attempted) *suicide* or self-mutilation.

8.1.12. **Muscle, nerve or joint complaints**
Lumbar pain, lumbago, inflammation of the tendon sheath, torn calf muscle, tennis elbow, golf arm, hernia (intestinal fracture) and hernia nuclei pulposi, and the consequences thereof, are not covered by this insurance.
This exclusion does not apply to the cover of *incapacity for work*. A maximum benefit period of 28 days per event applies to these conditions.
Furthermore, this exclusion does not apply to the cover of costs of *medical treatment*, but these are reimbursed, with a maximum of 20% of the sum insured per *event*.

8.1.13. **Risky enterprise**
No right to a benefit exists in the case of an *accident* as a result of, or occurring during a risky enterprise, unless such risky enterprise was reasonably necessary in connection with the proper carrying out of the *insured's* profession or with legitimate self-defence or saving of himself, others, animals or goods or an attempt thereat.

8.1.14. **Contests**
No right to a benefit exists in the case of an *accident* that occurred during participation of the *insured* in contests with motor vessels or motor vehicles, whereby the speed is the paramount factor and/or during the preparation of such contests.

8.2. Loss of right to payment

8.2.1. Any right to a payment shall lapse if the *policyholder* and/or the *insured* and/or *beneficiary* fail to meet any obligation to report, disclose, inform or cooperate as defined in these General Terms and Conditions or in the law, insofar as the reasonable interest of *insurer* has been prejudiced as a result.

8.2.2. Any right to a payment shall lapse if the *policyholder* and/or the *insured* and/or *beneficiary* fail to meet any obligation to report, disclose, inform or cooperate as defined in these General Terms and Conditions or in the law, with the intent to mislead the *insurer*, unless such deception does not justify the lapsing of the right.

Article 9. General obligations following an *accident* or in the event of missing or disappearance of the *insured*

If there is a possible covered *accident* or missing or disappearance of the *insured*, the *policyholder* and/or *insured* and/or *beneficiary* and/or any

party interested in the insurance shall have a number of obligations. This article sets out the general obligations. The following articles include special obligations in the event of *death* and *permanent disablement*, *incapacity for work* and *costs of medical* and/or *dental treatment*.

The *policyholder* and/or *insured* and/or *beneficiary* and/ or any party interested in the insurance shall have the following obligations:
- to ensure that the *accident* or the missing or disappearance of the *insured* is reported to the *underwriters* by e-mail, by letter or by telephone, as soon as possible;
- to inform the *underwriters*, the best they can, of all the details in respect of the *accident* the *insured* has been involved in and truthfully answer all questions put to them;
- to cooperate with the claims adjusters appointed by the *underwriters* (such as claims adjusters and medical advisors) in the event of a possibly necessary (medical) investigation into the cause of the *accident*.

Furthermore, the *policyholder* has the following obligations:
- to ensure, as well as possible, that the *insured* fulfils all his obligations set out in Article 9., 10. and 11.;
- if consequently asked, to provide the *underwriters* with information demonstrating that the person for/by whom payment is required was insured at the time of the *accident*, and to give the *underwriters* the opportunity to verify that data.

Article 10. Rights and obligations in the event of *death*

10.1. Obligations in the event of *death* of the *insured*

In the event of *death* of the *insured*, the *policyholder* and/or *beneficiary* and/or any party interested in the insurance shall have the following obligations in addition to the obligations set out in Article 9. above:
- to ensure that the *death* of the insured is reported to the *underwriters* by e-mail, letter or telephone as soon as possible, but at least 36 hours before the funeral or cremation; **Please note:** If it is decided to report the *death* by letter, it must be ensured that this letter has reached the *underwriters* at least 36 hours before the funeral or cremation;
- to ensure that, if considered necessary by the *underwriters*, the funeral or cremation of the *insured* is postponed to a later date;
- to cooperate with the experts appointed by the *underwriters* (such as claims adjusters and medical advisors) in the event of a possibly necessary (medical) investigation into the cause of the *accident* and/or the cause of *death*. This shall include at least: autopsy, laboratory examination and if the funeral has already taken place, exhumation of the deceased.

10.2. *Death* benefit

10.2.1. After it has been established that the cause of *death* of the *insured* is a covered *accident*, the sum insured for *death* is paid to the *beneficiary* or *beneficiaries*.

10.2.2. **Missing or disappearance**

In case of missing or disappearance of an *insured*, the sum insured for *death* - if it is likely beyond any reasonable doubt that the *insured* died as a result of a covered *accident* - shall be paid to the *beneficiary* or *beneficiaries*. *Underwriters* may require that a statement of presumption of *death* be submitted.

10.2.3. **Disablement benefit already paid out**

If a sum has already been paid with regard to *permanent disablement* as a result of the same *accident*, and the *insured* dies as a consequence of this *accident* within the period referred to in Article 11.2.6. of these General Terms and Conditions, only the difference between the amount payable on *death* and the already paid amount paid for *permanent disablement* shall be paid. Where such payments due to *permanent disablement* have exceeded the sum insured for *death*, it is not required to refund the difference to the *underwriters* as undue payment.

10.2.4. **No *beneficiary***

If, in case of *death* of the *insured*, it appears that there is/are no *beneficiary*/*beneficiaries* and no *beneficiary* can be designated on a legal basis, the payment obligation will expire. Under no circumstances shall the benefit on account of this insurance become due to the State of the Netherlands or any other State, nor shall this benefit be made available for the settlement of debts of the *insured*.

10.2.5. **No transfer**

The claim of the *beneficiary* against the *underwriters* regarding the benefit in the event of *death* cannot be transferred to third parties.

Article 11. Rights and obligations in the event of (possible) *permanent disablement*, *incapacity for work* or *costs of medical* and/or *dental treatment*

11.1. Obligations in the event of (possible) *permanent disablement*, *incapacity for work* or *costs of medical* and/or *dental treatment* as a result of a possible covered *accident*

If the *insured* has an *accident*, as a result of which the *insured* may suffer (a degree of) *permanent disablement*, or could become incapacitated, or would have to incur *costs for medical* and/or *dental treatment*, the *policyholder* and/or *insured* shall have a number of obligations, in addition to the requirements set out in Article 9. above.

The *policyholder* and/or *insured* must ensure that the *accident* is reported to the *underwriters* by e-mail, by letter or by telephone, as soon as possible after the *accident*. The 'accident claim form' can be used for this purpose, which can be downloaded from the website of the *underwriters*: www.hienfeld.nl.

Furthermore, the *insured* has the following obligations:
- to seek medical treatment as soon as possible and to continue to receive treatment as long as this is reasonably necessary and to continue to follow the instructions of the attending physician;
- to undergo a medical examination carried out by a medical practitioner to be designated by the *underwriters* or to have himself admitted for observation in a *hospital* or institution, whether or not in the Netherlands, designated by the *underwriters*;
- to provide or cause to provide the claims adjusters appointed by the *underwriters* with all information that they need to determine the degree of *permanent disablement* and to render all cooperation with the retrieval of medical data by the medical advisor of the *underwriters*;
- answer truthfully and completely all questions asked by the *underwriters* or the claims adjuster(s) appointed by the *underwriters* and not to withhold any facts or circumstances which may be of relevance in order to determine the extent of *permanent disablement*;
- to notify the *underwriters* of complete or partial recovery as soon as possible.

11.2. *Permanent disablement* benefit

What is paid in the event of *permanent disablement*?

11.2.1. **Benefit percentage of the sum insured**

If the *insured* suffers (a degree of) *permanent disablement* as a result of a covered *accident*, the *underwriters* shall pay the *beneficiary* a percentage of the sum insured specified in the *policy*. This is the benefit percentage, which is determined on the basis of whether there

is full or partial loss (of function) of one or more parts of the body or organs. To determine the amount of the benefit percentage, see Article 11.2.8. et seq.

11.2.2. **Compensation of interest**
If within a period of 2 years after the date on which the *accident* was reported to the *underwriters* the benefit percentage cannot yet be assessed, the *beneficiary* shall be entitled to a simple interest of 6% per annum on the final amount to be compensated for *permanent disablement*. In that case, the interest will be calculated from the 730th day of receipt of the report of the *accident* by the *underwriters* to the day that the *underwriters* have prepared the benefit proposal.

How and when is the degree of permanent loss or loss of function of the affected body part or organ determined?

11.2.3. **Method of assessment**
The degree of permanent loss or loss of function of the body part or organ shall be determined by the *underwriters* based on the report(s) of the claims adjusters appointed by them, subject to the criteria set out in the latest edition of the "Guides to the Evaluation of Permanent Impairment" of The American Medical Association (A.M.A.), if needed supplemented by the guidelines of the Dutch associations of specialists.

11.2.4. **Effect of illness, ailment or infirmity**
If the *insured* suffers from an illness, ailment or infirmity before the *accident* or an illness, ailment or infirmity develops after and independently from the *accident*, the adverse effect on the consequences of the *accident* and/or on the degree of the permanent loss or loss of function shall be taken into consideration when assessing the degree of permanent loss or loss of function. The benefit to be paid shall not exceed the amount that would have been paid if the *insured* had not suffered from this illness, ailment or infirmity.

11.2.5. **Effect of psychological response(s)**
The psychological response to the *accident* itself and/or to the physical injury/*permanent disablement* caused by the *accident* shall never be taken into account when assessing the extent of permanent loss or loss of function.

11.2.6. **Time of assessment**
The degree of permanent loss or loss of function of the affected body part or organ is assessed as soon as the final medical condition of the *insured* is stable according to medical opinion, but in any case within 3 years from the date of the *accident*, unless agreed otherwise. At the end of this 3-year period or period to be agreed, the degree of permanent loss or loss of function shall be assessed based on the degree of disablement existing at that moment. Changes occurring after this period shall not affect the level of benefit. Upon improvement, the *underwriters* shall not be entitled to (partial) refund of all payments made and in case of deterioration the *beneficiary* shall not be entitled to a higher benefit.

11.2.7. **Effect of *death***
If, following a covered *accident*, the *insured* dies as a result of a different cause than the *accident*, the degree of permanent loss or loss of function shall be assessed on the basis of the condition of the *insured* which would probably have been definitively assessed on the basis of available medical reports upon reaching a medically stable final condition, in the event the *insured* had not died.

How and when is the benefit percentage determined?

11.2.8. **Method of assessment**
The amount of the benefit percentage is determined on the basis of 3 aspects:
- is there a question of one or more affected body part(s) or organ(s)?
  is there a question of full or partial loss or loss of function of the affected body part(s) or organ(s) / what is the degree of permanent loss or loss of function of the affected body part or organ?
- is the affected body part or organ included in the benefit scale below?

11.2.9. **Benefit scale**
In the event of permanent <u>full</u> loss or loss of function of the body parts or organs listed below, the benefit percentage stated next to them shall apply.
- visual system 100%
- power of speech 35%
- hearing in one ear 30%
- hearing in one ear if under this insurance a benefit has already been paid due to loss of hearing in the other ear 20%
- hearing in both ears 50%
- auricle 5%
- nose 10%
- the smell or the taste or both 10%
  (partial loss of smell, taste or of both is not considered a disablement)
- thumb 25%
- index finger 15%
- any other finger 10%
- arm to the shoulder joint 75%
- big toe 10%
- any other toe 5%
- leg up to the knee joint 55%
- leg to the hip joint 70%
- spleen 5%
- kidney 20%
- lung 25%
- pancreas 70%
- complete set of teeth 2,5%
  with a maximum of € 12,000.00, however (no benefit shall be paid in case of loss of less than 50% or in case of partial damage(s).
  A complete set of teeth is defined as: 28 to 32 elements of the natural set of teeth and non-removable dentures.
- the total loss of the integrated complex higher functions of the brain as a result of traumatic injury to the brain 100%
- the total loss of the ability to use language as a result of traumatic injury to the brain 90%
- spinal column with total loss of typical spinal column action and motor function without any neurological symptoms 75%
  Permanent disablement may also be assumed in case of the following diagnoses. The benefit percentage lies between the ..... percentages shown next to the relevant diagnosis and is determined by the (medical) claims adjuster(s).
- post-commotional syndrome 0-8%
  Post-commotional syndrome is defined as: prolonged complaints that occur after a concussion.
- whiplash injury without any objectively demonstrable neuropsychological loss of function and/or objectively demonstrable vestibular anomalies 0-8%

- whiplash injury with neuropsychological loss of function and/or vestibular anomalies 8-15%
  Whiplash is defined as: cervical acceleration/deceleration injury of the spinal column. Whiplash is caused by a forceful back-and-forth movement of the neck, for example during a rear-end collision.
  "Vestibular" anomalies are defined as balance disorders.

> **Example:**
>
> Suppose the *insured* suffers full loss of an index finger. According to the benefit scale above, the benefit percentage has been set at 15%. If the sum insured for *permanent disablement* is € 100,000.00, the *beneficiary* shall thus receive a payment of € 15,000.00 in this case.

11.2.10. **Partial loss**

In the event of permanent partial loss or partial loss of function of a part of the body or organ, the benefit percentage shall be calculated based on the degree of permanent loss or loss of function corresponding to the benefit percentage for permanent full loss or loss of function for said body part or organ in the benefit payment scale in Article 11.2.9.;

> **Example:**
>
> Suppose it is determined on the basis of the above guidelines that the degree of permanent loss of function of an index finger is 75%. According to the benefit scale, the benefit percentage for total loss of an index finger is 15%. In that case, the benefit percentage for partial loss of function of 75% is equal to (75% of 15% =) 11.25%. If the sum insured for *permanent disablement* is € 100,000.00, the *beneficiary* shall in this case receive a payment of 11.25% of € 100,000.00, thus € 11,250.00.

11.2.11. **Determining benefit percentage in other cases**

In case of total or partial loss or loss of function of parts of the body or organs not listed in the benefit scale above, the benefit payment for that specific body part or organ is determined in accordance with the criteria set out in the latest version of the 'Guides to the Evaluation of Permanent Impairment' of The American Medical Association (A.M.A.), if needed supplemented by the guidelines of the Dutch associations of specialists. The degree of permanent loss or loss of function of parts of the body or organs shall also be determined, for which the work performed (at the time of the *accident*) of the *insured* shall be taken into consideration. (**Please note:** this is not equivalent to the degree of occupational disability under the Work and Income Capacity for Work Act or similar schemes (Wet werk en inkomen naar arbeidsvermogen)). In that case, the benefit shall be determined on the basis of the highest percentage.
Please note: in the case of permanent loss or loss of function of several body parts or organs, this provision applies exclusively to the body part or organ that is not included in the benefit scale.

> **Example:**
>
> Suppose the *insured* suffers a pelvic fracture. This is a body part that is not included in the benefit scale. According to the above guidelines, the benefit percentage, without taking into account the work of the *insured*, has been determined at 40%.
>
> Suppose this *insured* is a painter, the benefit percentage, taking into account his activities, could be determined at 50%.
>
> If the sum insured for *permanent disablement* is € 100,000.00, the *beneficiary* shall receive a payment of (50% - being the highest percentage - of € 100,000.00 =) € 50,000.00.

11.2.12. **Multiple loss**

In the event of permanent loss or loss of function of several parts of the body or organs, the benefit percentage shall first be determined on the basis of the above provisions for each part of the body or organ separately. These percentages are subsequently added up and/or combined, with a maximum of 100%.

> **Example:**
>
> Suppose the *insured* suffers full loss of a thumb and an index finger. According to the benefit scale, the benefit payment for a thumb is 25% and for an index finger is 15%. In this case, the total benefit percentage is 40%. If the sum insured for *permanent disablement* is € 100,000.00, the *beneficiary* shall receive a payment of (40% of € 100,000.00 =) € 40,000.00.
>
> Suppose the *insured* suffers full loss of both lower legs. According to the benefit scale the benefit percentage has been determined at 55% per lower leg. In this case, the total benefit percentage is 100%, being the maximum amount. If the sum insured for *permanent disablement* is € 100,000.00, the *beneficiary* shall receive a payment of € 100,000.00 in this case.
>
> Suppose the *insured* suffers full loss of a lower leg. According to the benefit scale the benefit percentage for loss of a lower leg has been determined at 55%. In addition, the *insured* suffers a thumb injury as a result of the same *accident* for which the degree of permanent loss of function of the thumb is determined at 50%. According to the benefit scale, the benefit percentage for total loss of a thumb is 25%. In that case, the benefit percentage for partial loss of function of a thumb of 50% is equal to (50% of 25% =) 12.5%. If the sum insured for *permanent disablement* is € 100,000.00, the *beneficiary* shall receive a payment of € 67,500.00 (i.e. 55% + 12.5% = 67.5% of € 100,000.00).

11.2.13. **Time of final decision**

Underwriters must make a final decision within 14 days from receipt of the final report of their medical advisor and any other information necessary for a proper assessment of the right to benefits.

11.3. Temporary benefit in case of *incapacity for work*

11.3.1. If the *insured* becomes incapacitated as a result of a covered *accident*, the *underwriters* will pay the *beneficiary* the sum insured stated in the *policy* for the duration of the *incapacity for work* and part of this sum in case of partial *incapacity for work*, for a maximum of 365 days after the day of the *accident*.

11.3.2. The right to a benefit commences on the day on which the *insured* underwent medical treatment and is also incapacitated for work.

11.3.3. The benefit is calculated by multiplying the sum insured for *incapacity for work* stated in the *policy* by the percentage of *incapacity for work* and the number of days the *incapacity for work* has lasted. The benefit is paid at the end of the *incapacity for work* or at the end of the maximum payment term, but the *underwriters* may also choose to pay the amounts as a (periodic) advance to the *beneficiary*.

11.3.4. The (degree of) *incapacity for work* shall be assessed by the *underwriters* based on the report(s) of the claims adjusters or employment counsellors they have appointed.

11.3.5. The payment ends in the following cases:
- as soon as the *insured* is able again to carry out the work related to his occupation as stated in the *policy*;
- as soon as the medical treatment has ceased;
- if a benefit for *permanent disablement* has been provided under this insurance contract with regard to the same *accident*;
- in case of *death* of the *insured*.

In any case, the payment shall end no later than 365 days after the day of the *accident*.

11.3.6. If a covered *accident* does not result in *incapacity for work* of the *insured*, but does incur *costs of medical treatment* as a result of this *accident*, the *underwriters* will reimburse such costs. Reimbursement of *costs of medical treatment* shall not exceed the maximum sum insured (per day) for *incapacity for work* stated in the *policy*, times 365 days after the day of the *accident*;

11.3.7. This provision shall not apply if the *insured* is already entitled to reimbursement of these costs on a different basis under this insurance contract (for example, see Article 11.4. Of these General Terms and Conditions).

11.3.8. The concurrence regulation set out in Article 16.4. applies to this provision.

11.4. Payment in case of *costs of medical* and/or *dental treatment*

11.4.1. If, as a result of a covered *accident*, the *insured* incurs *costs of medical* and/or *dental treatment*, such costs will be reimbursed by the *underwriters*, with a maximum of the sum insured for *costs of medical* and/or *dental treatment* as stated in the *policy*, for no longer than 365 days after the day of the *accident*. A deductible of € 25.00 per *event* applies.

11.4.2. Costs for which the *insured* submits a claim with the *underwriters*, must be proven by original, itemised invoices.

11.4.3. Reimbursement of *costs of medical* or *dental treatment* is subject to the following conditions:
- the *insured* proves that the costs incurred are a result of the *accident*;
- the *insured* has effected health insurance in the Netherlands;
- the costs cannot be recovered from a liable third party.

The costs will be reimbursed only after it has been established that these conditions have been met.

11.4.4. The concurrence regulation set out in Article 16.4. applies to this provision.

11.4.5. The statutory deductible of the basic health insurance will not be reimbursed.

Article 12. Payability, payment and discharge

Payability, payment and discharge

Payment of the benefit shall occur (if applicable by means of an intermediary) within 14 days from receipt by the *underwriters* of a benefit receipt signed by the *beneficiary* and drawn up by the *underwriters*, according to which full acquittance and discharge will be granted. The claim shall only be due and payable from 14 days after receipt by the *underwriters* of the signed benefit receipt.

Article 13. *Premium*

13.1. Payment of *premium*

The *policyholder* is obliged to pay the *premium*, the policy costs and any insurance premium tax in advance. The amount due must be paid no later than on the premium due date. The *initial premium* must be paid no later than within 30 days from the date of the first premium invoice.

13.2. Non-payment, lapse of insurance cover

13.2.1. If the *policyholder* does not pay or refuses to pay the *initial premium* at the latest on the 30th day after the date of the first premium invoice, no cover will be provided. **Please note:** no reminder is required for this.

13.2.2. If the *policyholder* may pay the *premium* in instalments and fails to pay or fails to pay an instalment on time, the total amount of the overdue instalments shall become immediately due and payable in full.

13.2.3. If it should be deduced from a notification from the *policyholder* that he will fail to pay or fail to pay in time the *subsequent premium*, the cover will be suspended with regard to all occurrences that take place or have taken place after the premium due date. In that case, the *underwriters* may also terminate the insurance with immediate effect.

13.2.4. If the *policyholder* fails to pay or fails to pay in time the *subsequent premium* or an instalment thereof, the insurance will be cancelled or the cover will be suspended if, the *policyholder* has ineffectively received a reminder after the premium due date for payment of the total outstanding *subsequent premium* (including the instalments not yet expired) within a period of 14 days, stating the consequences of the non-payment, starting on the day after the reminder.

13.2.5. If the *policyholder* fails to pay the outstanding *subsequent premium* (including the instalments not yet expired) within the period of 14 days, beginning on the day after the reminder, the *policyholder* shall be due (extrajudicial) collection costs.

13.2.6. Despite cancellation of the insurance or suspension of the cover, the *policyholder* will still be bound to pay the outstanding *premium*.

13.2.7. If the insurance has been suspended, but not cancelled, the cover will again come into force on the day following the day the *underwriters* have received the amount due, including statutory interest and (extrajudicial) collection costs. In case of payment by instalments, this means that all unpaid instalments must have been paid in full, including statutory interest and (extrajudicial) collection costs.

Article 14. Changes (in risk, *premium* and/or terms and conditions)

14.1. En-bloc revision

14.1.1. Within the scope of an en-bloc revision for similar insurances, the *underwriters* are entitled to review the *premium* and/or terms and conditions in the same manner. An en-bloc revision shall always apply to a group of insurances and is used, for example, when the *premium* is no longer sufficient to cover the risk.

14.1.2. The *policyholder* shall be notified of any en bloc revision in advance and in writing.

14.1.3. If the terms and conditions of the insurance contract are changed to the detriment of the *policyholder* or the person entitled to the benefit, the *policyholder* shall have the right to terminate the insurance contract from the date the change takes effect. The *policyholder* shall have this right at least up to one month after the *policyholder* has been notified of the change.

14.1.4. If the insurance refers to several groups of persons *insured* specified in the *policy*, the right to terminate only refers to those groups to which the proposed en bloc revision refers.

14.1.5 The option for the *policyholder* to terminate the insurance shall not apply if:
- the change of the *premium* and/or terms and conditions ensue from statutory regulations or provisions that are directly related to and have direct consequences for this insurance;
- the change is only to the benefit of the *policyholder* (for example, if the change is a reduction of the *premium* with the same cover or an extension of the cover with the same *premium*), or;
- the change in the *premium* directly ensues from provisions in the *policy* and/or these General Terms and Conditions.

14.2. Change of risk

14.2.1. The *policyholder* and/or the *insured* are obliged to immediately notify the *underwriters* of a possible change of risk and in any case within

30 days after the day on which the risk changes. Notice must be in writing (this means by letter or e-mail).
A possible change of risk shall at least include:
- if the *insured* changes profession or is going to conduct substantially different professional activities or
- If one or more conditions compared to the information provided at the conclusion of the insurance change significantly; this is certainly the case when the *insured* starts working with machinery.

14.2.2. In the event of an increase in risk, both the *underwriters* and the *policyholder* shall have the right to cancel this insurance contract, with due observance of a notice period of 2 months.

14.2.3. In the event of an increase in risk, *underwriters* shall have the right to make interim changes to the *premium* or the conditions. In that case, the *policyholder* will be informed in writing of the desired adjustment. If the terms and conditions of the insurance contract are changed to the detriment of the *policyholder* or the person entitled to the benefit, the *policyholder* shall have the right to cancel the insurance contract from the date the change takes effect. The *policyholder* shall have this right at least up to one month after the *policyholder* has been notified of the change.

14.2.4. **Please note:** An increase of risk does not automatically fall under the insurance cover. An increase of risk shall only be covered once the *underwriters* have accepted the changed risk in writing and, if necessary, the *policy*, the *premium* and/or the insurance terms and conditions have been adjusted in accordance with the said change.

Article 15. Special provisions in respect of an *insured* living abroad

15.1. *Insured* abroad

With respect to the *insured* living abroad, the *underwriters* shall have the right to have any *permanent disablement* established in the Netherlands.

15.2. Foreign currency

If this insurance applies to an *insured* established in a country with another currency than the Euro, the sums insured stated in Euro in the *policy* will be converted to the other currency on the basis of the official rate of exchange (closing rate) published by the European Central Bank, valid on the day of the *accident*. If on that day no rate of exchange is published, conversion shall be on the basis of the rate of exchange published on the next day.

Article 16. General Provisions

16.1. Insurance period

This insurance has been entered into for the period indicated in the *policy* and is renewed each time for the same period and under the same conditions, unless the insurance has been cancelled in a timely manner by one of the parties before expiry of the said period. Notice must be in writing (for the *policyholder* this means by letter or e-mail), with due observance of a notice period of 2 months before expiry of the period indicated in the *policy*.

16.2. Premature termination

16.2.1. The insurance may be terminated prematurely in writing by the *underwriters* with immediate effect, if the obligations under these General Terms and Conditions and/or obligations under the law have not been fulfilled by or on behalf of the *policyholder*, the *insured* or the *beneficiary* or the person entitled to the benefit, with the intent to mislead the *insurer* and/or the *underwriters*.

16.2.2. The insurance may - in addition to the specific cases listed in the General Terms and Conditions - be terminated prematurely in writing (for the *policyholder* this means by letter or e-mail) by the *underwriters* and by the *policyholder*, with due observance of a notice period of 2 months in the following cases:
- the *policyholder* applies for a moratorium and/or the *policyholder* is granted a moratorium;
- the *policyholder* is declared bankrupt;
- the *policyholder* (if a natural person) relies on the Debt Rescheduling Natural Persons Act and/or this Act is declared applicable to the *policyholder*;
- a FISH or CDD check shows that the *policyholder*, *insured*, *beneficiary* or another interested party is included in a relevant database or on a public sanction list.

16.2.3. The cover of an *act of war* as defined in Article 3.11. and 5.1. of these General Terms and Conditions may be prematurely terminated in writing by *underwriters* and by the *policyholder* (for the *policyholder* this means by letter or e-mail) should such a risk materialise, or if the risk threatens to happen, with due observance of a period of 14 days. During this period, consultations may be held on possible preservation of this cover.

16.2.4. In case of any other specific grounds for cancellation referred to in this *policy*, a notice period of 2 months must be observed, unless a different period is specified.

16.3. Insurance cover termination

16.3.1. The cover for an *insured* shall end automatically at the end of the policy year in which the *insured* has reached the age of 75.

16.3.2. The cover for the *insured* shall automatically end on the first premium due date after the day on which the *insured* no longer resides in the Netherlands; the cover for temporary *incapacity for work* and/or *costs of medical* and/or *dental treatment* shall immediately end at the moment the *insured* no longer resides in the Netherlands.

16.4. Concurrence scheme

16.4.1. Where these General Terms and Conditions refer to "concurrence", it shall mean that if the *insured* or the *policyholder* has another insurance (such as health insurance) that also gives the right to reimbursement of the relevant costs, or the costs are reimbursed by a benefits or a social insurance agency, this insurance shall only reimburse the costs that are not reimbursed by said other insurance or other benefits or social insurance agency (or would be reimbursed if this insurance did not exist). In that case, this insurance will only provide additional cover, therefore, with a maximum of the amount specified in the relevant provision.

16.5. Notifications / address

16.5.1. Notifications by the *underwriters* and/or the *insurer* to the *policyholder* and/or the *insured* and/or *beneficiary* may be forwarded in a legally valid way to the address of the relevant party last known to the *underwriters* and/or the *insurer*. Correspondence from the *underwriters* and/or *insurer* to the *policyholder* and/or *insured* shall in principle take place via the insurance agent of the *policyholder*.

16.5.2. All notifications and/or other correspondence from the *policyholder* and/or the *insured* and/or the *beneficiary* to the *insurer* must be addressed to the *underwriters*.

16.6. Disputes

16.6.1. Complaints Procedure

Complaints relating to (the implementation of) this insurance contract or any requests preceding them may in the first instance be

submitted to:
- the Board of Directors of W.A. Hienfeld B.V.,
  Postbus 75133, 1070 AC Amsterdam;

Underwriters prefer that a complaint is submitted by letter or e-mail (info@hienfeld.nl)
If the complaint cannot be resolved to the satisfaction of the submitter, the complaint may be submitted to:
- KiFiD (Financial Services Complaints Board)
  Postbus 93257, 2509 AG Den Haag.

16.6.2. Disputes in connection with this insurance contract shall be submitted to the competent court, unless the parties agree on a different method of conflict resolution, such as mediation or arbitration.

16.7. Applicable law

Dutch law applies to this insurance contract.

16.8. Privacy

16.8.1. *Underwriters* process your personal data in accordance with the Data Protection Act and comply with the Code of Conduct for the Processing of Personal Data by Financial Institutions. This code of conduct can be requested via www.verzekeraars.nl.

16.8.2. Any personal data provided upon application for and/or amendment of an insurance contract or when submitting a claim are processed by the *underwriters* for the purpose of:
- assessing and accepting the *policyholder* and/or the *insured*. For this purpose, the *underwriters* make use of a CDD investigation (CDD means Customer Due Diligence, or "know your customer") based on the FISH (Fraud Information System Holland) database.
- the implementation of agreements;
- conducting targeted marketing activities and targeted offers;
- compliance with statutory requirements;
- conducting statistical and scientific analyses;
- conducting fraud checks and compliance with (Sanctions) laws and regulations by means of the FISH database and the Compliancy Check.

16.8.3. To properly perform their work, the *underwriters* are affiliated with the Central Information System Foundation (CIS) in The Hague. The objective of the foundation is to collect and store insurance data for insurance companies and authorised agents to combat fraud and crime. To achieve this goal, affiliated parties may also exchange data among themselves.

16.9. Terrorism

The latest version of the Terrorism Cover Clauses Sheet by Dutch Terrorism Risk Reinsurance Company (Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V. - NHT) applies to this insurance contract, if and insofar as the *insurer* is affiliated with the NHT. The applicable Clauses Sheet has been annexed to these General Terms and Conditions. Upon request, the *underwriters* will send you the latest version of the clauses sheet free of charge. The text can also be viewed on www.hienfeld.nl/nht.

Clauses Sheet Terrorism Cover
by the Dutch Terrorism Risk Reinsurance Company (NHT)

Article 1 Definitions

Where they appear in this clauses sheet and the provisions based thereupon, the following terms shall, unless otherwise stipulated, be understood to mean:

1.1 Terrorism:
Any violent act and/or conduct - committed outside the scope of one of the six forms of acts of war as referred to in Article 3:38 of the Financial Supervision Act [Wet op het financieel toezicht] - in the form of an attack or a series of attacks connected together in time and intention as a result whereof injury and/or impairment of health, whether resulting in death or not, and/or loss of or damage to property arises or any economic interest is otherwise impaired, in which case it is likely that said attack or series - whether or not in any organisational context - has been planned and/or carried out with a view to effect certain political and/or religious and/or ideological purposes.

1.2 Malevolent contamination:
The spreading (whether active or not) - committed outside the scope of one of the six forms of acts of was as referred to in Article 3:38 of the Financial Supervision Act - of germs of a disease and/or substances which as a result of their (in)direct physical, biological, radioactive or chemical effect may cause injury and/or impairment of health, whether resulting in death or not, to humans or animals and/or may cause loss of or damage to property or may otherwise impair economic interests, in which case it is likely that the spreading (whether active or not) - whether or not in any organisational context - has been planned and/or carried out with a view to effect certain political and/or religious and/or ideological purposes.

1.3 Precautionary measures:
Any precautionary measures taken by the authorities and/or insured parties and/or third parties in order to avert the imminent risk of terrorism and/or malevolent contamination or - if such has manifested itself - to minimise the consequences thereof.

1.4 Dutch Terrorism Risk Reinsurance Company [Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V.] (NHT):
A reinsurance company incorporated by the Dutch Association of Insurers, to which any liability to pay compensation under any insurance contract which may arise from the manifestation of the risks referred to in Articles 1.1, 1.2, and 1.3, may be ceded.

1.5 Insurance contracts:
a) Non-life insurance contracts insofar as they pertain to risks situated in the Netherlands in accordance with the provisions of Article 1 (1) (p) of the Financial Supervision Act.
b) Life insurance contracts insofar as they are entered into with a *policyholder* whose regular residence is in the Netherlands, or, if the *policyholder* is a legal entity, with the establishment of the legal entity to which the insurance contract pertains, whose registered office is in the Netherlands.
c) Funeral in kind insurance contracts insofar as they are entered into with a *policyholder* whose regular residence is in the Netherlands, or, if the *policyholder* is a legal entity, with the establishment of the legal entity to which the insurance contract pertains, whose registered office is in the Netherlands.

1.6 Insurers authorised in the Netherlands:
Life, funeral in kind and non-life insurers who are authorised by the Financial Supervision Act to carry on the insurance business in the Netherlands.

Article 2 Limitation of the cover for the terrorism risk

2.1 If and insofar as, subject to the descriptions contained in articles 1.1, 1.2 and 1.3, and within the limits of the applicable policy conditions, cover is provided for the consequences of an event which is (directly or indirectly) related to:
- Terrorism, malevolent contamination or precautionary measures,
- Any act or conduct in preparation for terrorism, malevolent contamination or precautionary measures,

hereinafter to be collectively referred to as 'the terrorism risk', the liability to pay compensation on the part of the insurers in respect of any submitted claim to indemnity and/or benefit, shall be limited to the amount of the payment which the insurer receives in respect of said claim under the reinsurance of the terrorism risk with the NHT, in the event of an insurance with wealth creation increased by the amount of the wealth creation which had been realised under the insurance in question. With regard to life insurances the amount of the realised wealth creation shall be set at the premium reserve to be adhered to pursuant to the Financial Supervision Act with respect to the insurance in question.

2.2 The NHT shall provide reinsurance cover for the aforementioned claims up to a limit of liability of Euro 1 billion in respect of any one calendar year. The aforementioned sum shall be eligible for annual adjustment and shall apply to all insurers associated with the NHT together. Any adjustment shall be announced in 3 national newspapers.

2.3 Contrary to the provisions contained in the aforementioned paragraphs of this article, the limit of indemnity under this contract with respect to any insurance pertaining to:
- loss or damage to immovable property and/or the contents thereof;
- consequential loss due to loss of or damage to immovable property and/or the contents thereof,

shall not exceed Euro 75 million in respect of any one *policyholder* and any one insured location per annum for all participating insurers as referred to in article 1 together, irrespective of the number of policies issued.
For the application of this paragraph insured location shall be understood to mean: all objects insured by the *policyholder* existing at the address of premises to which the insurance applies, as well as all objects insured by the *policyholder* located outside the address of premises to which the insurance applies whose use and/or purpose is in relation to the business activities at the address of premises to which the insurance applies.
As such shall in any case be considered all objects insured by the *policyholder* which are located at a distance of less than 50 metres from each other and of which at least one is situated at the address op premises to which the insurance applies.
For the application of this paragraph it shall be provided that, with regard to legal entities, companies and partnerships which are joined in a group, as referred to in Section 2 (24) (b) of the Netherlands Civil Code, all group companies together shall be regarded as one *policyholder*, irrespective of which group company(y)(ies) belonging to the group has/have taken out the polic(y)(ies).

Article 3 Payment Protocol NHT

3.1 The reinsurance of the insurer with the NHT shall be subject to the Claims Settlement Protocol (hereinafter to be referred to as the Protocol). On the basis of the provisions laid down in said protocol, the NHT shall be entitled to defer any payment of indemnity or the sum insured until such time as the NHT is able to determine whether and to which extent it has had at its disposal sufficient financial resources in order to settle in full all claims for which the NHT provides cover in its capacity as reinsurer. Insofar as the NHT is fount not to have sufficient financial resources at tis disposal, it shall be entitled in accordance with the provisions in question to pay a partial compensation to the insurer.

3.2 The NHT shall, with due regard for what has been stated in provision 7 of the Protocol, be authorised to decide whether an event in connection with which a claim to compensation is made should be considered as a consequence of the manifestation of the terrorism risk. Any decision taken to that effect and in accordance with the aforementioned provision by the NHT shall be binding upon the insurer, *policyholder*, insured parties, and the parties entitled to compensation.

3.3 Not until the NHT has notified the insurer of the amount, whether as an advance or not, which will be paid in respect of any one claim to compensation, shall the insured or the party entitled to the payment be entitled to lay claim to the payment as referred to in article 3.1 in this respect towards the insurer.

3.4 The reinsurance cover by the NHT shall pursuant to provision 16 of the Claims Settlement Protocol only apply to claims for indemnity and/or benefit which are reported within 2 years after the NHT has established that a certain event of circumstance is regarded as a manifestation of the terrorism risk within the context of the Clauses sheet.

This Clauses Sheet was filed with the Chamber of Commerce in Amsterdam on 23 November 2007 under unaltered number 27178761.