General Conditions of insurance - Corporate Mobility

(Version 2016.5)

Art. 1. Subject matter

The insurance cover is defined by the policy, these general conditions and any special conditions included in the policy.

Art. 2. Definitions

Accident

An accident is deemed to be any sudden and unintentional indemnifiable event, caused to the human body by an extraordinary external cause which compromises physical safety or results in death, but excluding psychological or mental disorders (cf. art. 4 LPGA).

Insured

The insurance covers private persons having subscribed a FIM license and/or a continental license and/or an international license valid for a Competition listed in the FIM calendar (i.e. World Championships, Grand Prix Championships, Continental Championships and/or Events listed by the FMN on the FIM calendar).

Insurer

TSM Compagnie d'Assurances, Société coopérative, Rue Jaquet-Droz 41, Case postale CH – 2301 La Chaux-de-Fonds is the insurer of all risks.

Scope of application

The scope of application of the assistance/insurance covers the entire world, unless another scope of application is indicated for the different elements of insurance in the insurance policy.

Competition

A competition is a competition organised by the FIM and/or its continental Unions (CONU) and/or its affiliated Federations (FMN), such as World Championships, Grand Prix Championships, Continental Championships and/or Events listed by the FMN on the FIM calendar. The insurance covers consequences (Medical expenses, death & disability benefits) of an accident/illness suffered by the insured during a competition and/or during the direct trip to and from the competition.

Home

Home means the insured's place of residence prior to travelling.

Epidemic

A contagious disease affecting a large number of people at the same time and classified as such by the World Health Organisation.

War

Any activity arising out of the use or attempted use of an armed force between nations including civil war, revolution, invasion. War does not include acts of terrorism or attacks.

Accommodation

A middle range hotel room + breakfast. No other temporary accommodation can give rise to reimbursement of any kind.

Hospitalisation

Unexpected and necessary stay, for a period of more than 24 hours, in an official public or private care facility, medically prescribed, for medical treatment following an illness or accident (not treatment of a cosmetic nature or the consequences thereof) of which the insured was not aware prior to leaving.

Illness

An illness is deemed to be any involuntary impairment of physical health which is not due to an accident and which requires a medical examination or treatment or renders the person unfit for work.

Family members

Close family as well as the parents, grandparents and siblings of the insured.

Policyholder

The FIM acting on behalf of the holders of a racing license that covers the World Championships, the continental Championships and/or the international Events listed by the FMN on the FIM calendar.

Usual place of residence

The usual place of residence is considered the insured's usual place of residence as indicated on the intranet of the FIM.

Early return

The early and necessary return of the insured to his home country or usual country of residence occurring during the trip.

Loss occurrence

Any event likely to give rise to the involvement of the Insurer.

Terrorism/attack

An act which:

- is committed for political, religious, ideological or similar reasons, involving the use of violence, or the unlawful use of force, or an unlawful act which endangers human life or material property;
- is committed by any person or group of persons acting alone or on behalf of any organisation or government (de jure or de facto), or in relation with such governments or organisations.

Ticket

A plane ticket in the same class as that used by the insured for the trip or a 1st class train ticket. The Insurer may ask the insured to use his ticket if the latter can be used or changed. Otherwise, when the assistance service has paid for his return, the insured must forward his original ticket unused to the Insurer or such amount as is reimbursed to him by any authorised body.

Art. 3. Benefits

The benefits described below are limited depending on the upper limit selected in the Policy.

I. MEDICAL EXPENSES

1. Benefits and events insured

1.1. Medical expenses abroad

Unless there are conditions to the contrary stated in the special conditions, in case of illness or accident, the Insurer advances, covers and reimburses, as the principal benefit (see specific limits in the special conditions), on a secondary or complementary basis, the costs for urgent medical care and/or hospitalisation following illness or an accident occurring and having been observed during a trip, and remaining as the responsibility of the insured after involvement of his health insurance plan (or other social insurance) or of other complementary private insurance if applicable. In the event of no such cover existing or if it has been lawfully suspended due to non-payment of premiums, the Insurer may limit reimbursement based on the amounts indicated in the special conditions.

1.2. Urgent dental care

Cover is provided for urgent dental care following an event occurring during travel (not able to be deferred due to the state of health of the insured) and undertaken for the following care: bandaging, filling, root canal or extraction.

Reimbursement in addition to or in the absence of a primary Health Insurance plan and of any other supplemental plant to the limit of the maximum amount of 1000 CHF per event per insured.

2. Specific exclusions

In addition to the general exclusions under this policy, the insurance does not cover:

- the cost of prostheses, equipment, spectacles and contact lenses;
- costs relating to any cosmetic treatment and the consequences or sequelae thereof;
- the cost of spa cures, stays in convalescent homes and rehabilitation centres;
- deductions and excesses under other insurance policies;
- epidemics;
- benefits relating to treatments and care received abroad, if the person went to a foreign country for this purpose;
- general and routine check-ups;
- illnesses resulting from medical measures of a prophylactic or therapeutic nature or arising out of the diagnosis (e.g. vaccines, radiation treatment) unless they are influenced by an insured illness;
- the sequelae of contraceptive interventions or abortions.

II. MEDICAL ASSISTANCE

1. Benefits and insured events

The Insurer pays and makes the necessary arrangements for the provision of the guarantees and benefits set out above. These guarantees and benefits are provided 24/7 in the event of accident or illness suffered by the insured whilst on a trip.

1.1. Search and rescue costs

The Insurer pays the search and rescue costs necessary and justified to save the life or physical well-being of the insured. The costs in question must be justified by the situation. Furthermore, all cover is excluded in the event of the insured being kidnapped and if the insured is more than 200 km offshore.

1.2. Medical transportation

Medical evacuation

Where the primary emergency services are non-existent in the country of travel, the insurer organises and pays for emergency transportation to the nearest hospital with appropriate medical facilities, subject to the approval of the insurer's medical team on the means and place of evacuation.

Medical repatriation

The insurer's doctors contact the local doctors treating the insured and take the decisions best suited to the insured's condition based on the information obtained and medical requirements only.

If the Insurer's medical team recommends repatriation of the insured, the Insurer organises and pays for said repatriation based solely on medical requirements.

The destination of repatriation is:

- either the most suitable hospital;
- or the nearest hospital in the home country or the assigned country;
- or the insured's home or usual place of residence.

The final choice of the place of hospitalisation, the date, the need for the insured to be accompanied and the means used are a matter solely for the Insurer's medical team.

1.3. Sending out a doctor

If the circumstances require it, the Insurer's medical team may decide to send out a doctor in order to better assess the measures to be taken and to organise them. The Insurer pays the travel costs and consultation costs of the doctor which it has appointed.

1.4. Monitoring in-patient and out-patient care

Throughout his treatment, the insured has access to the insurer's medical team who can advise him if need be.

The medical team must have access to the insured's medical records. Therefore, the insured expressly authorises the Insurer's medical team to request medical results and reports from the doctor treating the insured locally.

1.5. Assistance in the event of death

Repatriation in the event of death

With the agreement of the deceased's family, the Insurer organises and pays for the repatriation of the insured's body (or his ashes) from the place of death to the place of interment in his home country or country or origin.

The Insurer pays the costs of post mortem treatment, laying in a coffin and making the arrangements necessary for transportation.

Funeral and ceremonial costs and the costs of local convoys, interment or cremation remain payable by the insured's family.

The choice of companies involved in the repatriation process is a matter solely for the insurer.

If desired, the Insurer pays the costs of interment locally, up to the amount which it would have been liable to pay in the event of repatriation of the insured's mortal remains.

Assistance with formalities following a death

If the presence locally of a member of the insured's family or a close relative proves to be essential for identifying the body of the deceased insured and the formalities of repatriation or cremation, the Insurer provides a return ticket. This benefit can only be claimed if the insured was alone in the location at the time of his death.

The Insurer pays the costs of accommodation for a period of 3 consecutive nights.

Costs of coffin

The Insurer pays the costs of a coffin required for transport.

1.6. Return of the person accompanying the insured in the event of medical repatriation or death

If, following a medical repatriation or the death of the insured, the insured person who was travelling with the insured also has to return early, the Insurer organises and pays for a ticket home, provided that the means initially intended for his return trip are not usable or cannot be changed. The Insurer reserves the right to use the initial ticket.

This cover cannot be used in conjunction with the "Visit by close family members" cover.

1.7. Visit by close family members

If the insured's condition prevents him from being repatriated and if the local hospitalisation is more than 5 consecutive days, the insurer organises and pays for a return ticket and accommodation locally for 2 close family members.

This cover is only granted in the absence, locally, of a legally adult member of the insured's family.

1.8. Medical advice 24/7

The Insurer will provide medical advice to any insured calling the helpline. In an emergency situation and insofar as it is able, the Insurer may put the insured in contact with doctors appointed by the insurer and help the insured to find the most appropriate solution to his health problem, i.e. taking of medication, medical treatment or hospitalisation. Involvement of the doctor is limited to providing objective information. Under no circumstances is the purpose of the service to issue a personalised medical consultation or to encourage self-medication. If this were to be requested, the Insurer's doctor would advise the insured to consult the doctor treating him.

1.9. Access to the network of local medical service providers

At the insured's request, the helpline will provide the contact details of a medical service provider listed on its network. The helpline may, subject to what is available locally, arrange an appointment for the insured. The cost remains payable by the insured. The cost remains payable by the insured.

1.10. Second medical opinion

A "Second Medical Opinion" is an assessment of the case carried out by another doctor. A second medical opinion is a service intended to identify whether the diagnoses made are correct and whether the treatment prescribed is in line with the current state of scientific knowledge, as well as

the patients' needs. The Insurer's part consists of arranging an appointment with a third-party doctor. The insured remains responsible for paying for the consultation.

1.11. Sending out medication which cannot be found locally

In the event of it being impossible to find essential medication locally, which was prescribed prior to departure by the doctor treating the insured in his home country or in the event of illness or accident, the insurer looks for it in Switzerland, on condition that the medication is not available locally. If the medication is available, it is sent as quickly as possible, subject to the constraints of local legislation and the means of transport available. This cover is provided for one-off requests. Under no circumstances can it be granted as part of long-term treatments requiring regular sending or a request for a vaccine. The cost of the medication remains payable by the insured.

1.12. Linguistic assistance

If necessary, the insurer provides the insured with a free translation service by means of a telephone conference set up between the insured, the doctor treating the insured and the insurer's medical officer for questions relating to medical treatment arranged by the Insurer. This service is provided in English, or in other languages depending on the availability of the doctors. The Insured does not undertake any written translation.

1.13. Psychological assistance

In the event of a request for psychological assistance following a trauma caused by the insured being attacked or dying abroad, the insurer's team puts the insured or members of the insured's close family in contact with a psychologist and/or organises an appointment with a psychologist.

III. TRAVEL ASSISTANCE

These benefits are used provided that the tickets originally intended for use by the insured for his trip are not usable or cannot be changed. When the Insurer pays for a new ticket, the costs of the return trip originally reserved are not reimbursed.

1. Interruption of trip

1.1. Benefits

If the insured has to interrupt his trip early, the Insurer organises and pays the costs in respect of the non-used part of the trip pro rata to the cost of the insured arrangement and a ticket back home. In order to enable the insured to return to the initial trip location, the Insurer pays for a return ticket.

1.2. Insured events

- In the event of the death, accident or illness of the insured;
- In the event of the death, accident or illness requiring hospitalisation for more than 5 days of a member of the family or a work replacement, if the presence of the insured person at the place of work becomes essential. This cover is granted when the date of hospitalisation or death is after the insured's departure date;
- In the event of being summoned unexpectedly before the court;
- In the event of damage to the home or professional premises of the policyholder;
- In the event of the death, accident or illness of the person accompanying the insured, registered on the same booking.

2. Extension of stay

If, following an illness or accident of the insured or member of his close family accompanying him, the insured is prevented from returning on the date initially intended and if the case does not require hospitalisation or medical repatriation, the insurer organises and pays for the costs of extending the stay at the insured's hotel, as well as those of the insured persons travelling with the insured provided that they stay with him.

The Insurer pays for the cost of extending his accommodation and for a ticket home. This cover can only be granted upon recommendation from the Insurer's medical team.

IV. SUM INSURED FOR ACCIDENTAL DEATH & ACCIDENTAL PERMANENT DISABLEMENT

1. Sum insured for accidental death

If it is established that the insured has died as a result of an insured accident within a period of two years following said accident, the Insurer pays the agreed sum insured in the event of death to the persons below, with each group only being the beneficiary in the absence of the preceding group:

- The registered spouse/partner;
- Children and adopted children.

The insured may, at any time, by written communication, appoint other beneficiaries.

If there is no surviving heir, the Insurer pays only the funeral costs, up to a maximum of 10% of the amount agreed in the event of death.

Any disablement benefits already obtained under this policy will be deducted from the indemnity in the event of death. Under no circumstances can the amount paid exceed the maximum amount stated in the policy.

2. Permanent accidental disablement

Permanent accidental disablement must be observed, from a medical standpoint, as the consequence of an insured accident within the period of two years, at the latest, following the day of the accident.

The rate of disability as well as the corresponding indemnity are set based on the scales indicated hereafter:

loss of both legs or both feet, both arms or both hands	100%
simultaneous loss of one arm and one hand and one leg or one foot	100%
total paralysis, incurable mental disorder preventing any professional activity	100%
loss of an arm at or above the elbow	70%
loss of forearm or one hand	60%
loss of a thumb	22%
loss of an index finger	15%
loss of any other finger of the hand	8%
loss of a leg at or above the knee	60%
loss of a leg below the knee	50%
loss of a foot	40%
total blindness	100%
loss of an eye	30%
loss of sight in second eye in case of those already blind in one eye	70%
loss of hearing in both ears	60%
loss of hearing in one ear	15%
loss of hearing in one ear, when that of the other ear had already been completely lost prior to the accident	45%

Total loss of use of a limb or organ is equivalent to losing it completely.

In case of partial loss of use, the degree of disablement will be reduced accordingly.

In the case of the simultaneous loss or loss of use of more than one limb, the percentages will be added together. However, the total not under any circumstances exceed 100%.

In those cases not specified above, the degree of disablement will be set according to the estimate of a doctor referring to the percentages shown above and taking into account the situation of the person insured.

If, prior to the accident, the parts of the body were already mutilated or affected by total or partial loss of use, this will be taken into account when assessing the insured disablement, by deducting the pre-existing degree of disablement in accordance with the rules above.

In those cases, not specified above, the degree of disablement is determined based on medical findings. The theoretical medical disablement is always the determining one.

If the degree of disablement is less than or equal to 25%, the insurer pays the corresponding percentage of the simple disablement sum insured agreed.

If the degree of disablement is more than 25%, the amount of progressive indemnity is determined using the scale below.

Degree of disablement %	Benefits %	Degree of disablement %	Benefits %	Degree of disablement %	Benefits %
26	27	51	78	76	100
27	29	51	81	77	100
28	31	52	84	78	100
29	33	52	87	79	100
30	35	53	90	80	100
31	37	53	93	81	100
32	39	57	96	82	100
33	41	58	98	83	100
34	43	59	99	84	100
35	45	60	100	85	100
36	47	61	100	86	100
37	49	62	100	87	100
38	51	63	100	88	100
39	53	64	100	89	100
40	55	65	100	90	100
41	57	66	100	91	100
42	59	67	100	92	100
43	61	68	100	93	100
44	63	69	100	94	100
45	65	70	100	95	100
46	67	71	100	96	100
47	69	72	100	97	100
48	71	73	100	98	100
49	73	74	100	99	100
50	75	75	100	100	100

Unless specified otherwise in the policy, the insurer provides indemnity in accordance with the progressive scale.

2.1. Limit on benefits

The insurer pays:

<u>in the event of death</u>

- of insured children who had not yet reached their 16th birthday at the time of the accident, CHF 10,000 maximum,
- of insured persons who were 65 or more at the time of the accident, one half of the agreed sum insured;

<u>in the event of disablement</u>

- of insured children who had not yet reached their 16th birthday at the time of the accident, CHF 200,000 maximum,
- of insured persons who were 65 or more at the time of the accident, a life annuity instead of the sum insured. This annual annuity is CHF 83 for each CHF 1000 of disablement sum insured where the degree of disablement is 100% (gradation according to the degree of disablement as stated in the table above);

The disablement benefit is paid as soon as the extent of the permanent disablement has been noted and determined, but no later than two years after the date of the accident. If it takes more than 6 months to determine or note the degree of disablement, the Insurer makes partial indemnity payments to the insured, based on the medical findings and commensurate with the current level of disablement. The total partial indemnity payments due to the insured must not, however, exceed 50% of the final simple disablement capital. Only the insured is entitled to the disablement benefit; the right is not transferable.

Where several insured persons suffer an accident in the same, unique means of transport, the indemnity payable by the insurer is limited to the maximum amount stated in the policy in the event of death and disablement. If the claims exceed this amount, it will be allocated proportionally.

2.2. Cost of professional rehabilitation

If, following an accident for which the insurer has paid benefits, professional rehabilitation is necessary, the insurer pays the appropriate costs up to a maximum of 10% of the amount specified for disablement (without taking the progression into account).

2.3. Loss event

The general provisions of application and the provisions below are applicable:

- In the event of death following an accident, the Insurer must be notified in writing within 72 hours. If the insurer so requests, the heir must grant permission for a post-mortem examination or exhumation.
- The following documents must be given to the Insurer:
    - a detailed medical certificate and/or the original of a death certificate,

2.4. Specific exclusions

In addition to the general exclusions under this policy, the following are also excluded from cover:

- Accidents suffered by the drivers of motor vehicles or cyclists who, at the time of the accident, were driving with a blood alcohol level equal to or above the rate set by current regulations in Switzerland or whilst under the effect of drugs;

2.5. Influence of factors other than the accident

Where the effect on health is only partially attributable to the insured accident, the Insurer's benefits are reduced in accordance with the influence of other factors as determined by a medical investigation.

Art. 4. General exclusions

In addition to the exclusions specific to each insurance hereunder, unless an extension to the contrary is specified in the policy and in the special conditions, cover excludes any event and the consequences thereof resulting from:

- an intentional act or serious negligence or omission on the part of the insured;
- intentionally committing crimes and offences and attempting to commit them;
- deliberate failure to comply with the regulations of the country visited or carrying out activities not permitted by the local authorities;
- taking part in altercations, except in case of legitimate defence;
- events related to war or civil war, declared or undeclared. However, the covers apply when the insured person is taken suddenly and unexpectedly by war or civil war while traveling abroad. However, no claim will be taken into account, after the 14th day from the beginning of the war or civil war in the area of the country where the insured stays. The above warranty extension does not apply to trips within or across countries on whose territories are already taking place assimilable events in war or civil war, unless the policyholder insurance has taken the necessary measures in terms of security assistance coverage approved by the Insurer or the Insurer has granted the first extension beyond 14 days;
- natural catastrophes, such as windstorms, earthquakes, volcanic eruption, tidal wave or other disasters, unless stated otherwise;
- ionising radiation, of whatever kind, including, in particular, radiation resulting from the transmutation of the atom;
- the use of alcohol (blood alcohol level found to be higher than the rate set under current Swiss regulations), the abusive and deliberate use or ingestion of medicines, drugs or tranquillisers which have not been medically prescribed; this exclusion is not applicable for cases of repatriation of remains;
- sexually transmissible diseases, especially HIV and the consequences (AIDS);
- benign ailments or lesions which may be treated locally and which do not prevent the insured from continuing his trip;
- convalescence, ailments in the course of treatment and not yet consolidated and/or requiring a subsequent schedule of treatment;
- the potential consequences (check-ups, additional treatment, recurrences) of an ailment which gave rise to repatriation;
- events consequent upon illnesses and accidents which have not been noted by a doctor and proven by

means of a medical certificate at the time of occurrence;
- conditions associated with pregnancy, apart from an unforeseeable complication prior to the 28th week;
- childbirth and the consequences thereof for new-born babies;
- voluntary abortions and abortions required for medical reasons;
- psychological problems, any form of mental illness;
- events such as suicide, attempted suicide or self-harm and the consequences thereof;
- loss events which are the subject of a declaration by a person (expert, doctor, solicitor, etc.) who is a relative or relative by marriage of the insured or who would favour the insured;
- the cancellation or amendment of the trip, notably by the organiser, service provider or travel agency or the interruption or cessation of business of thereof.

Art. 5. Restrictions on application

1. Limit of liability

The insurer cannot be held liable for potential damage of a professional, commercial or other nature, suffered by an insured or the policyholder following an incident which required the involvement of the emergency services.

The insurer cannot take the place of local or national emergency or search and rescue organisations and does not pay the costs incurred as a result of their involvement unless contractually stated otherwise.

2. Exceptional circumstances

The Insurer cannot be held liable for the non-performance or delayed performance of services resulting from armed conflicts, general mobilisation, any requisition of men and/or property by the authorities, any act of sabotage or terrorism, any social conflict such as strike, riot, civil commotion, any restriction on the free movement of property and people, natural disasters, the effects of radioactivity, epidemics, any infectious or chemical risk, all instances of force majeure.

Art. 6. General conditions of application

1. Validity of covers

The assistance / insurance covers are granted for all losses occurring during the whole period of validity of this policy to any person insured hereunder for the insured travel.

The covers cease automatically, without further notification, on the date on which the insured no longer pays the fees for the international racing License covering the World Championships, the continental Championships and the international Events included by the FMN on the FIM calendar.

2. Inception date

The obligations of the Insurer come into effect on the date shown in the policy.

3. Period of the contract

The contract is entered into for the period shown in the policy, and in accordance with the special conditions.

4. Modification

Any modification of the provisions of the present insurance contract, as desired by one of the parties, will have to be the subject of a written agreement which is been signed by both parties.

5. Triggering of cover

Only the benefits arranged by or with the consent of the Insurer are covered. The insurer intervenes within the framework set by the national and international laws and regulations. Except in exceptional circumstances or instances of force majeure, the insured must notify the insurer and declare its loss within 30 working days following the date of the loss occurrence and/or in accordance with the arrangements defined for each type of cover. After this period, the insured can limit the coverage or forfeits all right to indemnity.

6. Forfeiture of right to benefits

Non-compliance by the insured with its duties to the Insurer results in the forfeiture of its rights against the Insurer.

7. Inspection

The Insurer reserves the right to have inspected, at any time and by any person of its choice, the documents evidencing the information on which the premium is calculated, throughout the period of the insurance and for two years following expiry of the contract. If the policyholder has not provided accurate information about the basis on which the premium is calculated, the Insurer's duties are suspended from the date on which the declaration for the calculation of the premium within the meaning of the previous paragraph should have been made, and until the day on which the additional payment (including interest and costs) arising out of an inaccurate declaration, is paid.

8. Verification of covers

8.1. Declaration

The insurer has direct access to the FIM file, permitting it to perform real-time verification of validity of the License.

8.2. Authorisation to provide benefits

The policyholder will provide the Insurer with the name and contact details (telephone number, direct line, e-mail and fax) of the authorised person (at the policyholder), who must be contacted by the insurer in the event that the insured requesting one of the types of cover described above is not listed on the data base of insureds. The policyholder will notify the Insurer immediately of any change of authorised person and/or contact details.

The insurer will only provide the services subject to reimbursement with the written consent of the authorised person. Only for persons whose capacity of insured is not certain

In the event of the illness or accident of an insured, if the insurer is unable to reach the policyholder's authorised person, it authorises the insurer to arrange and pay for the services required for the insured's health. The Insurer reserves the right to demand reimbursement of benefits which are not covered.

9. Financial Terms

9.1. Basis for calculating the premiums

In order to calculate the premiums and invoices, the policyholder undertakes to send the Insurer the information necessary for the calculations (number of licensees, etc.) specified in the policy. This information will be submitted at the frequency set out in the policy.

9.2. Due date, payment by instalments, reimbursement, notice

The premium is set for each policy year. It is payable in advance, by no later than the first day of the agreed payment months. The first premium, including Swiss federal stamp duty, falls due when the policy is issued, but no earlier than the start of the insurance.

In the event of payment by instalments, the portions of the premium payable during the course of the policy year are deemed to have simply enjoyed a deferment period.

If the contract is cancelled for whatever reason prior to the expiry of the policy year, the premium paid for the unexpired period is not reimbursable and in the case of payment by instalments, the premium payable for the unexpired period remains payable to the Insurer.

If the premiums are not paid on the agreed due dates, the policyholder is sent notice, in writing at its expense, to pay the amount within 14 days. The notice sets out the consequences of delays in payment of the premium. If this notice does not produce any effect, the duties of the Insurer are suspended between the aforesaid expiry date and payment in full of the premium, including Swiss federal stamp duty.

9.3. Premium statement

The policyholder must pay, at the start of each policy period, the deposit premium as stated in the policy. The premium statement is drawn up at the end of each policy period or when the contract is cancelled, based on the calculation of new and departing insureds pro rata for the same period. To this end, the insurer issues a form to the policyholder and asks it to note thereon all the information enabling it to draw up the statement. The additional premium arising out of the statement must be paid within 30 days of being requested by the insurer from the policyholder. The Insurer reimburses the policyholder for any return premium within the same period, as soon as the final statement is drawn up. If the policyholder does not return the form for drawing up the premium statement within 30 days of receipt or if it does not pay the additional premium within the stated period, the Insurer is entitled to proceed in accordance with article 11.2.

9.4. Adjustment of the premiums

The Insurer may ask for the premiums, excesses and general conditions to be adjusted, as indicated in the special conditions.

Art. 7. Arrangements for cover

1. Obligations of the insured

The Licensee must send the Insurer the following information and documents:

- the nature, circumstances, date and place of occurrence of the loss event;
- the original invoices of all expenses;
- the original lists and/or statements of reimbursement from any payment organisation affected and copies of the invoices for expenses.

2. Arrangements for applying cover

Medical expenses

Involvement is limited to the maximum amount insured, and on condition that the Licensee sends the insurer:

- The original invoices for the medical expenses;
- Certificate of refusal to pay from social and private insurers.

Request for reimbursement from the Licensee to the Insurer:

The Licensee will first submit its claims for reimbursement to its usual social organisations and will give the Insurer:

- Copies of paid invoices + prescription;
- Copy of the medical report;
- Original statements from social organisations;
- Bank details.

Advance of hospitalisation costs by the Insurer: the insurer will send back to the insured the invoices paid in advance. The insured will have 30 days from receipt of the invoices to request reimbursement of the amounts due from its social organisations and will then pass these on to the Insurer. The Insurer will re-invoice the excess and quota share which are not refundable.

Search and rescue costs

- The Insurer must be notified no more than forty-eight hours after the mission and the service must have been ordered by the relevant local authorities or official emergency organisations.
- The insured must provide the following information: the nature, circumstances, date and place of occurrence of the loss giving rise to the search costs locally, the original invoices of all expenses incurred for the search and the original lists and/or statements of reimbursement from any payment organisation affected and copies of the invoices for expenses.

Psychological assistance

- The request for psychological assistance must be made within 3 months from the date of occurrence of the trauma.
- The consultations paid for by the Insurer are granted within a period of 6 months from the date of occurrence of the trauma.

Interruption of trip

The Licensee must send the Insurer the following information and documents:

- Medical certificate with the diagnosis or death certificate or summons to the court or loss declaration in the event of damage at home or at the professional premises;
- Initial invoice for reserving the trip;
- Invoice of cancellation costs or cost of unused services.

Art. 8. Legal framework

1. Confidentiality

The Insurer undertakes to take the necessary measures to ensure the continued confidentiality of the information sent to it in connection with this insurance, not to disclose such information nor to use it for purposes other than those specified in this insurance policy.

2. Subrogation

Having provided assistance or paid the indemnity, the insurer is subrogated, up to the amount of such assistance or indemnity, to the rights and actions of the insured or policyholder against the third parties responsible for the loss.

If, for reasons attributable to the insured or policyholder, subrogation can no longer apply in the Insurer's favour, the latter can demand reimbursement of the indemnity paid up to the amount of the loss suffered.

Subrogation cannot prejudice the insured or policyholder if they have only been indemnified in part. In this case, the

insured or policyholder may exercise its rights in respect of the balance due preferably against the Insurer.

Except in cases of malicious actions, the Insurer cannot seek to recover against the descendants, ascendants, spouse and direct relatives of the insured, nor against persons living within his household, his guests and his household staff.

However, the insurer may seek to recover against these persons insofar as their liability is effectively covered by a contract of insurance.

3. Subsidiarity

The right to benefits is subsidiary and additional to the benefits from social, private or third-party payer insurances

If an insured person is entitled to benefits under another contract and/or another contract of insurance, the cover is limited to the part of the insurer's benefits which exceeds those under the other contract and/or other contract of insurance.

As part of this insurance, an advance is however granted against these benefits. The heir must assign its rights to the Insurer up to the amount of the advance granted.

The Insurer does not provide any benefit to compensate for the excess under another policy.

4. Waiver

As regards said benefits, the Insurer acts as a local agent and arranges certain services from third parties on behalf of the beneficiary or insured, in particular third-party services authorised by the Insurer. The Insurer is not responsible for the quality of the third-party services, or for damage resulting therefrom.

5. Sanctions policy

No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

6. Time limits

Amounts receivable under the contract of insurance are limited to two years from the date on which the duty arises, in accordance with article 46 of the Swiss Law on Insurance Contracts.

7. Jurisdiction and applicable law

The insurance contract is subject to Swiss law. The place of jurisdiction is the location of the headquarters of TSM in Chaux-de-Fonds, Switzerland, inasmuch as the law does not imperatively require another place of jurisdiction.

Customer information about the insurance (Article 3 LCA)

1. Contract partners

Your contract partners are:

TSM Compagnie d'Assurances, Société coopérative, Rue Jaquet-Droz 41, Case postale CH – 2301 La Chaux-de-Fonds is (hereafter referred to as "the Insurer")

2. Applicable law, Basis of the contract

This insurance contract is subject to Swiss law. The quotes or policy, the contractual terms and the applicable laws, notably the federal Swiss law on insurance contracts, of 2 April 1908 (LCA), in its revised version of 17 December 2004, form the contractual bases. A policy is issued once the Policyholder has accepted the quote.

3. Insurer risks and scope of cover

The insured risks and the scope of the cover are shown in the quote/policy, as well as in the General Conditions of Insurance and any Special or Additional Conditions.

4. Amount of the premium

The amount of the premium depends on the risks insured under the policy and the scope of cover required. You will find all information about the premium and any charges in the quote/policy.

5. Entitlement to return of the premium

If the policy is cancelled prior to the end of the policy period agreed by the parties, the Insurer shall have a duty to return the portion of the premium in respect of the unexpired period of insurance.

However, no premium shall be returned if:

- The Insurer has provided indemnity as a result of the disappearance of the risk;
- The Insurer has provided indemnity for a partial loss and the insured cancels the insurance in the first policy year.

6. Period and termination of the insurance

The insurance commences on the day stated in the quote/policy.

If a certificate of insurance or provisional cover note has been issued, the Insurer shall provide cover until the policy is issued to the extent stated in the cover note/in accordance with the statutory provisions. The insurance is entered into for the period stated in the quote. Insurances entered into for a specific period without any renewal clause shall end automatically on the day stated in the quote/policy.

The policyholder may then terminate the insurance by means of cancellation:

- following any loss event for which indemnity is payable, no later than 14 days after becoming aware of the payment by the Insurer;
- if the Insurer has breached the statutory duty of information pursuant to Art. 3 of the Law on the Contract of Insurance, in which case notice of cancellation must be given no later than 4 weeks after becoming aware thereof, but in any event no later than one year after the breach of duty.

The Insurer may terminate the insurance:

- if the Policyholder failed to disclose material facts when entering into the insurance or misrepresented them to the Insurer; the Insurer's right to cancel shall expire 4 weeks after becoming aware of the breach of the duty of disclosure;

The Insurer may terminate the insurance by means of rescission:

- if the insured is in arrears with payment of the premium, has been warned and the Insurer has chosen not to pursue payment of the premium;
- if the Policyholder fails to comply with its duty to cooperate with the investigation of the facts; in this case the Insurer is entitled, after expiry of an additional period of two weeks to be agreed in writing, to withdraw from the contract of insurance within 2 weeks retroactively;
- in the event of insurance fraud.

This list of possibilities for termination of the insurance is not exhaustive. Further termination options are stated in the policy conditions and in the statutory provisions of the LCA.

7. Data processing

The Insurer is authorised to obtain and process the data required for handling the insurance and claims. The Insurer is also authorised to obtain necessary information from third parties and to inspect official documents. The Insurer undertakes to treat the information obtained as confidential. Data is stored physically and/or electronically.

Where necessary, data is passed to interested third parties, namely to co-insurers, reinsurers and other unrestored insurers in this country and abroad. Furthermore, information may be passed to other liable third parties and their liability insurers for the purpose of pursuing recoveries.

TSM Compagnie d'Assurances
Société coopérative
Cours de Rive 2
CH – 1204 Genève
info@tsm-assistance.com
Tél +41 (0)22 819 44 00
Fax +41 (0)22 819 44 99
www.tsm.ch