THE AMARIZ SANTE HEALTH INSURANCE POLICY

PREAMBLE:

This Policy wording, the application form, Certificate of Insurance, Table of Benefits and any endorsement(s) attached form the entire Policy. The **Insured Person** must read them carefully and then keep them in a safe, accessible place. Throughout this Policy certain words are shown in bold type. These are defined terms and have specific meanings when used in this Policy. The meanings are set out in the 'Definitions' section.

This insurance policy is not designed to replace the French Social Security. To be eligible for this insurance policy, the **Policyholder** must therefore either be up-to-date with the payment of his/her compulsory Social Security contributions on the date of completing the application form or not meet the criteria for being covered by the French Social Security.

There are 5 levels of cover for this health insurance policy:
-GOLD Health insurance
-SILVER Health insurance (excluding Consultations)
-HOSPITALISATION insurance
-TOP-UP insurance (LUXURY, COMFORT or CLASSIC cover)
-BRONZE Temporary Health insurance

The Certificate of Insurance will show which level of cover applies to each **Insured Person** and the Table of Benefits will show the benefits payable, in accordance with the terms and conditions of this Policy.

The **Insurer** has appointed the **Administrator** who shall have the authority to review application forms and collect premiums on behalf of the **Insurer** and settle claims approved by the **Insurer** up to the full amount. All communications and notices to the **Insurer** concerning this Policy shall be made direct to the **Administrator**.

INFORMATION PROVIDED TO THE INSURER:

In deciding to accept this Policy and in setting the terms and premium, the **Insurer** has relied on the information the **Policyholder** and **Insured Persons** (if applicable) have given to the **Insurer**. The **Policyholder** and **Insured Persons** (if applicable) must take care when answering any questions the **Insurer** asks by ensuring that all information provided is accurate and complete.

If the **Insurer** establishes that the **Policyholder** and **Insured Persons** (if applicable) carelessly provided them with false or misleading information, it could adversely affect this Policy and any claim.

For example, the **Insurer** may:
- treat this Policy as if it had never existed or refuse to pay a claim or part of a claim and return the premium paid. The **Insurer** will only do this if they provided insurance cover which they would not otherwise have offered;
- amend the terms of this Policy. The **Insurer** may apply these amended terms as if such terms were already in place if a claim has been adversely impacted by the **Policyholder's** and **Insured Person's** (if applicable) carelessness;
- reduce the amount the **Insurer** pays on a claim in the proportion the premium paid bears to the premium the **Insurer** would have charged; or
- cancel the Policy in accordance with the "Cancellation" condition below.

The **Insurer** will write to the **Policyholder** via the **Administrator** if they:
- intend to treat this Policy as if it never existed; or
- need to amend the terms of this Policy.

If the **Policyholder** or the **Insured Person** (if applicable) becomes aware that information they have given the **Insurer** is inaccurate or not complete, the **Policyholder** or the **Insured Person** (if applicable) must inform the **Administrator** as soon as reasonably practicable.

Notifying the **Insurer** of any changes or inaccuracies or incomplete information:
The **Policyholder** or the **Insured Person** (if applicable) must notify the **Administrator**:
- without delay if they become aware that information they have given the **Insurer** is inaccurate or not complete;
- within fourteen (14) days of them becoming aware about any changes in the information they have provided to the **Insurer** which happens before or during the **Policy Year**.

When the **Insurer** is notified that information the **Policyholder** or **Insured Person** (if applicable) previously provided is inaccurate or not complete, or of any changes to that information, the **Insurer** will tell the **Policyholder** and **Insured Person** (if applicable) if this affects the insurance. For example, the **Insurer** may amend the terms of the Policy, or require the **Policyholder** to pay more for the insurance, or cancel the Policy in accordance with the "Cancellation" condition below.

If the **Policyholder** or the **Insured Person** (if applicable) fails to notify the **Insurer** that information they have provided is inaccurate or not complete, or they fail to notify the **Insurer** via the **Administrator** of any changes, this Policy may become invalid and the **Insurer** may not pay a claim, or any payment could be reduced.

DEFINITIONS:

The following definitions apply to this Policy:

ACCIDENT: Any bodily injury, unintentional on the part of the **Insured Person** resulting from a sudden and unforeseen action from an external cause.
Accident shall include but not be limited to:

- acts of aggression on the **Insured Person**;
- suffocation, drowning or immersion syncope;
- poisoning or burns (including gas and steam burns) by poisonous or corrosive substances or by bad food;
- snake bites, cases of rabies or anthrax caused by animal bites or stings;
- electrocution, being struck by lightning;
- infectious stings or bites and their consequences.

ADMINISTRATOR: Amariz Limited, Imperial House, 1 Harley Place, Bristol, BS8 3JT, United Kingdom.
'**BASE DE REMBOURSEMENT**': The base rate used by the French Social Security system to calculate its reimbursements. It is determined conventionally between the Social Security bodies, the medical practitioners' unions, and the hospitals and other medical establishments.
CHRONIC ILLNESS(ES): Illness contained in the list of thirty (30) chronic illnesses (ALD 30) recognised by the French Social Security and covered at 100% of the French Social Security's '**Base de Remboursement'**.
CONTRIBUTION TO HOSPITAL ACCOMMODATION EXPENSES: Lump sum contribution for each stay in a hospital or clinic, as well as in any establishment, centre and nursing home for treatment, convalescence and rest.
HOSPITALISATION: A medically-prescribed stay of at least one (1) night in a private or public hospital approved by the Department of Health or country equivalent, in order to medically or surgically treat an **Accident**, **Illness**, **Chronic Illness** or **Maternity**. Hospitalisation at home, day case hospitalisation and a course of therapy are considered to be 'everyday medical treatment'.
ILLNESS: Any change in health or pathological state certified, treated or diagnosed by a qualified medical doctor, consultant or specialist.
Illness shall include but not be limited to:

- dermatosis, even if caused by external agents;
- varicose veins, sciatica, rheumatism, attacks of poliomyelitis and non-traumatic epilepsy;
- cardiac, cerebral, or vascular injuries, such as aneurysmal rupture or apoplexy;
- blackouts and injuries which may result therefrom;
- consequences of exertion and overwork and other complaints resulting therefrom, such as a strained back, lumbago, muscular or tendinous ruptures and tears;
- all types of hernia;
- sunstroke and its consequences and complaints resulting from atmospheric influences in general;
- injuries caused by X-rays, radium and its constituents and derivatives, unless they are caused, for the **Insured Person** being treated, by defective functioning or false manipulation of instruments.

INSURED PERSON: All persons named in the Certificate of Insurance as an Insured Person.

- The **Policyholder**
- the **Spouse** and
- their dependent children, who are covered under this Policy until the end of the **Policy Year** following their twentieth (20^{th}) birthday (at which point they should take out their own insurance policy).

can all be Insured Persons.
INSURER: ArgoGlobal SE - Malta.
MATERNITY: The state of pregnancy, childbirth, the consequences of childbirth as well as the pathological complications of these events.
POLICY EFFECTIVE DATE: The date on which this Policy comes into force as indicated in the Certificate of Insurance. Or, in respect of an endorsement for an increase in cover, from the effective date of that increase in cover.
POLICYHOLDER: The person named in the Certificate of Insurance who has paid the premium.
POLICY YEAR:
The period of time from the **Policy Effective Date** until the next Annual Renewal Date indicated in the Certificate of Insurance and annually thereafter.
PREMATURE NEW-BORN: The birth of a baby before the standard period of pregnancy is completed. A premature birth is considered to occur when the baby is born before thirty seven (37) weeks' gestation counting from the beginning of the last menstrual period, as defined by the World Health Organisation.
SPOUSE: The **Policyholder's** non-divorced or non-separated wife or husband or common-law spouse, or their partner linked under the *Pacte Civile de Solidarité* (PACS) system, or a person able to prove that he/she has been living in a marriage like relationship with the **Policyholder** for a minimum of 6 months.

TERRORISM: An act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisations(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.
WAITING PERIOD: The period following the date of the **Insured Person's** inclusion in this Policy as indicated in the Certificate of Insurance or from the effective date of an increase in cover in respect of an **Insured Person**, at the end of which entitlement to benefits is established. The **Waiting Period** is counted from the date of the **Insured Person's** inclusion in this Policy indicated in the Certificate of Insurance or the effective date of an increase in cover.
Treatment carried out during a **Waiting Period**, for **Illness, Chronic Illness** and **Maternity** whose first symptoms appeared, or which were medically certified, treated or diagnosed during this period, cannot give rise to the payment of benefits, even after the **Waiting Period** has expired.

ARTICLE 1: PURPOSE AND SCOPE OF THE INSURANCE

BENEFICIARIES:
All the **Insured Persons** listed on the Certificate of Insurance are beneficiaries of the insurance.

SCOPE OF THE INSURANCE:
The purpose of the insurance is to reimburse the medical, surgical, hospital and clinical expenses actually incurred by the **Insured Person** resulting from an **Accident**, **Illness**, **Chronic Illness** or **Maternity** or the incurring of funeral expenses by the **Policyholder** or the **Insured Person**'s estate as a result of the **Insured Person** dying during the **Policy Year**, on the basis of the option chosen by the **Policyholder** in respect of the **Insured Person**, within the limits as indicated in the Table of Benefits and covered by terms and conditions of this Policy.

Cover and the entitlement to benefits cease on the effective date of cancellation as indicated under the 'Cancellation' section of this Policy. When the **Policyholder** ceases to be covered under this Policy for whatever reason, their **Spouse** and dependent children will no longer be covered. Cover under this Policy is lifelong, subject to annual renewal as detailed under the 'Duration of Cover' section, provided this Policy remains in force other than in respect of dependent children of the **Policyholder** and **Spouse** whose cover will cease at the end of the **Policy Year** following their twentieth (20^{th}) birthday. In the event of deterioration of the **Insured Person's** state of health, the **Insurer** shall not be able to exclude such person from the Policy or increase the premium(s) in respect of them.

ARTICLE 2: COMMENCEMENT OF THE POLICY

Cover under this Policy in respect of an **Insured Person(s)** commences on the **Policy Effective Date** or the date of their inclusion in the Policy as indicated in the Certificate of Insurance, if that is later. Such date is determined by the date requested by the **Policyholder** or the date the **Administrator** receives the application form if that is later, subject to medical acceptance by the **Insurer** except that Top-Up Insurance (Classic Cover) is not subject to medical acceptance. In the event of further medical investigation being necessary for one or more of the persons listed on the application form, such medical evidence must be forwarded to the **Insurer** for acceptance. Until the **Insurer's** decision to cover the applicable person has been received by the **Policyholder**, **Accident** cover only shall be provided for a maximum of two (2) months from the date requested by the **Policyholder** or from the date of receipt of their application form by the **Administrator** if that is later, in respect of such person. The **Insurer** reserves the right to ask for any proof of state of health or medical examination. The foregoing does not apply to the new-born children of a **Policyholder** (or **Spouse)** who has been paying premiums for more than three (3) months, and the new-born children are added to this Policy within two (2) months of their birth. For the **Premature New-born** children of a **Policyholder** (or **Spouse)** who has been paying premiums for more than three (3) months, an application must be completed for the **Premature New-born** child within fourteen (14) days of the child being born.

WAITING PERIODS:

IN RESPECT OF GOLD and SILVER HEALTH INSURANCE:
- No **Waiting Period** for **Accidents**. A medical certificate as confirmation of the **Accident** will be required.
- Three (3) months for **Illness** and **Chronic Illness**.
- Ten (10) months for **Maternity**.
- Nine (9) months for dentures, dental implants and orthodontic treatment, psychotherapy and neuropathology, orthopedic and auditory prostheses and equipment, hydrotherapy, spa therapy and cures and sexually-transmitted diseases.

IN RESPECT OF HOSPITALISATION INSURANCE:
- No **Waiting Period** for **Accidents**. A medical certificate as confirmation of the **Accident** will be required.
- Three (3) months for **Illness** and **Chronic Illness**.
- Ten (10) months for **Maternity**.
- Nine (9) months for psychotherapy and neuropathology, orthopedic and auditory prostheses and equipment, hydrotherapy, spa therapy and cures and sexually-transmitted diseases.

IN RESPECT OF TOP-UP INSURANCE:
- Ten (10) months for **Maternity** (for COMFORT and LUXURY cover).
- Six (6) months for dentures, dental implants and orthodontic treatment (for COMFORT and LUXURY cover).
- No **Waiting Period** (for CLASSIC cover).

IN RESPECT OF BRONZE TEMPORARY HEALTH INSURANCE:
- No **Waiting Period**

The **Waiting Period** is waived:
- If the **Insured Person** can prove they were covered by an equivalent scheme up to 3 months or less before the date of the **Insured Person's** inclusion in this Policy, as indicated in the Certificate of Insurance (a detailed certificate of cancellation or similar justificatory document and details of the previous cover should be provided).
- For new-born children of the **Policyholder** (or **Spouse)** who are added to this Policy before they are two (2) months old (provided that the **Policyholder** has been paying premiums for more than three (3) months).

DURATION OF COVER:

This Policy is concluded from the **Policy Effective Date** until the next Annual Renewal Date indicated in the Certificate of Insurance, or the Policy Expiry Date for Bronze cover.
The Policy is renewed tacitly at each successive Annual Renewal Date for a further period of one year unless:
- for the **Insurer**, the notice not to renew is at least two (2) months before the 31st December by the giving of notice to the **Administrator**;
- for the **Policyholder**, the notice not to renew is at least one (1) month before the 31st December by the giving of notice to the **Administrator**.

In addition to the foregoing, the **Insurer** and the **Policyholder** may cancel the Policy in accordance with the 'Cancellation' condition.

CANCELLATION:

- By the Insurer

The **Insurer** can cancel this Policy or cover in respect of an **Insured Person** by giving the **Policyholder** thirty (30) days' notice in writing via the **Administrator**. If the whole Policy is cancelled this will end cover in respect of all **Insured Persons.**

The **Insurer** will only do this for a valid reason (examples of valid reasons are as follows):
- Non-payment of premium; See 'Non-Payment of Premiums' section below.
- Non-cooperation or failure to supply any information or documentation requested by the **Insurer**;
- Threatening or abusive behaviour or the use of threatening or abusive language.

If the **Insurer** cancels this Policy or cover in respect of an **Insured Person,** the **Administrator** on behalf of the **Insurer** will notify the **Policyholder** at their last known address.

- By the Policyholder

COOLING OFF PERIOD FOR GOLD, SILVER, HOSPITALISATION AND TOP-UP INSURANCE: After completing the application form, the **Policyholder** may cancel this Policy within thirty (30) days of receiving the Policy or from the **Policy Effective Date**, if this is later, without penalty and without reason, provided the **Insurer** has not paid any claims during the cooling off period.

COOLING OFF PERIOD FOR BRONZE TEMPORARY HEALTH INSURANCE: After completing the application form, the **Policyholder** may cancel this Policy within fourteen (14) days of receiving the Policy or from the **Policy Effective Date**, if this is later, without penalty and without reason, provided the **Insurer** has not paid any claims during the cooling off period.

Outside of the cooling off period, the **Policyholder** may only cancel this Policy or cover in respect of an **Insured Person** in the case of a premium rate increase at any time during the **Policy Year**. The **Policyholder** must exercise the option to cancel during the two (2) weeks following the date on which they are notified of the new premium rates. The cancellation will take effect one (1) month after notification by recorded delivery letter to the **Insurer** via the **Administrator**.

Outside of the cooling off period, any refund of applicable premium paid will be subject to a deduction for any time for which the Policy has been in force. This will be calculated on a proportional basis. For example, if the annual policy has been in force for six (6) months, the deduction for the time this Policy has been in force will be half the annual premium.

PREMIUMS:

Premiums are payable in full by the **Policyholder** on or before the **Policy Effective date** and on or before each successive Annual Review Date or on or before the effective date of an increase in cover, as applicable. However, the **Insurer** may accept monthly, quarterly or six (6) monthly payments where requested by the **Policyholder**.
Premiums are based on the ages of the **Insured Persons** up to the age of eighty (80), at the **Policy Effective Date** or date of the inclusion of the **Insured Person** in this Policy as indicated in the Certificate of Insurance, if it is later.
In the event of persons, up to the age of eighty (80), being added to or deleted from this Policy during the **Policy Year**, the additional premium payable by or return premium due to the **Policyholder** shall be calculated on a pro rata basis in respect of such additions and deletions.

NON-PAYMENT OF PREMIUMS:

The payment of a premium only covers the **Insured Person** until the due date of the following annual renewal premium. Cover is suspended whilst the premium is unpaid. If one of the premiums is not paid within ten (10) days of its due date, the **Administrator** will send a recorded delivery letter to the **Policyholder** informing him/her that after a period of thirty (30) days from the date of sending of this letter, the non-payment of the premium will lead to the suspension of cover. No benefits are payable for medical, surgical, hospital and clinical expenses incurred or funeral expenses incurred for death which occurred during periods of suspension of cover, or resulting from **Accident**, **Chronic Illness**, **Illness** or **Maternity** which is medically diagnosed or arose during these periods.

INSURANCE PREMIUM TAX:

The premium payable under this Policy may be subject to compulsory insurance premium tax, which shall be payable by the **Policyholder** at the appropriate rate. The applicable insurance premium tax is indicated in the Certificate of Insurance and/or on the applicable premium debit note(s) / invoice(s).

In the event that the rate or application of insurance premium tax changes during the **Policy Year** and any premium payable during the **Policy Year** is subject by law to such change or application, then that premium payable shall incorporate such change or application.

ARTICLE 3: COVER

COVERED EXPENSES: The **Insurer** shall reimburse directly, or via the **Administrator** or one of its authorised administrative organisations, the medical, surgical, hospital and clinical expenses incurred during the **Policy Year** by the **Insured Person,** which result from an **Accident, Illness**, **Chronic Illness** or **Maternity** including such expenses incurred for the consequences of surgical procedures undergone by the **Insured Person**, provided such expenses have been medically prescribed and are indicated in the Table of Benefits and covered by terms and conditions of this Policy.

FUNERAL EXPENSES: If the **Insured Person** dies anywhere in the World excluding Iran, Democratic Peoples' Republic of Korea, Russia, Syrian Arab Republic and Ukraine during the **Policy Year** the **Insurer** shall reimburse directly, or via the **Administrator** or one of its authorised administrative organisations, expenses incurred by the **Policyholder** or the **Insured Person's** estate for:

- all reasonable funeral, burial or cremation and associated expenses; or
- all reasonable expenses incurred in transporting the **Insured Person's** body or ashes to a place nominated by the legal representative of the **Insured Person's** estate;

regardless of whether the death is connected in any way to an **Accident**, **Illness**, **Chronic Illness** or **Maternity** for which there has been a valid claim for medical, surgical, hospital or clinical expenses under this Policy or not.

POLICY LIMITS: As indicated in the Table of Benefits. After having deducted claims payments from other **Insurers**, reimbursements or acceptances from any other source, this Policy shall pay up to the levels of reimbursement and upper limit for each **Insured Person** each **Policy year** indicated in the Table of Benefits, but cannot however exceed the amount actually spent by the **Insured Person** or the **Policyholder** in respect of dependent children covered by this Policy or the **Policyholder**/estate of the deceased **Insured Person** in respect of funeral expenses.

ARTICLE 4: EXCLUSIONS

In addition to any specific exclusion(s) indicated in the Certificate of Insurance that may apply to an individual **Insured Person**, the below exclusions shall apply to all **Insured Persons**.

This Policy does not cover claims in respect of the following:

- all medical, surgical, hospital and clinical expenses incurred before the date of the **Insured Person's** inclusion in this Policy, indicated in the Certificate of Insurance, or resulting from **Accident, Illness** or **Chronic Illness** or disabilities contracted prior to this date (unless otherwise agreed by the **Insurer**).
- all medical, surgical, hospital and clinical expenses resulting from **Accident, Illness** or **Chronic Illness** or disabilities which are first medically diagnosed after the end of cover.
- any claim caused intentionally by the **Insured Person**.
- resulting from the **Insured Person's** participation in military service, war, civil war or act of foreign enemy, riots, strikes, lockouts, civil commotion, rebellion, revolution, insurrection, fighting (unless it is in legitimate defence), **Terrorism**, military or usurped power or illegal act, including resultant imprisonment.
- resulting from **Accident, Illness** or **Chronic Illness** caused by the **Insured Person's** participation in any type of race, match, bet (being the outcome of an unpredictable event) or record attempt other than normal competitive sport, exhibition, acrobatics and aviation other than as a passenger on normal commercial airlines; nor the practice or playing of the following sports: parachuting, rallying, and competitions involving the use of land-based motor vehicles, micro-lite and hang-gliding;
- resulting from the release of weapon(s) of mass destruction, (nuclear, chemical or biological), whether such involve(s) an explosive sequence(s) or not;
- resulting from **Accident, Illness** or **Chronic Illness** caused by drunkenness, alcoholism, or the misuse of drugs;
- treatment which is not directly linked to an **Accident**, **Illness**, **Chronic Illness** or **Maternity**, for example rejuvenation, weight control, sleep, detoxification, aesthetic treatments and therapies and such like (unless they result from a covered **Accident**);
- following ill-health due to explosions or radiation caused by nuclear reaction, transmutation of the nucleus of an atom or radioactivity;
- following abortions for non-medical reasons;
- caused by specific neuropsychiatry, with the exception of the psychiatric illnesses normally covered by the French Social Security as **Chronic Illnesses**;
- relating to the costs of all stays which are usually reimbursed according to the criteria applicable to 'long stays', whatever the type of establishment;
- for private rooms and **Contribution to Hospital Accommodation Expenses** in the following cases: convalescence and rest homes, neuropsychiatry, rehabilitation, gerontology or dietary centres, and other similar establishments.
- expenses incurred by **Premature New-born** children after fourteen (14) days from the date of birth until thirty (30) days following discharge from hospital.
- expenses incurred during **Hospitalisation** in a private room for personal convenience such as telephone use, water and television use.

The above exclusions shall not apply in respect of funeral expenses.

In respect of an **Insured Person** who is pregnant on the date of their inclusion in this Policy as indicated in the Certificate of Insurance and who was previously insured during the three (3) months preceding such date: the **Insurer** is not obliged to reimburse claims for the standard costs of pregnancy being the standard costs of midwifery and childbirth nor obliged to pay the lump sum payment for **Maternity** if indicated in the Table of Benefits. All other costs incurred, for example, complications of pregnancy and childbirth, will be reimbursed provided that it is not a multiple birth and the **Insured Person** has had no complications in a previous pregnancy or childbirth. If the **Insured Person** cannot provide proof of previous insurance, the **Waiting Period** of ten (10) months for **Maternity** will apply.

The fact that the **Insurer** has reimbursed medical expenses, even on several occasions, does not mean that they tacitly renounce the right to apply a restriction or exclusion provided for under this Policy.

ARTICLE 5: CLAIMS

Claims should be made to the **Insurer** via the **Administrator** using the claim forms provided to the **Insured Person** or the **Policyholder** in respect of dependent children covered by this Policy or the **Policyholder**/legal representative of the **Insured Person**'s estate in respect of funeral expenses. Claims payments will be made by cheque or bank transfer payable either to the **Insured Person** or the **Policyholder** in respect of dependent children covered by this Policy or the **Policyholder**/legal representative of the **Insured Person**'s estate. Medical, surgical, hospital, clinical expenses and funeral expenses are reimbursed by the **Insurer** or the **Administrator** as quickly as possible and, in any case, within one (1) month of receipt of the supporting documents. In the case of a hospital, clinic, chemist, radiologist or laboratory requesting settlement of an invoice, the **Insurer** or the **Administrator** shall pay the establishment in place of the **Insured Person** or the **Policyholder** in respect of dependent children covered by this Policy, within the limits of cover.

CLAIMS FORMALITES:
In order to be reimbursed, the **Insured Person** or the **Policyholder** in respect of dependent children covered by this Policy should send the original treatment form, duly completed and signed, as well as any detailed supplementary fee notes and invoices confirming the amounts spent and the nature of the treatment provided or, in respect of funeral expenses, the **Policyholder**/legal representative of the deceased **Insured Person**'s estate should send the original death certificate.

A medical certificate is required for all medical acts and treatment carried out in hospital. A request for prior authorisation should be sent to the **Insurer** or the **Administrator** for orthoptics as well as courses of physiotherapy and speech therapy, failing this reimbursement will be limited. The total of the various reimbursements obtained by an **Insured Person** or the **Policyholder** in respect of dependent children covered by this Policy cannot exceed the amount they have actually spent. Previous reimbursements will therefore automatically be taken into account. Costs incurred during a stay of up to three (3) months during the **Policy Year** in any country outside the European Economic Area excluding Iran, Democratic Peoples' Republic of Korea, Russia, Syrian Arab Republic and Ukraine are reimbursed under the Policy after having deducted claims payments from other insurers, reimbursements or acceptances from any other source. They are reimbursed in EUR (Euros) according to the French Social Security's '**Base de Remboursement'**, provided that they are for medically-prescribed treatment. The receipt and the invoice should be sent together to the **Administrator**.

DAILY LUMP SUM IN THE EVENT OF HOSPITALISATION (for **Insured Persons** aged under seventy six (76) on the day they are admitted to hospital only):
In order to obtain the payment of benefits due, the **Insured Person** or the **Policyholder** in respect of dependent children covered by this Policy must submit to the **Administrator** a medical certificate specifying the number of consecutive nights they have spent in hospital as well as the reason for the **Hospitalisation**. Benefits will be paid to the **Insured Person** or the **Policyholder** in respect of dependent children covered by this Policy monthly in arrears from the fourth (4^{th}) consecutive night of **Hospitalisation** until the **Insured Person** is discharged or until the three hundred and sixty fifth (365^{th}) consecutive night in hospital in accordance with the Table of Benefits.

Where the **Insured Person** is the victim of an **Accident** caused by a third party, he/she must declare this **Accident** to the **Insurer** as soon as possible. The **Insurer** has the right to recover any benefits they have paid out as a result of the **Accident** from the responsible party and the **Insured Person** shall do and concur in doing and permit all such acts as may be necessary or required by the **Insurer** for enforcing any rights or remedies against such party. Should the **Insured Person** prevent this recovery from being carried out for any reason, the **Insurer** would not be liable for any benefits up to the amount which they would otherwise have been able to recover.

The **Insurer** reserves the right to request additional medical information in order to assess a claim. The **Insured Person** must undertake any appraisal or examination considered to be necessary by the **Insurer**; failing this, payment of benefits will be declined.

ARTICLE 6: TIME LIMIT FOR MAKING/DISPUTING CLAIMS

Claims must be made within two (2) years of the date of the individual treatment as evidenced by the original copy of the invoice. Claims can only be disputed up to three (3) months after their payment.

ARTICLE 7: TERRITORIAL LIMITS AND FOREIGN STAYS

Insured Persons may be of any nationality, but must reside in the European Economic Area. Cover is valid outside this territory excluding Iran, Democratic Peoples' Republic of Korea, Russia, Syrian Arab Republic and Ukraine, for any stay of up to three (3) months. However, in respect of funeral expenses, such expenses incurred as a result of death of the **Insured Person** occurring anywhere in the world excluding Iran, Democratic Peoples' Republic of Korea, Russia, Syrian Arab Republic and Ukraine during the **Policy Year** are covered.

ARTICLE 8: FRAUDULENT CLAIMS

1. By the Policyholder

If the **Policyholder** makes a fraudulent claim under this Policy the **Insurer**:

(a) is not liable to pay the claim; and

(b) may recover from the **Policyholder** any sums paid by the **Insurer** to the **Policyholder** in respect of the claim; and

(c) may by notice to the **Policyholder** treat the Policy as having been terminated with effect from the time of the fraudulent act; and

(d) need not return any of the premiums paid.

2. By an Insured Person who is not also the Policyholder

If a fraudulent claim is made under this Policy by or on behalf of an **Insured Person**, the **Insurer** may exercise the rights set out in paragraph 1 above as if there were an individual Insurance policy between the **Insurer** and the **Insured Person**. However, the exercise of any of those rights shall not affect the cover provided under the Policy for any other **Insured Person**.

ARTICLE 9: LAW AND JURISDICTION

The construction of the terms and conditions of this Policy, and any dispute arising from it, shall be determined by the laws and the courts of Malta. The **Insured Person** may alternatively choose the law and the courts of the country in which the **Insured Person** is habitually domiciled.

ARTICLE 10: COMPLAINTS

If the **Insured Person** has any questions or concerns about this Policy or the handling of a claim, in the first instance they must contact the **Administrator**:

Amariz Limited, Imperial House, 1 Harley Place, Bristol, BS8 3JT, United Kingdom. Tel. 0117 974 5770, Email: info@amariz.co.uk.

ARTICLE 11: SANCTIONS

The **Insurer** shall not provide any benefit under this Policy to the extent of providing cover, payment of any claim or the provision of any benefit where doing so would breach any sanction, prohibition or restriction imposed by law or regulation.

ARTICLE 12: DATA PROTECTION

The **Policyholder** and the **Insured Person** should understand that any information provided will be processed by the **Insurer** and the **Administrator** in compliance with the provisions of the General Data Protection Regulation (GDPR), for the purpose of providing insurance and handling claims or complaints, if any, which may necessitate providing such information to other parties, both in and outside of the EEA. This shall include those situations where further medical investigation is considered necessary in order to process the application form, personal and medical information the **Policyholder** and the **Insured Person** have provided may be given to the **Insurer's** Consulting Doctor and the **Policyholder** and the **Insured Person** shall receive written confirmation of this, including details of who the information has been sent to. The 'Terms & Privacy' section of the website www.amariz.co.uk provides additional information.

ARTICLE 13: REGULATION

ArgoGlobal SE – Malta is authorised and regulated by the Malta Financial Services Authority.

ARTICLE 14: SEVERAL LIABILITY

The subscribing insurers' obligations under contracts of insurance to which they subscribe are several and not joint and are limited solely to the extent of their individual subscriptions. The subscribing insurers are not responsible for the subscription of any co-subscribing insurer who for any reason does not satisfy all or part of its obligations.