1. Definitions

Accountant
A chartered accountant or an Accounting Consultant.
Deductible
The percentage stated on the policy schedule of the insured wage and salary bill that, pursuant to this insurance, is still payable by the policyholder.
Employee
The person who is employed by the policyholder based on a contract of employment in accordance with civil law, or who performs work in an employment relationship that has an equal status to employment and by virtue of which is insured under the Work and Income according to Working Capacity Act (WIA). The person who is aged between 65 and 67 years who is employed by the policyholder based on a contract of employment in accordance with civil law, or who performs work in an employment relationship that has an equal status to employment and for whom the policyholder has an obligation to continue payment of wages. Not covered by this definition of employee are the employees who have no relationship of authority referred to in the Civil Code (article 7:610), such as directors – major shareholder.
Employers' costs
The percentage by which payments as allowance for the employers' costs can be increased. The maximum percentage is 25% of the wage and salary bill.
Incapacity for work
There is considered to be incapacity for work if, solely on account of an accident or illness, the employee is unable to perform the (suitable) work agreed between him and the employer. There is not considered to be incapacity for work if the employee is not prepared to perform the agreed work, or if the employer does not enable the employee to perform the agreed work.
Insured wage and salary bill
The wage and salary bill for which cover is provided during a year of insurance to the policyholder. When determining the insured wage and salary bill, for each employee only the wage and salary bill (including increases) up to € 125,000,- is taken into account.
IVA
Income Support Provision for Fully Disabled Persons
Obligation to continue payment of wages
The obligation to continue payment of wages in the event of illness pursuant to the Civil Code (Article 7:629) and the provisions in respect of this in the contract of employment, including the obligation to continue payment of wages to the employee's surviving relatives. For the purposes of this policy, the continuation of payment of wages is deemed to relate to the insured wage and salary bill, plus a percentage for employers' costs if applicable.
Occupational expert
The registered expert who, among other things, assesses which duties, given certain medical restrictions, an employee can still perform.
Premium percentage
The premium for each € 100,- of the insured wage and salary bill.
Suitable work
Work suited to the employee's strengths and skills, in the opinion of the company doctor or the Employee Insurances Implementing Agency (UWV).
UWV
Employee insurances Implementing Agency.
Wage and salary bill
The wage and salary bill is determined in accordance with the Law on Standardisation of the concept of Wages (Wet uniformering loonbegrip). Understood to be meant by the concept of wages is the sum of the uniform annual salary of all of your employees that you declare to the Tax Authorities.
WGA
The Return to Work Scheme for the Partially Disabled.
WIA
The Work and Income according to Working Capacity Act.
Working Conditions Service and/or company doctor
The certified expert service/person in the prevention of absenteeism, guidance and working conditions as referred to in the Working Conditions Act (Arbeidsomstandighedenwet).

2. The purport of the insurance

The objective of the insurance is to (partly) indemnify the policyholder for the continued payment of wages in the event that its employees are incapacitated for work, taking into account the provisions in these Special Conditions and on the policy schedule.

3. Registration and acceptance

The policyholder undertakes to submit for insurance the full wage and salary bill of all employees eligible for this insurance. Prior to the effective date of the insurance, the insurer reserves the right to request a list of all employees who are, at that time (partially) incapacitated for work. Partly based on this list, the insurer shall assess whether the insurance can be accepted and, if so, at what premium and under which conditions.

4. Exclusions

4.1 Exclusions relating to the employee

There is no entitlement to payment if the employee:

a. is able to claim a benefit under the IVA, unless an early IVA benefit is awarded (in which case the IVA benefit is deducted from the insurance payment);
b. can claim benefits pursuant to the Sickness Benefits Act (Ziektewet);
c. can claim benefits due to pregnancy or childbirth pursuant to the Employment and Care Act (Wet Arbeid en Zorg), including if this benefit is maximised, or during a period of leave of absence pursuant to the Employment and Care Act;
d. has reached the age of 67 years;
e. works abroad for a period that exceeds 3 months and the first day of incapacitation for work falls within the period in which the employee is abroad;
f. is not prepared to perform the agreed work that he is deemed capable of by the company doctor/ occupational expert;
g. does not work for reasons other than incapacity for work;
h. is rightfully deprived of his freedom.
i. the policyholder's obligation to continue payment of wages is extended pursuant to article 7:629 section 11 of the Civil Code.
j. becomes unfit for work and in the five preceding years, has already completed the qualifying period for Incapacity for Work Insurance Act (WAO)/WIA and during this period of time failed to request a WAO/ WIA assessment and/or payment time ;
k. becomes incapacitated for work and previous to this

has had 104 weeks entitlement to continued payment of wages with the same employer. This exclusion does not apply if, based on a new contract of employment (newly stipulated work), a new obligation has arisen for the employer in terms of continued payment of wages.

4.2 Exclusions relating to the policyholder

There is no entitlement to payment if the policyholder:

- **a** does not follow the advice provided by the Working Conditions Services and/or company doctor and does not adhere strictly to the legal obligations;
- **b** is not obliged to continue to pay wages;
- **c** intentionally provides a incorrect presentation or makes a false statement in respect of the employee's incapacity for work and/or the continued payment of wages;
- **d** neglects to offer the employee suitable work, whilst this can and should be reasonably expected of the policyholder;
- **e** does not enable the employee to perform the agreed work in respect of which the employee is deemed capable by the company doctor/occupational expert.
- **f** does not fulfil the obligations defined in article 6 of these Special Conditions.

4.3 General exclusions

In addition to the general exclusions stipulated in the General Terms and Conditions, no payment is given if the cause of the loss arose on account of, was accentuated by, or exacerbated by intentional act or omission or recklessness of the policyholder, insured party or an interested party in relation to the payment.
The exclusion in the General Terms and Conditions, that no payment is made if the loss is caused by, arose during or ensued from atomic nuclear reactions, does not apply if the loss ensues from incorrect medical treatment of the employee with radioactive radiation.

4.4 Liable third party

If a third party is involved when the incapacity for work arises, the policyholder is obliged to inform the insurer of this as soon as possible. The policyholder also has to inform the insurer if he intends recovering the (lost) wages from this third party. The policyholder is obliged to immediately inform the insurer if the liable third party reimburses the (lost) wages. The policyholder has to keep the insurer informed about the recourse, or provide the insurer will all information and to offer assistance to enable recovery from a liable third party. This may include the legal transfer of the claim to the insurer. If the loss is (partly) recovered from a third party, the payment made by the insurer is deemed to have been made as an interest-free advance payment and this will be claimed back (pro rata).

4.5 End of the payment

The payment to the employee ends:

- **a** once the duration of the benefit defined on the policy schedule has expired, but after 104 weeks at the latest;
- **b** on the day on which the employee is no longer (deemed) incapacitated for work;
- **c** on the day on which a fixed-term employment contract ends, taking into account the maximum duration of the benefit;
- **d** on the day on which the employee's employment with the policyholder ends;
- **e** on the day that the employee reaches the age of 67 years;
- **f** on the day on which the employee voluntarily takes (partial) early retirement or if pre-pension or pension plan is effected, or if he takes severance;
- **g** at the time at which the employee is entitled to a benefit in accordance with the IVA, unless an early IVA benefit has been awarded (the IVA benefit is deducted from the insurance payment);
- **h** on the 30th day after the death of the employee;
- **i** on the day that the policyholder ceases or suspends the insured party's wages;
- **j** at the time that the insurance ends.

5. Term and end of the insurance

Supplementary to the provisions in the General Terms and Conditions and these Special Conditions, the following provisions apply.

5.1 End of the insurance

- **a** the insurance shall end at the policyholder's request if the policyholder or its legal successor has let it be known that it does not wish to continue the insurance after a merger or corporate takeover of the policyholder's company on the date of the merger or the takeover. The merger or takeover has to be proven in writing;
- **b** If, in respect of the incapacity for work of an employee, the policyholder deliberately provides an incorrect presentation or makes a false statement, the insurer is entitled to immediately cancel the insurance;
- **c** the policyholder and the insurer are entitled to immediately end the insurance if:
  - The policyholder applies for a moratorium of payment;
  - The policyholder is declared to be bankrupt;
  - The policyholder files for bankruptcy;
  - The policyholder is dissolved or loses or changes its legal personality;
  - The policyholder invokes the Natural Persons Debt Rescheduling Act *(Wet schuldsanering natuurlijke personen) (Wsnp)*, or if this act is declared applicable to the policyholder:
  - The insurable interest of the policyholder has ceased to exist because of closure of the company. In that case, the insurance ends on the date of the company closure. A proof of deregistration by the Chamber of Commerce has to be submitted showing the company closure;
  - The policyholder's insurable interest has to have ceased to exist, because the company no longer has employees. In that case, the insurance ends on the date of dismissal of the last employee. Proof of deregistration from the UWV has to be submitted.

5.2 Cessation of the payment

If the insurance ends, after the final date there is no longer an entitlement to payment. This includes for people who were already incapacitated for work prior to the final date.

5.3 Non-terminability

Contrary to the provisions in the General Terms and Conditions, this insurance is, in principle, is not subject to termination by the insurer, except for in the cases outlined in these Special Conditions.

6. Obligations of the policyholder and insured party

6.1 Information on employees
At the request of the insurer, the policyholder is obliged to regularly provide a list of the details of current employees.

6.2 Obligations of the employer
- The employer is obliged to comply with the obligations outlined in the Gatekeeper Improvement Act (Wet verbetering poortwachter). If the employer fails to do so, the entitlement to payment lapses.
- Within 48 hours, the notification of incapacity for work has to be incorporated in the absence records and/or reported to the Working Conditions Service and/or company doctor.
- If a notification is not received within 48 hours, the insurer reserves the right not to pay the benefit until the date of notification.
- After 6 weeks of absence a Claim Form (Schade Aanvraagformulier) (SAF) which has been completed in full and truthfully has to be sent to the insurer and/or Meijers.
- Every 8 weeks (as from week 14), the 8-week absence progress form has to be completed in full and truthfully and sent to the insurer and/or Meijers.
- After receipt of the progress forms, the insurer has the opportunity for a file audit to be performed by an independent advisor after receiving authorisation from the employee. The advisor can be a company doctor, a specialist in occupational medicine, occupational expert, lawyer or registered case manager.
- If when determining the level of a payment the employer, in respect of this insurance, becomes aware of the fact that notification of an absence, recovery and/or partial recovery has not been dealt with, the employer is obliged to immediately inform the insurer of this.

6.3 Incapacity for work during a stay abroad
If the incapacity for work occurs during a stay abroad, the employee has to take the following steps:
- **a** to immediately inform the employer of the incapacity for work;
- **b** to visit a medical specialist or local general practitioner as soon as possible for a medical certificate. This has to include, at the very least, the following information: nature of the illness, the therapy prescribed and the progress. The certificate is not submitted to the employer or insurer, but to a company doctor in the Netherlands, who will use the information in this certificate to determine whether the absence is with good reason;
- **c** to return to the Netherlands as soon as possible;
- **d** if a return to the Netherlands is not possible, the employee has to ask for a medical certificate of unfitness to travel to be prepared. This certificate has to be written in Dutch, English, French, German or Spanish.

Deviating from the procedure defined in article 6 can result in losing the right to a payment.

6.4 Re-integration
Within the bounds of possibility, the policyholder will do everything in his power to enable an employee, who is covered by the insurance, to return to the employment process and will ensure that the employee refrains from everything that could delay or impede his reintegration. In addition, within the bounds of possibility, the policyholder will do everything in his power to ensure that the employee cooperates in the reintegration process.

6.5 Notifications
The policyholder is obliged to inform the insurer immediately, but in any case within 2 months, of:
- **a** the application for moratorium of payment, filing for bankruptcy or otherwise no longer fulfilling or being able to fulfil his obligations in terms of continued payment of wages in the event of illness, as defined in the Civil Code;
- **b** the termination of the contract with the Working Conditions Service and/or the company doctor, or entering into a contract with another (Working Conditions) service.
- **c** amendment of the terms and conditions of employment in respect of incapacity for work;
- **d** notification of absence, which occurs shortly before threatened dismissal or immediately after having been given notice of dismissal. In addition to the notification to the insurer, the Working Conditions Service and/or the company doctor also have to be informed.
- **e** the refusal of suitable employment by an employee who is incapacitated for work. In addition to the notification to the insurer, the Working Conditions Service and/or the company doctor also have to be informed.

6.6 Changes in the level of risk
In the event that the policyholder decides to carry out other business activities with a clearly increased risk of absenteeism due to illness, the policyholder is obliged to inform the insurer in writing of this as soon as reasonably possible. In these cases, the insurer is entitled to revise the premium percentage and/or the conditions, or to terminate the insurance. If the policyholder does not agree to this change, within 1 month of being informed of this he is entitled to terminate the insurance prematurely. In that case, the insurance shall end on the date on which the change in circumstances occurred.

6.7 Not reporting the change in the level of risk
If the policyholder fails to inform the insurer of a change in the level of risk, when the policyholder notifies the insurer of a claim the latter will also assess whether the change in the level of risk carried with it an increase in the (level of) risk. If there was no increase in the (level of) risk, the entitlement to a payment is upheld. If there is an increase in the risk that, as a result, the insurance would only be continued at a higher premium percentage, the payment shall be made in proportion to the premium that was paid to the premium owed on account of an increase in the (level of) risk. If in the opinion of the insurer, the increase in the risk that was reported late was such that it would not be feasible to continue the insurance, there is no entitlement to payment.

6.8 Cooperation
If it is found that the employer has not fulfilled the obligations outlined in article 6, the insurer is entitled to consider the payment that has already been made as undue and the entitlement to future payments lapses if on account of that the interests of the insurer are moderately harmed. The employer's negligence can, among other things, be discovered following a file audit and/or assessment by the Department of Social Securities (UWV).

7. Payments

7.1 Calculation of the total sum of all payments

The total sum of all payments is calculated by adding together the payments that are made for each employee during the year of insurance. Payments for each employee are determined for each working day for which the policyholder has paid a salary in accordance with the obligation to continue payment of wages, based on the percentage of the insured wage stated on the policy sheet. The first day of absence is considered to be the day on which the employee has become incapacitated for work and the employee should have performed his work under his contract of employment, with due regard for the provisions regarding late notification.
When calculating the maximum period of time during which a payment will be made, the periods of incapacity for work are added together, if they follow one another with an interruption of less than 4 weeks.
When determining the amount to be paid, the following provisions apply in the following situations:

- the payment is calculated based on the agreed wage and salary bill, including, if applicable, employers' costs included in the insurance;
- salary that amounts to more than the maximum amount covered for each employee for each year stated on the policy schedule, is disregarded when determining the payment;
- the amounts that the policyholder can deduct from the salary that is continued to be paid, because of the payments or income from employment that are owed to the employee, are deducted from the payment;
- the payment is determined pro rata for days on which only partial salary is continued to be paid, or when there is partial incapacity for work;
- value of the salary has to be assigned to modified work;
- if and insofar as there is (partial) recommencement of work on a therapeutic basis, in any case after 4 weeks, counting from the date of (partial) recommencement of work, a payment is no longer given for the continued payment of wages for the portion of the day on which therapeutic work takes place.

7.2 Payment of the benefit

If during a year of insurance the total sum of all payments exceeds the deductible, after incorporating the premium payment in arrears, the excess is paid as soon as possible to the policyholder.

7.3 Obligations

The Working Conditions Service/company doctor has/have to be informed on the day of the change of all changes in the degree of incapacity for work, or this is to be incorporated in the absence records. For the purposes of an audit, the insurer can ask the policyholder to obtain authorisation from its employee. If requested by the insurer, a further breakdown of the wage and salary bills for each employee has to be provided. The policyholder is obliged to cooperate fully in fulfilling these obligations. If the policyholder fails to fulfil its obligations and on account of that the interests of the insurer are moderately harmed, the insurer reserves the right to not to make payments.

7.4 Prescriptive periods when loss is rejected

The claim by a party entitled to a payment is prescribed by three years after the insurer has acknowledged the claim for payment or has unequivocally rejected the claim in writing.

8. Premium payment in arrears and adjustment of the premium and premium percentage

8.1 Advance premium

The premium stated on the policy schedule is an advance premium. At the start of each year of insurance, the advance premium will be calculated based on final wage and salary bill for the past year and the premium percentage for the new year of insurance. If this information has not yet been received, a provisional advance premium will be calculated. The final premium for the past year will be determined based on the final wage and salary bill. The difference between the advance premium and the final premium for the past year will be offset against the advance premium for the new year of insurance.

8.2 Obligations

After a request to that end by the insurer, the policyholder is obliged to provide a list of employee details, as soon as possible but in any case within 3 months, including details of those persons entering and leaving employment. The format stipulated by the insurer has to be used for this list.
If requested by the insurer, a specification of the wage and salary bills for each employee, as well as a specification of the wages that were continued to be paid in the event of illness, certified by an accountant, have to be provided. The costs associated with these lists shall be borne by the policyholder. The policyholder is obliged to cooperate fully in fulfilling these obligations. If the policyholder fails to fulfil its obligations and on account of that the interests of the insurer are moderately harmed, the insurer reserves the right to terminate the insurance.

8.3 Determining the premium percentage and the deductible

The premium percentage and the deductible are recalculated each year based on the claim figures of the past 3 calendar years or, if these are not available, the claim figures that are available for the term of the insurance and the composition of the workforce. As far as these are available, the claim figures will be deduced from the monthly reports provided by the Working Conditions Service. The new premium percentage and the deductible apply with retrospective effect as from 1 January of the relevant calendar year. If the premium percentage increases by more than 25% in comparison to the past year, the policyholder has to right to reject in writing such a rise within a period of 30 days of being informed of the changed premium percentage. In that case, the insurance contract is terminated on the first day of the calendar month after the rejection of the increase in premium was received in writing by the insurer. In the event that it is rejected, the premium percentage for the term between 1 January of the relevant calendar year and the date that the contract is terminated, will be set at 125% of the most recently applicable premium percentage.

8.4 Non-provision of specifications

If a salary specification requested pursuant to this article is not sent to the insurer within the period of time stipulated by the insurer, the insurer reserves the right to suspend the cover provided by the insurance as from the time that the stipulated term has passed, for as long as the information is not provided. The cover again becomes effective and any claims will again be dealt with on the day after all of the requested specifications have been received by the insurer. If the requested specifications are not provided and the cover has been suspended

for a period of 3 months, the insurer is entitled to terminate the insurance. Before the insurance is terminated, the policyholder shall receive written notification from the insurer in which the date of termination is stated.

9. Payment of premium

9.1 The policyholder has to pay the advance premium and the costs in advance on no later than the 25th day after this is due.

9.2 Supplementary to the provisions in the General Terms and Conditions in respect of payment of premium that is owed and the consequences of non-payment or late payment of that premium, the following applies. If the policyholder does not fulfil its obligation to pay the renewal premium, the insurer shall suspend the cover after the policyholder has ineffectively received a demand for payment within a period of 14 days, after the due date, stating the consequences of the non-payment, starting on the day after the demand. The cover is not revived with retrospective effect, but for the first time as from the day following the day on which the premium was paid. Employees who become incapacitated for work during the suspension, will be re-included in the insurance after receipt of the premium and the costs, so that there is at least 4 weeks of full incapacity for work and recommencement of the normal activities.

9.3 The premium for the current year will be reduced in an equitable manner only in the event of premature cancellation of this insurance contract by the insurer or in the event of a merger or take-over of the policyholder's company.

9.4 All judicial and extrajudicial costs incurred by the broker in order to collect overdue premium instalments and the statutory interest that is potentially owed, shall be borne by the policyholder.

9.5 The broker has the right to offset payments that are owed with unpaid premium instalments if the term stipulated in section 1 of this article has expired.

Legal Assistance Clause

The General Terms and Conditions observed by the insurer also apply to this Legal Assistance Clause, which are available on request.

10. Scope of the cover

a The policyholder is entitled to legal assistance when recovering loss that it has sustained, consisting of loss of income on account of incapacity for work, in accordance with a person who is liable to pay damages to the policyholder, or its employee, and the employer is legally subrogated in accordance with the payment that it has made to its employee.
b The broker does not provide assistance insofar as the policyholder can claim representation of its interests under a different insurance, which may or may not be from an earlier date.

11. The provision of legal assistance

The broker provides legal assistance if it deems there is a reasonable chance of success in the case reported by the policyholder. Experts who are employed by the broker are responsible for dealing with the request for legal assistance. If necessary, the broker is authorised to instruct a lawyer, a loss adjuster or other experts to represent the insured party's interest on behalf of the insured party. The broker is not liable for claims that may ensue from the actions of a lawyer or other experts whose services are engaged.

12. The reimbursement of legal assistance

After approval by the insurer, in respect of the legal assistance that is provided, the broker will reimburse an amount of up to no more than € 3,000,- for each accident that resulted in lost wages, the following costs:

a The fees and advance payments, insofar as those are generally deemed to be customary, of the experts whose services are engaged by the broker;
b The costs of witnesses insofar as these are awarded by a judge;
c The costs of the proceedings, that are to be borne by the insured party or for which he is fined in a final and conclusive judgement;
d The necessary travel and accommodation expenses to be incurred in consultation with the broker if he is ordered to appear in person in a foreign court or if this is urgently required by the lawyer whose services are engaged;
e The costs associated with the enforcement of a judgement within 5 years after this judgement became irrevocable.

13. The threshold sum

The policyholder can only claim legal assistance if the interest of the request amounts to at least € 250,-.

14. The area in which legal assistance is provided

Legal assistance is provided in Europe and in the countries around the Mediterranean Sea, provided that the court in one of those countries is competent and the law of one of those countries applies.

15. The insured party's obligations

A policyholder that wishes to invoke legal assistance, shall inform the broker of its request as soon as possible after the occurrence of the event that resulted in loss; the policyholder has to provide all non-medical information that may relate to the circumstance and the scope of its claim.