Contents

These conditions only apply if reference is made to these on the policy schedule.

1. Definitions

In these terms and conditions, the following terms shall have the following meanings:

1.1 Insurer
The insurer(s) named on the policy schedule represented in this matter by Meijers Assuradeuren BV as authorised representative.

1.2 Policyholder
The policyholder is the person with whom this insurance contract is entered into.

1.3 Insured party
Unless stipulated otherwise on the policy schedule, all employees employed by the policyholder and in the event of whose death or permanent disability as a result of an accident any payment is made. The insured party is at least 13 years old, unless stipulated otherwise on the policy schedule, and is not older than 85 years.

1.4 Broker
The party through the mediation of which the insurance is concluded.

1.5 Beneficiary
The (legal) entity who, according to the policy schedule, has been designated to receive a payment under this insurance. If a payment is to be made to the husband or wife, partner, the children or the heirs, this is considered to mean:

- the husband/wife of the insured party at the time of the accident;
- partner: the insured party's partner, as stipulated in the notarial cohabitation contract or in accordance with the 'registered partnership' at the time of the accident, or the man or the woman with whom the insured party shared a household prior to the accident for at least 6 months. The partner is not a relation by blood or affinity of the insured party in the direct line or second removed in the collateral line;
- the legal, legitimised or adopted children, as well as the legal, legitimised and adopted descendants of the pre-deceased children by substitution; the distribution among whom shall be in accordance with the statutory provisions;
- the persons who, in accordance with testamentary disposition or the law are entitled to a share in the inheritance, including their heirs and successors by universal title; the distribution among whom shall be in accordance with the statutory provisions.
- In no event is the State of the Netherlands a beneficiary.

1.6 Visitor
The natural person, who is legitimately, other than for reason of payment, at a site of or in a building used by the policyholder and who is registered as a visitor.

1.7 Accident
A sudden violent action from an outside source, against the wishes of the insured party, against the insured party's body, as a result of which physical injury is sustained which can immediately be established medically, resulting in death or permanent disability.
Also understood to be meant by accident:

1.7.1 Incorrect medical treatment
Incorrect medical treatment, provided this is directly associated with an accident that happened to the insured party at an earlier date.

1.7.2 Contamination following an involuntary fall
Contamination by germs, infection or an allergic reaction, if this contamination, infection or reaction is a direct result of an involuntary fall into the water or any other substance, or if it is the result of entering that water or other substance in an attempt to save a person, animal or property.

1.7.3 Swallowing substances or objects
Acute or involuntary swallowing of solid and/or liquid substances or objects that are hazardous to health, or gases or vapours (which are not viruses or bacterial germs).

1.7.4 Contamination by vaccinia, anthrax, foot and mouth disease, sarcoptes scabiei, trichophytia and Bang's disease

1.7.5 Suffocation and similar
Suffocation, drowning, freezing, corrosion through corrosive liquids, sunstroke, heat stroke, heat exhaustion, hypothermia, burning, lightning strike and other electrical discharge, as well as the sudden occurrence of a sprain, dislocation, muscle/tendon strain and/or tear, provided that the nature and location can be established medically

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

1.7.7 Wound infection and blood poisoning
Wound infection or blood poisoning by the penetration of germs into an injury caused by an accident

1.7.8 Accident caused by illness
An accident that (partly) occurred on account of illness, disease, infirmity or an abnormal physical or mental state of the insured party.

1.7.9 Complications from injury sustained from an accident
Complications or worsening in the insured party's condition following an accident, as a direct consequence of first aid, or from medical treatment necessitated by the accident.

1.8 Permanent disability
Total or partial permanent disability or loss of function of any part, capacity or organ of the insured party's body, without taking into account the insured party's occupation.

1.9 Acts of war
Armed conflict, civil war, revolt, internal civil commotion, riots and mutiny, such that these terms should be interpreted in accordance with the text filed by the Dutch Association of Insurers (Verbond van Verzekeraars) on 2 November 1981 at the Office of the District Court in The Hague under number 136/1981, or any replacement thereof.

1.10 Premium
The amount owed by the policyholder to the insurer pursuant to the contract of insurance, where a distinction is made between:
- initial premium: the first premium that is charged when the insurance is taken out or following an interim change of the insurance;
- renewal premium: the premiums following the initial premium, which are payable following (tacit) renewal and on each premium due date.

1.11 Sums insured /Annual salary:
The insured party's salary that is awarded to the insured party for a period of 12 months immediately before the accident and that is or shall be declared to the Tax Authorities as pre-income tax salary, unless a different annual salary has been agreed. If the employment has not been in existence for a full period of 12 months, it shall be deduced that the employment had existed during the period referred to.

1.12 Cumulative limit
If More than one insured party is involved in an accident, for one and the same accident and for all insured parties together, an amount in excess of € 15,000,000.00 shall never be paid under Section A (Death) and Section B (Permanent disability). This amount will be passed on proportionally in the amounts to be paid to the separate insured parties.

1.13 Atomic nuclear reaction
All nuclear reactions during which energy is released, such as nuclear fusion, nuclear fission, artificial and natural radioactivity, radioactive radiation.

2. Payment in the event of death (section A)

2.1 Payment to the beneficiary
In the event of death of the insured party resulting from an accident, the sum insured for death will be paid to the beneficiary/beneficiaries named on the policy, or if this has been agreed with the policyholder, to the policyholder. A payment already made to this insured party relating to the same accident on account of permanent disability will be deducted from the payment owed on account of death. If the payment that has already been made on account of permanent disability is higher than payment on account of death, the insurers will not claim back the difference.

Funeral/cremation:
In the event that a payment is made for death caused by an accident, the insurers shall pay the costs for the funeral or cremation up to a maximum of € 7,500.00 for each insured party, provided that these costs are not insured (in full) elsewhere.

2.2 Missing, disappearance
If an insured party is missing or has disappeared and it can reasonably be assumed that the insured party has died as a result of an accident that is covered by the insurance, the sum insured for death will be paid. The insurers can request that a judicial declaration of (presumption of) death is submitted.

2.3 No beneficiary
If, in the event of the death of the insured party, it is found that no beneficiary/beneficiaries exist(s), there is no entitlement to a payment. In the absence of heirs of the insured party within the meaning of article 4:879 of the Civil Code, in no case shall the payment under this insurance be payable to the State of the Netherlands, and neither shall, in such a case, this payment be made available for settlement of the insured party's debts.

2.4 No transfer
The beneficiary's claim against the insurers in respect of the payment in the event of death, cannot be transferred to third parties.

3 Payment in the event of permanent disability (section B)

3.1 In the event of permanent disability of the insured party as a direct and sole consequence of an accident, in the event of full loss (of function) of the parts of the body or organs listed below, the percentage stated after the involved part of the body or organ for the permanent disability sum insured will be paid to the beneficiary stated in the policy.
As far as necessary, contrary to article 6:83 of the Civil Code, this claim of the beneficiary/beneficiaries/policyholder will be due and payable for the first time fourteen days after the insurers have received the final report from the medical advisor, as well as all medical and other information that may reasonably be required to correctly assess the right to a payment.

3.2 Disability scale
Gliedertax (compensation scheme) disability scale

No.	Description	
1	The visual system	100%
2	The hearing in both ears	100%
3	The hearing in one ear	30%
4	The hearing in one ear if, under this policy, a payment has already been made on account of the loss of hearing in one ear	70%
5	Auricle	5%
6	The nose	10%
7	The smell, the taste or both	10%
8	Full natural set of teeth, however, up to a maximum of € 12,000.00 (loss of less than 50% or in the event of partial damage, no payment will be made. Understood by full set of teeth is: 28 to 32 elements. Understood by set of teeth is: the natural set of teeth and/or a set of false teeth that cannot be removed).	2.5% max. € 12.000,-
9	A hand up to the wrist joint	70%
10	A thumb	30%
11	An index finger	20%
12	Every other finger	15%
13	The leg up to the hip joint	100%
14	The arm up to the shoulder joint	100%
15	A lung	30%
16	The spleen	10%
17	A kidney	20%
18	The complete loss of function of the pancreas	70%
19	A leg up to the knee joint	70%
20	A foot up to the ankle joint	65%
21	A big toe	15%
22	Another toe	5%

23	Cervical acceleration/deceleration injury of the vertebral column with neuropsychological and /or vestibular abnormalities	8-15%
24	Cervical (or lumbar) acceleration/deceleration injury of the vertebral column without objective demonstrable neurological/neuropsychological incapacitation symptoms and /or objective demonstrable vestibular abnormalities	0-8%
25	Post-commotional syndrome	0-8%
26	Permanent total uselessness of the vertebral column with complete loss of typical vertebral column action and movement functions with no neurological symptoms	75%
27	Incurable mental illness	100%
28	Loss of intellectual faculties	100%
29	Loss of brain function through traumatic damage to the brain	100%
30	As a result of traumatic damage to the brain, full loss of the integrated complex higher brain functions	100%
31	Full paralysis	100%
32	The power of speech	100%
33	The lower jaw through surgical treatment	30%
34	As a consequence of traumatic damage to the brain, the loss of the ability to speak	90%

3.3 The amount of the payment for partial loss (of function) When there is a partial loss or partial uselessness of one or more of the parts of the body or organs listed in the disability scale shown above, the percentage of the payment is ascertained in proportion to the aforementioned percentages, subject to the criteria laid down in the most recently published version of the "Guides to the Evaluation of Permanent Impairment" by The American Medical Association (A. M.A.), plus the guidelines of the Dutch specialist associations. In the event of loss or permanent uselessness of several parts of the body or organs, the percentages are added to one another and/or combined.

3.4 The amount of the payment for other permanent physical injury When there is total or partial loss or uselessness of parts of the body or organs not listed in the disability scale shown above, the degree of permanent disability is ascertained by (medical) experts: - According to the taxes applicable at that time, or according to the criteria laid down in the most recently published version of the "Guides to the Evaluation, of Permanent Impairment" by The American Medical Association (A. M.A.), plus the guidelines of the Dutch specialist associations, or; - Based on an assessment of the impact of the disability on the activities calculated for the strengths and skills of the Insured Party, and, with the education and past activities in mind, what can be asked of the insured party according to medical opinion.
The payment shall be determined based on the higher of the two percentages referred to above.

3.4.1 In the event of full or partial loss or unusability of parts of the body or organs not mentioned in the disability scale shown above of the insured parties named in article 4.1 (visitors) and article 4.3 (cover for trainees, volunteers, on-call workers and person(s) on trial placements, the degree of permanent disability is assessed by (medical) experts subject to the taxes applicable at that time, or subject to the criteria laid down in the most recently published version of the "Guides to the Evaluation, of Permanent Impairment" by The American Medical Association (A. M.A.), plus the guidelines of the Dutch specialist associations.

3.5 **Maximum payment**
For one and the same accident the total payment shall not exceed the amount stated on the policy schedule for permanent full disability, subject to the provisions of article 4.2 and subject to: in the event of Paraplegia or Quadriplegia, the following payment will be added to the payment to the insured party for permanent disability:
Paraplegia The permanent and full paralysis of the two lower limbs, bladder and rectum. € 25,000.00
Quadriplegia The permanent and full paralysis of the two upper limbs and the two lower limbs. € 50,000.00

3.6 Additional cover for cosmetic surgery If on account of deformity, disfigurement or defacement as a result of an accident covered by the insurance, treatment by a plastic surgeon would, in his opinion, lead to a reasonable chance of improvement or restoration of the foregoing, the companies will reimburse the costs associated with the surgery or out-patient treatment, the medication that is prescribed, bandages and other medication, as well as the costs of nursing in hospital, up to a maximum of 10% of the sum insured for permanent disability, up to a maximum of € 5,000.00 for each accident. The condition for the reimbursement of costs pursuant to this article is that the insured party can derive rights from a primary healthcare insurance entered into in the Netherlands, or similar provision. The present insurance only offers a so-called surplus or supplementary cover to a primary healthcare insurance or similar provision for insofar as the medical costs are not covered in accordance with the conditions of the healthcare insurance or similar provision, or would not be reimbursed under this primary healthcare insurance or similar provision under an excess or reimbursement maximum. Explicitly not understood by the aforementioned is contribution required by law. Notwithstanding the aforementioned, there is no entitlement to reimbursement of the aforementioned costs if these are covered in full or in part by another insurance which may or may not be of an older date, or could have been covered if the present insurance had not existed, or if a liable third party is obliged to pay those costs.

3.7 Dentistry costs If as a result of an accident covered by the insurance damage occurs to three or more natural permanent dental elements, the costs of repair are reimbursed up to a maximum of € 500.00 for each event for each insured party.

4. Supplementary cover

4.1 **Visitors**
Visitors are also covered by this insurance in respect of accidents that happen to them in a building or at a site used by the policyholder (used by the policyholder and that form part of the policyholder's permanent establishment for its business activities) for the following sums insured for each person:

- € 5,000.00 in the event of death;
- € 25,000.00 in the event of permanent full disability.

Not understood to be meant by visitors are the workforce of contracting companies, fitters, machine works, cleaning companies, utility companies and similar, that come to perform work in the policyholder's company, and neither are the temporary workers, trainees and other people working for remuneration in the policyholder's company. This visitor cover only has effect if the policyholder has insured all employees under this insurance. This cover

does not apply to those companies whose business activities also focus on receiving visitors, such as recreation parks, hotels or catering companies, zoos, banking establishments, cinemas, museums, shops, warehouses, public buildings, stations, (air) ports, etc. The provisions of article 4.2 (double payment) do not apply to visitors. The claims arising from this visitor insurance shall never exceed € 500,000.00 per event, or series of related events, as a result of which accidents occur. Payments pursuant to this visitor cover shall exclusively be made to the policyholder. Article 4.1 does not apply in respect of a visitor for whom, on any basis, there already a claim for cover under this policy and/or (a) associated policy or policies.

4.2 Double payment If the insured party dies or sustains 100% permanent disability as a result of an accident, the insurers shall double and pay the sum insured for death, respectively the sum insured for permanent disability if the accident results from:

- fire in a house;
- any accident that happens with public transport (with the exception of (air) craft), in which the insured party was sitting as a passenger.

Only in the event of a circumstance mentioned in the present article, the insurers shall never pay out more than € 500,000.00. However, if in accordance with this insurance a payment in excess of € 500,000.00 is made without utilising the provisions of this article, the insurer(s) shall pay that higher amount, however with due regard for the other maximum (if any) in force in this contract of insurance.

4.3 Cover for on-call workers, trainees, volunteers and persons on trial placements On-call workers, trainees, volunteers and persons on trial placements are also covered under this insurance in respect of accidents. It should be noted that this cover is only effective if no more than 5 persons from each of the aforementioned groups are present at the time of the accident and these persons are registered, stating the period they will be present. The cover for this group is maximised at the following for each insured party:

- € 25,000.00 in the event of death;
- € 50,000.00 in the event of permanent disability.

If, at the same time, more than the maximum of 5 persons are present from each of the aforementioned groups, these persons can be insured for an additional premium, which is then recorded on the policy. If there is no mention of these persons on the policy, in the event of a loss, the sums insured shall be reduced pro rata for each person.

4.4 Repatriation after death Should the insured party die as a result of an accident and a payment is made under this insurance, in addition to the sum insured for death, the insurer shall pay, up to a maximum of € 10,000.00 for each event for each insured party, the costs of repatriation of the body. This contribution applies purely and simply as an excess in addition to the sum insured elsewhere and is also only paid in the event that the costs incurred for transport are not or are only partially covered under any other insurance and/or provision, which may or may not be from an earlier date, if the present insurance had not existed.

4.5 Additional payment for surviving minor children In respect of an accident that is covered by the insurance, an insured party and his/her husband/wife or partner die at the same time or within 6 months of one another as a result of the same accident and only if there are surviving minor children, an additional amount of € 5,000.00 shall be paid for each child to the official guardian(s) assigned by notarial deed, up to a maximum of 10% of the capital insured for death and a minimum of € 5,000.00.

4.6 Costs for retraining In the event that a payment is made for the loss of a limb or the loss of sight, the insurer will pay back to the policyholder the reasonable costs for the retraining of the insured party to perform modified work, up to a maximum of € 10,000.00.

4.7 Replacement costs In the event that a payment is made for death as a result of an accident, the insurer will pay the reasonable recruitment costs for the replacement of the insured party to the policyholder, up to a maximum of € 10,000.00.

4.8 Daily allowance, hospital admission If as a direct and sole consequence of an accident an insured party is admitted to hospital, during the time of admission a payment will be made of € 75.00 each day. The period of payment commences on the day on which the insured party is admitted to hospital and ends on the day on which the insured party is discharged from hospital. The maximum period of payment is 365 days, which are not necessarily consecutive. For the following disorders considered equivalent to an accident, a maximum duration of payment applies of 28 consecutive days: hernia, backache (lumbago) and bulging of the disc between the vertebra in the spine (prolapsed disc and spinal disc herniation).

4.9 Coma If an accident results in the continuous unconscious state of the insured party, the insurer shall pay € 50.00 each day of admission, for a period of no more than 365 days. This payment shall be added to the payment for hospital admission.

5. Geographical area of cover and duration

Unless stated otherwise on the policy schedule, the insurance shall have effect throughout the world, 24 hours a day, whether or not the occupation is being carried out.

Limited cover:

This insurance only provides cover for accidents of on-call workers, trainees, volunteers and persons on trial placements that occur when performing work on behalf of the policyholder. The cover commences at the time that the insured party leaves his home or place of residence in order to travel directly and by the shortest route to the place where the aforementioned work is performed. The cover ends as soon as the insured party has again reached his home or place of residence directly and by the shortest route, after the work has come to an end. In the event of an accident, the policyholder is obliged to submit evidence that, at the time of the accident, the person involved was performing or was on the way to perform the work or occupation.

6. Exclusions

6.1 Intentional act or omission Accidents that arise on account of intentional act or omission or recklessness of, with the approval of or on account of incitement by the policyholder, the insured party, the beneficiary/beneficiaries or the interested party/parties in the insurance.

6.2 Suicide Accidents that occur on account of (attempted) suicide, self-maiming or on account of intentional recklessness.

7. Notification of an accident

7.1 Notification of a loss

7.1.1 Notification of death In the event of the death of an insured party, the policyholder or –and/or – the beneficiary, or the interested party in the insurance are obliged to inform the insurers of this at least 36 hours before the funeral or the cremation, by means of a fax, e-mail or by telephone. In the best way possible, any particular details have to be reported that happened to the insured party in relation to the death and the accident.

7.1.2 Notification of permanent disability In the event of an accident which can result in an entitlement to payment on account of permanent disability, the insurers, the insured party and the beneficiary are obliged to ensure that this accident is reported to the insurer as soon as possible, but no later than within 3 months after the accident.

7.1.3 Late notification of permanent disability If the insurer is not notified within the period of time specified in article 7.1.2, this shall not impact (the level of) the payment, on the condition that, to the satisfaction of the insurers, it can be proven that: - a covered accident happened to the insured party; - the permanent disability was as a direct and sole consequence of the accident; - after the occurrence of the accident, the insured party sought treatment from a doctor in good time, complied in all respects with the instructions of the doctor providing treatment and did everything possible to foster recovery; - the accident did not occur on account of one or more of the causes or circumstances named in article 6.

7.1.4 Missing, disappearance In the event that the insured party is missing or has disappeared, the policyholder and/or the beneficiary and/or interested party is/are obliged to inform the insurers of that as soon as reasonably possible. Insofar as this is relevant, article 7.2 applies by analogy.

7.2 Medical investigation and autopsy The policyholder and/or beneficiary and/or interested party is/are obliged to cooperate fully with the doctor and/or authorised person/persons appointed by the insurers in respect of a medical investigation that is potentially required (including a possible autopsy, laboratory tests and exhumation) into the cause of the accident and/or cause of death. They are obliged to answer the questions that are asked to the best of their ability and truthfully. The policyholder and/or beneficiary and/or interested party is/are obliged to ensure, to the best of their ability, that the funeral or cremation of the insured party does not happen before consent to that end has been received from the insurers.

7.3 Obligations of the insured party and the policyholder or interested party/parties: The insured party to whom the accident happened, or the beneficiary/beneficiaries respectively is/are obliged:

- to seek medical treatment as soon as possible and to continue to receive medical treatment if this is reasonably required, and to follow the instructions, without interruption, of the doctor providing treatment
- in any case, to undergo an examination or observation by a doctor appointed by the insurers, at the expense of the insurers, in a hospital or establishment appointed by the insurers which may or may not be located in the Netherlands;
- to provide all information deemed necessary by the insurers, or to arrange for this information to be provided, to the expert appointed by the insurers and to cooperate fully in requesting medical information on behalf of the medical advisor appointed by the insurers;
- to answer truthfully and in full all questions asked by the insurers or by the experts appointed by the insurers and not to withhold any facts or circumstances that may be of importance to establish the degree of permanent disability;
- to inform the insurers as soon as reasonably possible of full or partial recovery;
- to enable the insurers to perform a medical examination within the meaning of article 7.2.

If the insured party is affected by an accident, the policyholder is obliged:

- to the best of its ability, to help the insured party to fulfil the aforementioned obligations;
- when asked, to provide further information to the insurers, which shows that, at the time of the accident, the person for whom/by whom payment is requested, was insured and to give insurers the opportunity to verify the information that is provided.

8. Determining the degree of permanent disability

8.1 The method of determining the degree of disability
The degree of permanent disability is determined by a medical investigation to be performed in the Netherlands and – if required – investigation by other experts. The percentage of loss (of function) due to injury to one or more of the parts of the body or organs in accordance with the disability scale outlined in art. 3.2 is determined using criteria set out in the latest version of the 'Guides to the Evaluation of Permanent Impairment' by the 'American Medical Association' (A. M.A.), plus the guidelines of the Dutch specialist associations. When determining this percentage of disability, the occupation of the insured party is not taken into account. As regards injury to the parts of the body or organs not included in the disability scale in article 3.2, the method of determining the permanent disability takes place in accordance with the provisions of article 3.4.

8.2 Time at which the disability is determined The degree of permanent disability is determined as soon as, in medical opinion, there is deemed to be a steady state, but in any case within 3 years of the date of the accident, unless agreed otherwise. At the end of this three-year period, or otherwise agreed period of time, the degree of permanent disability will be determined, based on the disability that exists at that time. Once the degree of permanent disability has been determined, should any changes occur after that time, a claim cannot be made for additional payments, and neither can payments that have already been made be reclaimed.

8.3 Existing loss (of function) If loss (of function) of parts of the body or organs already existed prior to an accident, the degree of permanent disability that is determined after the accident will be reduced by the existing permanent disability in existence prior to the accident.

8.4 Death prior to the payment being determined The entitlement to payment on account of permanent disability

remains if, before the degree of permanent disability is determined, the insured party dies due to causes other than as a result of the accident that caused the disability. The level of the payment to be made in this situation is determined based on the medical reports that are available and the anticipated degree of permanent disability that, in the view of medical and – if necessary other – experts, would have been present in the event that the insured party had not died.

8.5 Interest payments If one year after the accident has happened the payment for permanent disability has not yet been determined, the insurers will pay the statutory interest at the time that the permanent disability is determined on the amount that is ultimately paid, deducted from which are any advance payments, as from the 366th day after the notification of the accident. The interest shall be paid at the same time as the payment.

9. Impact of existing abnormalities

If the consequences of the accident are multiplied by the illness, infirmity or an abnormal physical or mental state of the insured party, the consequences that the accident would have had if the insured party were to have been fully able-bodied and healthy shall be taken as a starting point to determine the payment. This rule does not apply if the existing illness, infirmity or abnormal physical or mental state of the insured party is the direct consequence of an earlier accident, for which the company has already made a payment or still has to make a payment under this insurance.

10. Loss of the entitlement to a payment

Every entitlement to payment is nullified if: - the policyholder and/or the insured party do/does not fulfil an obligation defined above in article 7.3, unless it can be proven that the latter is/are able to prove that they cannot be reasonably blamed for this, and only insofar as the interest of the insurers are moderately harmed by this; - in the event that the dependants refuse to give insurers their consent for a medical examination to be performed, as referred to in article 7.2.

11. Payment

11.1 Notification by the insurers in respect of entitlements to payment
After receipt of all of the information that it requires in order to assess the entitlement to a payment, the insurers shall inform the insured party, or in the event of the latter's death, the beneficiary, as soon as possible, of its position with respect to the entitlement to payment.

11.2 Payment and acquittance
The payment shall be made after the insurers have determined the (level of) the payment within fourteen days after the broker has received the customary form that it uses, signed by the beneficiary, in which full acquittance and discharge is given to the insurers.

11.3 Advance payments
In the event that the insurers made an advance payment available to the beneficiary, payment shall take place within fourteen days after the beneficiary has confirmed to the broker, by means of a customary form used by the broker that full acquaintance is granted for the advance (payment) to be made.

12. Occupation or activities

12.1 Change in the level of risk
If and as soon as it develops business activities on account of which there is a clearly increased level of risk in comparison to the risk of accidents when the contract of insurance was entered into, the policyholder is obliged to inform the broker/insurer(s) of this change in the level of risk immediately and in any case within 30 days.

12.2 Acceptable increase of risk
If in the opinion of the insurers, the (new) activities performed by the involved party mean an acceptable increase of risk, then in respect of the involved insured party, the insurers are entitled to charge a different premium and/or to set other conditions for the involved insured party. The policyholder is entitled to object in writing to this change within 30 days, in which case the insurance shall end for the involved insured party at the end of this period of time. If the insurers are not informed of an acceptable change in the level of risk, or if the insurance has not yet been amended, payment for occupational accidents shall be in the proportion of the old to the new premium that is owed by the involved insured party.

12.3 Unacceptable increase in risk
If in the opinion of the insurers the (new) activities performed by the involved party mean an unacceptable increase of risk, then in respect of the involved insured party, the insurers are entitled to end the insurance, observing a 30-day notice period.

13. Premium

13.1 Payment of the premium
The policyholder is obliged to pay in advance the premium, the costs and premium tax, if applicable. The amount that is owed has to have been paid on the premium due date at the latest.

13.2 Non-payment, lapse of insurance cover
If the policyholder has not paid or refuses to pay the initial premium on the 30th day after receipt of the request for payment at the latest, without further notice of default being required by the broker or the insurers, no cover will be given in respect of all events that take place after that time.If the policyholder does not fulfil its obligation to pay the premium on the premium due date, the cover shall be suspended 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,.If the broker and/or the insurer conclude from a notification by the policyholder that it shall fail to pay the renewal premium, the insurance shall end or the cover shall be suspended, without the foregoing demand for payment having been made.Despite suspension or cancellation of the cover, the policyholder is still obliged to pay the amount that is owed, plus the (extrajudicial) collection costs. The insurance again becomes effective on the day after the day on which the broker has received the amount that is owed.

13.3 Refund of premium
Except for in the event of premature cancellation of this insurance on account of the reasons described in articles 12.3 and 14.2, the current premium shall be reduced in an equitable manner.

13.4 Premium payment in arrears

At the request of the broker/insurer, from time to time the policyholder shall provide a statement of: - the total annual salary paid to the insured parties, and/or; - management fees, if any, that have been paid to the insured parties, and/or; - the number of insured parties, if applicable broken down in the insured category. If the statement differs from that stated on the policy schedule, a refund is given or an additional premium is charged. In addition, the renewal premium of the current year of insurance is modified.

14. Final stipulations

14.1 Term of the insurance
This insurance has been taken out for a term of 12 months, unless stated otherwise on the policy schedule, and is continued each time tacitly by the same term and under the same conditions, unless the insurance is cancelled by one of the parties in writing, taking into account a notice period of 2 months.

14.2 Premature termination
The insurance can be terminated in writing prematurely, if by or on behalf of the policyholder, the insured party or beneficiary/beneficiaries intentionally provided an incorrect statement of affairs with regard to the insured risk, or intentionally misapplied the obligations described in articles 7.1. to 7.3 inclusive. In this case, a notice period of 2 months shall be taken into account. If one of the parties involved in this contract, including the party or parties entitled to payment, have acted with the intention to deceive the other, both the insurers and the policyholders/insured parties are entitled to immediately cancel the insurance in writing. The insurance can be terminated prematurely in writing by the policyholder in accordance with the provisions of articles 12.3 and 14.3.

14.3 Collective revision The broker and/or the insurer are entitled to revise the premium and/or terms and conditions under the framework of a collective revision for similar insurances and to amend this insurance at any time according to the new premium and/or terms and conditions. The broker and/or the insurers shall inform the policyholder beforehand and in writing of the collective revision. The policyholder has up to 30 days after the date of amendment to unilaterally cancel the insurance, if the intended amendment would result in a higher premium and/or less advantageous terms and conditions for the latter. The insurance shall then end as from the date of the cancellation. If the insurance relates to several groups of insured parties, specified on the policy, the authority to cancel only concerns those groups to which the intended collective revision relates.

14.4 Address Notifications to the broker by the policyholder and/or the insured party can be made in a legally valid way to the last known address of the broker.

14.5 Disputes

14.5.1 Disputes regarding the degree of permanent disability Disputes that exclusively relate to the degree of permanent disability determined by insurers, respectively to the reports by medical and (if applicable) other experts that form the basis of that assessment shall – with the exclusion of the civil courts – be subjected to the decision of 1 or 3 arbitrators. Each of the arbitrators to be appointed has to be listed as a doctor/medical specialist in the register of the KNMG and live and work in the Netherlands. If the parties are unable to agree about the appointment of 1 or 3 arbitrator(s), each of them is entitled to unilaterally ask the President of the court of Amsterdam to appoint 3 arbitrators. The appointment by the President shall then be legally binding between the parties. Arbitrators shall decide in the highest instance and make legally binding decisions between the parties. Each of the parties shall meet half of the costs associated with the arbitration, unless the arbitrators decide that the costs of the arbitration shall be borne in full by the unsuccessful party.

14.5.2 Other disputes In respect of disputes other than those defined in article 14.5.1 including disputes about (the degree of) the insurance cover, the explanation of the terms and conditions of insurance and the existence of an obligation to pay, only the court of Amsterdam is competent.

14.6 Complaints procedure Complaints that relate to the conclusion and execution of the insurance contract can be submitted to your insurer and/or broker. After receipt of you complaint, we will contact you very soon. All complaints are dealt with by the management. If after having followed the internal complaints procedure you are not satisfied with the management's judgement, and if you do not run a business or company, within three months of the date on which the management adopted this position, you can take your complaint to:
The Financial Services Complaints Board,
P. O. Box 93257, 2509 AG The Hague.
Tel. 0900 – FKLACHT (0900-3552248)
Email: info@kifid.nl; www.kifid.nl.
The Financial Services Complaints Board is an independent disputes committee for the insurance sector. For more information about the complaints and disputes procedure and the associated costs, we refer you to (the website of) the Financial Services Complaints Board. If you do not wish to utilise the aforementioned complaints handling procedures, or if you are not satisfied with the way in which the complaint is dealt with, or the outcome thereof, you can submit the substance of the dispute to the competent court, unless a binding third-party ruling has been given.
Dutch law applies to our services.

14.7 Applicable law Dutch law applies to this contract of insurance.

14.8 Order of priority If according to the policy schedule one or more special clauses are declared applicable to this insurance, those special clauses shall always be given priority if these contradict the general terms and conditions of this insurance.

14.9 Personal data When insurance/a financial service is applied for, personal data is requested. This data is used by a broker to conclude and to execute insurance contracts or financial services for relationship management, to prevent and combat fraud against financial establishments, for statistical analyses and to be able to fulfil legal obligations.

Clauses Sheet Terrorism Cover

At the Nederlandse Herverzekeringsmaatschappij voor Terrorismeschade N. V. (NHT) – the Dutch Terrorism Risk Reinsurance Company

1. Definitions

Where they appear in this clauses sheet and the provision based thereupon, the following terms shall, unless otherwise stipulated, have the following meanings:

1.1 Terrorism

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

1.2 Malevolent contamination

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

1.3 Precautionary measures

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

1.4 Dutch Terrorism Risk Reinsurance Company (Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N. V.) (NHT)

A reinsurance company incorporated by the Association of Insurers in the Netherlands, to which any liability to pay compensation under any insurance contract which may arise from the manifestation of the risks referred to in Articles 1.1, 1.2 and 1.3, may be ceded.

1.5 Insurance contracts

- **a** Non-life insurance contracts insofar as they pertain to risks situated in the Netherlands in accordance with the provisions of article 1:1 of the Financial Supervision Act (Wet op het financieel toezicht), under "state where the risk is situated".
- **b** Life insurance contracts insofar as they are entered into with a policyholder whose regular residence is in the Netherlands, or, if the policyholder is a legal entity, with the establishment of the legal entity to which the insurance contract pertains, whose registered office is in the Netherlands.
- **c** Funeral in kind insurance contracts insofar as they are entered into with a policyholder whose regular residence is in the Netherlands, or, if the policyholder is a legal entity, with the establishment of the legal entity to which the insurance contract pertains, whose registered office is in the Netherlands.

1.6 Insurers authorised in the Netherlands

Non-life, life, and funeral in kind insurers as referred to in the Financial Supervision Act (Wet op het financieel toezicht) who are authorised to carry on the insurance business in the Netherlands.

2. Limitation of the cover for the terrorism risk

2.1 If and insofar as, subject to the descriptions contained in articles 1.1, 1.2 and 1.3, and within the limits of the applicable policy conditions, cover is provided for the consequences of an event which is (directly or indirectly) related to: - terrorism, malevolent contamination or precautionary measures, - any act or conduct in preparation for terrorism, malevolent contamination or precautionary measures, hereinafter to be collectively referred to as 'the terrorism risk', the liability to pay compensation on the part of the insurers in respect of any submitted claim to indemnity and/or benefit, shall be limited to the amount of the payment which the insurer receives in respect of said claim under the reinsurance of the terrorism risk with the NHT, in the event of an insurance with wealth creation increased by the amount of the wealth creation which has been realised under the insurance in question. With regard to life insurances the amount of the realised wealth creation shall be set at the premium reserve to be adhered to pursuant to the Financial Supervision Act (Wet op het financieel toezicht) with respect to the insurance in question.

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

2.3 Contrary to the provisions contained in the aforementioned paragraphs of this article, the limit of indemnity under this contract with respect to any insurance pertaining to: - loss of or damage to immovable property and/or the contents thereof; - consequential loss due to loss of or damage to immovable property and/or the contents thereof, shall not exceed EUR 75 million in respect of any one policyholder and any one insured location per annum for all participating insurers as referred to in article 1 together, irrespective of the number of policies issued. For the application of this paragraph insured location shall be understood to mean: all objects insured by the policyholder existing at the address of premises to which the insurance applies, as well as all objects insured by the policyholder located outside the address of premises to which the insurance applies whose use and/or purpose is in relation to the business activities at the address of premises to which the insurance applies. As such shall in any case be considered all objects insured by the policyholder which are located at a distance of less than 50 metres from each other and of which at least one is situated at the address of premises to which the insurance applies. For the application of this paragraph it shall be provided that, with regard to legal entities, companies and partnerships which are joined in a group, as

referred to in article 2:24b of the Civil Code, all group companies together shall be regarded as one policyholder, irrespective of which group compan(y) (ies) belonging to the group has/have taken out the polic(y) (ies).

3. Payment Protocol NHT

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

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

3.3 Not until the NHT has notified the insurer of the amount, whether as an advance or not, which will be paid in respect of any one claim to compensation, shall the insured or the party entitled to the payment be entitled to lay claim to the payment as referred to in article 2.18.3 in this respect towards the insurer.

3.4 The reinsurance cover by the NHT shall pursuant to provision 17 of the Protocol only apply to claims for indemnity and/or benefit which are reported within two years after the NHT has established that a certain event of circumstance is regarded as a manifestation of the terrorism risk within the context of this Clauses Sheet.