

Consumer Information Concept-Global

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General Customer Information

With the following information, we, DR-WALTER GmbH, would like to inform you about the insurance product CONCEPT-GLOBAL that we offer.

1. Type of insurance contract

CONCEPT-GLOBAL is a travel health insurance policy and optionally a supplementary combination of travel liability, travel accident, baggage and assistance insurance for international students and doctoral candidates, language and exchange students, high school students, trainees, travellers, au pairs, volunteers and work and travel participants.

CONCEPT-GLOBAL is a group insurance consisting of legally independent insurance contracts through which members of LAC Living Abroad Community e. V. (LAC) and participants from affiliated partner companies and organisations can insure themselves for the purpose of staying abroad. Upon joining this contract, you will receive a confirmation of acceptance, which specifies the insured person and the scope of insurance coverage.

The insurance product CONCEPT-GLOBAL is offered and managed exclusively by DR-WALTER GmbH (DR-WALTER) or its distribution partners.

2. Identity of the companies involved

To offer you this insurance product, DR-WALTER GmbH has teamed up with renowned insurance companies.

Health insurance coverage is provided by the insurer:

Barmenia Krankenversicherung AG
Barmenia Allee 1
42119 Wuppertal, Germany

Registered office: Wuppertal

Wuppertal local court (Amtsgericht) HRB 28475

Insurance coverage for accident, liability, and baggage insurance is provided by the insurer:

Dialog Versicherung AG
Adenauerring 7
81731 Munich, Germany

Registered office: Munich

Register court: Munich local court (Amtsgericht) HRB 234855

Insurance coverage for assistance insurance is provided by the insurer:

Europ Assistance SA, branch office for Germany
Nördliche Münchner Straße 27A
82031 Grünwald, Germany

General representative: Tim Schmidt

Munich commercial register: HRB 61 405

Principal office:

Europ Assistance SA (Public limited company under French law)
2 rue Pillet Will
75009 Paris, France

Paris commercial register: Nr. 451 366 405 RCS

Represented by its general director (Directeur Général): Antoine Parisi

Contract and service management is provided by:

DR-WALTER GmbH
Eisenerzstraße 34
53819 Neunkirchen-Seelscheid, Germany

Registered office: Neunkirchen-Seelscheid

Siegburg local court (Amtsgericht) HRB 4701

DR-WALTER GmbH acts as an insurance agent for one or multiple clients in accordance with section 34d (1) of the German Industrial Code (Gewerbeordnung).

The competent authority is the Chamber of Industry and Commerce IHK Bonn / Rhein-Sieg, Bonner Talweg 17, 53113 Bonn, T +49 228 2284 -0, F +49 228 2284 – 170, info@bonn.ihk.de, www.ihk-bonn.de.

DR-WALTER GmbH is registered in the register of insurance intermediaries under the number D-QAMW-L7NVQ-57. This information can be reviewed at any time at: DIHK | Deutsche Industrie- und Handelskammer, Breite Strasse 29, 10178 Berlin, T +49 30 20308 0, <https://www.vermittlerregister.info>

DR-WALTER GmbH has a direct interest of 100% in the voting rights of DR-WALTER Versicherungsmakler GmbH. No insurance company or parent company of an insurance company has a direct or indirect interest of more than 10% in voting rights or capital of DR-WALTER GmbH.

3. Authorised representatives of the companies involved

Legal representative of Barmenia Krankenversicherung AG is its management board as follows: Dr. Andreas Eurich (CEO), Frank Lamsfuß, Ulrich Lamy, Carola Schroeder, Chairman of the Board: Dr. h. c. Josef Beutelmann.

Legal representative of Dialog Sachversicherung AG is its management board.

Legal representative of Europ Assistance SA, branch office for Germany is its general representative.

Legal representatives of the DR-WALTER GmbH are its managing directors.

4. Main business activity of the insurers

Barmenia Krankenversicherung AG offers all types of health and long-term care insurance.

Dialog Versicherung AG offers all types of property and accident insurance.

Europ Assistance SA, branch office for Germany offers selected types of property and accident insurance in the field of travel insurance.

Legal and financial supervision is carried out by the Federal Financial Supervisory Authority (Bundesanstalt für Finanzdienstleistungsaufsicht), Graurheindorfer Str. 108, 53117 Bonn, Germany.

5. Guarantee and security fund

The following applies to Barmenia Krankenversicherung AG:

In agreement with the Federal Financial Supervisory Authority, Medicator AG, Gustav-Heinemann-Ufer 74c, 50968 Cologne, Germany, protects policyholders from the consequences of the insolvency of a health insurance company.

The following applies to Dialog Versicherung AG and Europ Assistance SA, branch office for Germany:

Setting up a guarantee fund is not required, since there are generally no guarantee funds set up for property and accident insurers.

6. Key features the benefits

Contract basis:

The consumer information describes type and scope of the insurance benefits and contains all other regulations.

The entire content is derived from the following documents:

- General Insurance Conditions Weltpolice – Concept-Global (AVB WP-CG), of Barmenia Krankenversicherung AG,
- General Liability Insurance conditions (AHB 2008) of Dialog Versicherung AG,
- General Accident Insurance Conditions (AUB 2008) including additional conditions for group accident insurance, as well as extensions of the AUB 88 version 2008, of Dialog Versicherung AG,
- General Insurance Conditions for the insurance of assistance services (Zusatzassistance 2014) of Europ Assistance SA, branch office for Germany,
- General Baggage Insurance Conditions (AVB Reisegepäck 2008) of Dialog Versicherung AG,

- Special conditions for personal liability, accident and baggage insurance of Dialog Versicherung,
- Supplementary special conditions for private liability insurance of Dialog Insurance,

The data to be provided by you and any documents to be submitted serve in particular to specify the desired insurance coverage.

Collateral agreements (e.g. verbal commitments made by your insurance agent) are only binding if they are confirmed in writing by DR-WALTER GmbH or the insurance company involved.

7. Total price of insurance

Premiums are calculated on a daily basis. They are payable in advance at the beginning of each insured calendar month for the entire calendar month.

The total daily premium is made up of the individual premiums for the selected insurance policies. The total daily premium is stated on the basis of your selection in the consultation protocol and your insurance confirmation.

The premiums for health and long-term care insurance are free of tax in accordance with section 4 no. 5 of the German Insurance Tax Act (VersStG).

The premiums for accident, liability, baggage and assistance insurance each include 19% insurance tax.

8. Taxes, fees and charges

In the event that you fall behind with your payments, the dunning costs specified in the insurance conditions as well as late payment fines, may be incurred. There are no other taxes, fees or charges.

9. Details on payment of premiums

(1) Premiums are calculated on a daily basis. They are payable in advance at the beginning of each insured calendar month for the entire calendar month.

(2) The first premium is to be paid immediately after the expiry of two weeks following the delivery of the insurance confirmation.

(3) The statutory provisions on default and reminders pursuant to Sections 37 to 39 of the German Insurance Contract Act (VVG) apply.

10. Obligations

(1) At the insurer's request, the policyholder and the insured person must provide any information required to establish the insured event or the insurer's liability to pay benefits and the scope thereof.

(2) At the request of the insurer, the insured person is obliged to be examined by a doctor appointed by the insurer.

(3) The insured person must, where possible, take steps to minimise the damage and refrain from any actions that could hinder recovery.

11. Consequences of breaches of obligations

(1) The insurer is wholly or partially exempt from its liability to pay benefits, subject to the restrictions prescribed in section 28 (2) to (4) of the German Insurance Contract Act (VVG), if any of the obligations specified in clause 10 is breached.

(2) The knowledge and fault of the co-insured person are equal to the knowledge and fault of the main insured person.

12. Obligations and consequences of a breach of obligations in the event of claims against third parties

(1) If the policyholder or an insured person has claims for compensation against third parties, they are obliged, without prejudice to the statutory subrogation pursuant to section 86 of the German Insurance Contract Act (VVG), to assign these claims in writing to the insurer up to the amount in which compensation (reimbursement of costs as well as goods and services) is paid under the insurance contract.

(2) The policyholder or the insured person has to assert his or her claim for compensation or any right to secure this claim properly and in due time and assist the insurer, where necessary, in enforcing such claim for compensation.

(3) If the policyholder or an insured person intentionally breaches the obligations specified in paragraphs 1 and 2, the insurer is not obliged to pay benefits to the extent that he cannot obtain compensation from the third party as a result. In case of a grossly negligent breach of obligations, the insurer is entitled to reduce its benefits in proportion to the severity of the fault.

(4) If the policyholder or an insured person has a claim for repayment of fees paid without a legal basis against the provider of services for which the insurer has provided reimbursement on the basis of the insurance contract, paragraphs 1 to 3 apply accordingly.

(5) Insofar as third parties are liable to pay benefits in case of an insured event or benefits can be claimed from insurance contracts with other insurance companies, their obligations to pay benefits take precedence; this applies even if only subordinate liability is also agreed in an insurance contract. The claims of the insured person remain unaffected thereby. If the insured event is first reported to the insurer, the insurer will make an advance payment and settle the claim in accordance with the terms and conditions.

(6) The policyholder must immediately inform the insurer about the conclusion or existence of other insurance contracts that have the same subject matter as this group insurance contract.

13. Validity of the information provided

information provided is generally not limited in time.

14. Conclusion of the contract

Membership is concluded for up to 15 months. Subject to statutory rights of revocation, insurance coverage begins on the date specified in the confirmation of acceptance, but

- not before payment of the premium and
- not before the start of the stay abroad.

No benefits will be paid for insured events that occurred before the start of insurance coverage. For further information, please refer to the respective insurance conditions.

For persons to be insured who do not meet the criteria of insurability, membership does not come into effect even if the premium is paid or received.

15. Information on the right of revocation in accordance with section 8 (2) no. 2 of the German Insurance Contract Act (VVG)

The complete information on the right of revocation can be found on the following pages.

16. Contract period

The maximum term of insurance coverage for individual insured persons is 15 months.

17. Information on the termination of the contract

The insurance coverage for individual insured persons ends automatically upon expiry of the agreed term and can be terminated during the agreed term on a daily basis.

18. Applicable law and place of jurisdiction

Unless otherwise agreed, the contract is governed by German law.

German law and German jurisdiction apply to all contractual provisions relating to CONCEPT-GLOBAL in general, membership of LAC and contract management by DR-WALTER GmbH.

19. Languages

The contractual provisions are drawn up in German. Communication during the term of the insurance policy will also be in German. If documents are provided in English, this is to be understood as a service provided by the insurer and has no effect on the agreed contract language.

20. Appeal proceedings

In the event of a disagreement, please contact DR-WALTER GmbH.

Our contact data are

DR-WALTER GmbH

Eisenerzstraße 34
53819 Neunkirchen-Seelscheid
Germany

T +49 22 47 91 94 -0
F +49 22 47 91 94 -40

Email: beschwerde@dr-walter.com

We will try to find a mutually acceptable solution as quickly as possible. If we don't succeed in this endeavor, you can also contact an extra-judicial arbitrator.

For complaints that affect your health or long-term care insurance, please contact the

Ombudsmann für private Kranken- und Pflegeversicherungen (ombudsman for private health and long-term care insurance)
Postfach 060222
10052 Berlin

T +49 800 2 55 04 44 (free of charge from German telephone networks)
F +49 30 20 45 89 31

Email: ombudsmann@pkv.de

For more information, please go to www.pkv-ombudsmann.de

If you have complaints that do not concern health or long-term care insurance, please contact the

Versicherungsombudsmann e. V.
Postfach 08 06 32
10006 Berlin

T 0800 3 696 000 (kostenfreie Rufnummer aus dem deutschen Telefonnetz)

T +49 30 206058 99 (aus dem Ausland)

F 0800 3 699 000 (kostenfreie Rufnummer aus dem deutschen Telefonnetz)

F +49 30 206058 98 (aus dem Ausland)

E-Mail: beschwerde@versicherungsombudsmann.de

Further information can be found on the Internet at: www.versicherungsombudsmann.de

The ombudsman also serves as a mediation body for the out-of-court resolution of disputes concerning insurance contracts with consumers and disputes between insurance intermediaries and policyholders. The insurer participates in the dispute resolution process. However, the ombudsman's decisions are not binding for the insurer. The possibility of initiating legal proceedings remains unaffected.

In addition, you can file a complaint with the

Bundesanstalt für Finanzdienstleistungsaufsicht (Federal Financial Supervisory Authority)
Graurheindorfer Straße 108
53117 Bonn
Germany

T +49 228 41080
F +49 228 4108 1550

Email: poststelle@bafin.de

Information on the right of revocation

Section 1

Right to revoke, consequences of revocation and special notes

Right of revocation

You can revoke your contractual declaration in writing (e.g., letter, fax, email) without giving reasons within 14 days after conclusion of the contract.

Your revocation period starts after you have received

- the insurance policy,
- the policy provisions, including the General Insurance Conditions applicable to the contractual relationship, which in turn include the tariff provisions,
- this information sheet,
- the fact sheet about the insurance products,
- and the other information listed in section 2

in each case in writing.

Timely sending of the revocation statement is sufficient for complying with the revocation period. Please send your revocation to:

Barmeria Krankenversicherung AG, Dialog Versicherung AG, Europ Assistance SA – Niederlassung für Deutschland, c/o DR-WALTER GmbH, Eisenerzstraße 34, 53819 Neunkirchen-Seelscheid

If you wish to send your revocation by fax, please send it to the following fax number: +49 22 47 91 94-40

If you wish to send your revocation by email, please send it to the following email address: vertrag@dr-walter.com

Consequences of revocation

In the event of an effective revocation, the insurance coverage shall end and the insurer shall reimburse you for the portion of the premiums attributable to the period after receipt of the revocation if you have agreed that the insurance coverage shall commence before the end of the revocation period. In this case, the insurer may retain the part of the premiums attributable to the period up to the receipt of the revocation; this is an amount equal to the number of days during which insurance coverage existed multiplied by 1/365 of the annual premium. The insurer shall reimburse any amounts to be repaid without delay, no later than 30 days after receipt of the revocation.

If insurance coverage does not commence before the end of the revocation period, the effective revocation shall result in any benefits received being returned and any benefits derived (e.g., interest) being reimbursed. If you have effectively exercised your right of revocation with regard to the insurance contract, you shall also no longer be bound by any contract related to the insurance contract. A related contract exists if it is related to the revoked contract and concerns a service provided by the insurer or a third party on the basis of an agreement between the third party and the insurer. A contractual penalty may neither be agreed upon nor demanded.

Special notes

Your right of revocation expires if the contract has been completely fulfilled by both you and the insurer at your express request before you have exercised your right of revocation.

Section 2

Further information required for the start of the deadline

With regard to the further information referred to in section 1 sentence 2, the information requirements are detailed below:

Subsection 1

Information requirements for all classes of insurance

The insurer is required to provide you with the following information:

1. the identity of the insurer and of the branch, if any, through which the contract is to be concluded; the commercial register in which the legal entity is registered and the corresponding registration number must also be provided;

2. the address for service of the insurer and any other address relevant to the business relationship between the insurer and you, in the case of legal persons, associations of persons or groups of persons also the name of an authorized representative; insofar as the notification is made by transmitting the contractual provisions including the General Insurance Conditions, the information shall be provided in a prominent and clearly designed form;
3. the insurer's principal business activity;
4. information on the existence of a guarantee fund or other compensation arrangements; the name and address of the guarantee fund must be provided;
5. the essential features of the insurance benefit, in particular information on the type, scope and due date of the insurer's benefit;
6. the total price of the insurance, including all taxes and other price components, with the premiums shown individually if the insurance relationship is to comprise several independent insurance contracts, or, if an exact price cannot be stated, information on the basis of its calculation, enabling you to verify the price;
7. details regarding payment and fulfillment, in particular the method of payment of premiums;
8. the time limit of the validity of the information provided, for example, the validity period of limited offers, especially with regard to the price;
9. information on how the contract was drafted, in particular on the start of the insurance and the insurance coverage, as well as the duration of the period during which the applicant is to be bound by the application;
10. the existence or non-existence of a right of revocation as well as the conditions, details of the exercise, in particular the name and address of the person to whom the revocation is to be declared, and the legal consequences of the revocation, including information on the amount you may have to pay in the event of revocation; insofar as the notification is made by transmitting the contractual provisions, including the General Insurance Conditions, the information shall be provided in a prominent and clearly designed form;
11. a) information on the contract period;
b) information on the minimum term of the contract;
12. information on the termination of the contract, in particular on the contractual terms of termination including any contractual penalties; if the notification is made by transmitting the contractual provisions including the General Insurance Conditions, the information shall be provided in a prominent and clearly designed form;
13. the member states of the European Union whose law the insurer uses as a basis for establishing relations with you before concluding the insurance contract;
14. the law applicable to the contract;
15. the languages in which the terms and conditions of the contract and the advance information referred to in this subsection will be communicated and the languages in which the insurer undertakes, with your consent, to communicate during the term of this contract;
16. possible access for you to an extrajudicial complaint and appeal procedure and, if applicable, the conditions for such access; it must be expressly stated that this does not affect the possibility for you to take legal action;
17. name and address of the competent supervisory authority and the possibility of lodging a complaint with this supervisory authority.

End of information on the right of revocation

Insurance Conditions Weltpolice Concept-Global (WP-CG)

Contents from the Group Insurance contract relevant to you

As per 01 June 2025

1. Insured persons

(1) All persons who are temporarily staying abroad as international students and doctoral candidates, language and exchange students, au pairs, volunteers, high school and work and travel participants, and who are members of LAC e.V. are eligible for insurance.

The maximum age of entry for insured persons is 29. In exceptional cases, persons older than 29 may also be insured.

Foreign countries are defined as all countries except the home country of the insured person.

The home country is the country to which an insured person is returned in the case of a medically necessary return transport or death. The insured person must have either citizenship or a permanent residence permit for the specified home country.

(2) The contracting parties agree that the rights and obligations arising from this contract exist exclusively between the policyholder and the insurer. At the time of conclusion of the contract, the policyholder can only be a company with its registered office in Germany. All correspondence will be conducted exclusively between the contracting parties.

2. Registration and deregistration, term, termination

(1) The reporting is made by means of a list containing the following data on the insured persons: surname, first name, date of birth, gender, home country, start of insurance.

(2) Any changes to the above data must be communicated immediately.

(3) The maximum period of insurance is 15 months.

(4) Joining the group insurance must be completed before leaving the home country and for the entire duration.

(5) The insurance ends – including for pending insured events – at the time agreed in the insurance confirmation;

- upon expiry of the maximum period of insurance;
- upon termination of the stay abroad or upon return to the home country;
- upon cessation of the prerequisites set forth in clause 1 of this contract;
- upon the death of the insured person;
- upon return transport to the home country of the insured person.

3. Subject matter, scope, and area of validity of the insurance coverage

1) The insurer provides coverage for illnesses, accidents and other events specified in the contract. If agreed, the insurer also provides additional services directly related thereto. In the event of an insured event, the insurer reimburses expenses for medical treatment and other agreed benefits.

Notwithstanding any other contractual provisions, insurance coverage only applies insofar and as long as there are no economic, trade, or financial sanctions or embargoes of the European Union or the Federal Republic of Germany directly applicable to the contracting parties. This also applies to economic, trade, or financial sanctions or embargoes imposed by the United States of America on Iran, insofar as they are not opposed to any European or German legal provisions.

(2) An insured event is the medically necessary treatment of an insured person due to illness or consequences of an accident. The insured event begins with the medical treatment; it ends when, according to medical findings, the need for treatment no longer exists. If the treatment has to be extended to an illness or consequences of an accident that is not causally related to the illness or consequence previously treated, this constitutes a new insured event in this respect.

The following are also considered insured events:

- examination and treatment due to pregnancy, premature birth or miscarriage, or an unforeseen medically necessary termination of pregnancy;

- childbirth;
- patient return transport;
- transport of mortal remains or funeral at the place of death.

(3) The insurance coverage extends to the expenses incurred in the country of stay.

(4) The scope of insurance coverage is determined by the contract, subsequent written agreements as well as statutory regulations. The insurance relationship is governed by German law.

(5) The insurance coverage is valid in the following regions:

Region 1: Worldwide – Worldwide, except USA and Canada

Region 2: Worldwide – including USA and Canada

The target region is the region in which the insured person(s) is(are) staying or will be staying. If insurance cover applies in region 1, it also applies in region 2 for temporary travel (for a maximum of six weeks), but only for medical emergencies, consequences of an accident, and death.

The change to another region must be reported to the insurer immediately.

Insurance coverage also applies in the event of travel interruption in the home country for a maximum of 4 weeks during the entire duration of the insurance coverage.

4. Start of insurance coverage, waiting periods, and excess

(1) Insurance coverage begins on the date and at the time specified in the insurance confirmation, but not before payment of the initial premium and not before the start of the stay abroad.

(2) The waiting periods are calculated from the start of the insurance coverage.

The waiting periods for pregnancy treatment and childbirth are 4 months.

(3) Excess only for travelling the USA: for treatment in the emergency room, an excess of €250 will be charged. Such excess is waived for inpatient admission.

5. Scope of the liability to pay benefits

(1) We cover 100% of the costs of medically necessary treatment in the event of illness or accident consequences, pregnancy and childbirth, and medically justified termination of pregnancy – provided that these are carried out or prescribed by a doctor. Transport costs and other services are also insured.

Insurance coverage is provided to the following extent:

a) Medically necessary treatments

- Inpatient treatment in hospital, including surgery, accommodation, meals and care;
- Outpatient medical treatment, including examinations using X-ray diagnostics;
- Medically prescribed medicines, bandages and dressings, and remedies. Nutritional supplements, tonics, cosmetic preparations and similar products are not reimbursable, even if they contain medicinal substances and have been prescribed by a doctor. Expenses for remedies are reimbursed up to €250 per insurance period;
- Outpatient initial treatment for mental illness up to €1,500 per insurance period;
- Inpatient emergency treatment for mental or psychic disorders occurring for the first time, up to €20,000 per insurance period;
- Assistive devices (e.g. walking aids or wheelchair rental), provided they become necessary for the first time as a result of an accident or illness during the insured stay, up to €500 per insurance period.

b) Medically necessary dental treatment

- Reimbursement of pain-relieving dental treatment, including simple fillings and repairs to dentures and dental prostheses, up to €350 per insurance period;
- Accident-related dental treatment, provided it is medically necessary, up to €1,000 per insurance period.

c) Additional costs

- If a patient return transport is not possible by the end of the insured stay due to medical reasons, the costs of medical treatment will be covered until the patient is fit for transport, up to a maximum of 90 days;
- Telephone costs incurred when contacting the emergency call centre will be reimbursed up to €25 per insured event.

d) Pregnancy and childbirth

If the pregnancy occurs during the insured stay and the waiting period described in clause 4 par. 2 has expired, the following benefits will be covered:

- Medical check-ups up to and including the 12th week of pregnancy;
- Two ultrasound examinations, beyond these only if medically necessary;
- Treatment of pregnancy complications;
- Outpatient or inpatient childbirth, including medically necessary caesarean section;
- Medically indicated termination of pregnancy;
- Services provided by obstetricians and midwives;
- Postnatal care for mother and child. The scope of benefits for the newborn is limited to €30,000.

If pregnancy already exists before the start of the insured stay or before the expiry of the waiting period defined in clause 4 par. 2, insurance coverage is only provided in the event of acute, unforeseen complications affecting mother or child.

e) Patient transport and transport of mortal remains

- Medically necessary patient transport abroad to a hospital for inpatient admission or primary care, provided that this is carried out by a recognised emergency service;
- Medically reasonable and justifiable patient return transport to the patient's home country, place of residence or the nearest suitable hospital;
- When travelling: also to the place of stay or the nearest suitable hospital in the country of stay;
- Transport of mortal remains to the place of residence in the home country before departure or funeral abroad up to the amount of the costs for the transport of mortal remains, up to a maximum of €30,000.

(2) If medical treatment or other measures exceed what is medically necessary, we reserve the right to reduce the reimbursement to an appropriate level. The fees may not exceed what is considered reasonable in the country of treatment. Otherwise, they will be reduced to the customary rates in that country.

(3) The insured person is free to choose any doctor or dentist who is authorised to provide medical treatment under the law applicable in the country of stay.

(4) In the event of medically necessary inpatient treatment, the insured person is free to choose from among the hospitals generally recognised in the country of stay which are under permanent medical supervision, have sufficient diagnostic and therapeutic facilities, work according to scientifically recognised methods and keep medical records.

(5) The insurer provides coverage within the scope of the contract for examination or treatment methods and medicines that are predominantly recognised by conventional medicine. The insurer also pays for methods and medicines that have proven to be equally promising in practice or that are used because no conventional medical methods or medicines are available; however, the insurer may reduce its benefits to the amount that would have been incurred if available conventional medical methods or medicines had been used.

6. Limitation of the liability to pay benefits

(1) There is no liability to pay benefits for

- Costs for medical treatment of illnesses, complaints and abnormalities and their consequences which the insured person was already suffering from at the start of the insurance coverage, as well as all costs for medical treatment of illnesses, complaints and abnormalities and their consequences which were medically advised or treated in the last 6 months prior to the start of the insurance coverage;
- Medical treatments and other medically prescribed measures which, at the start of the insured stay, you knew would be necessary for medical reasons if the insured stay was carried out as planned (e.g. dialysis);
- Costs for medical treatment and other medically prescribed measures, as well as for patient transport, rescue and recovery measures in connection with the practice of sports for remuneration, as well as the following sports: motorcycle or car racing, including training for such activities, parachuting, paragliding, bungee jumping, base jumping, mountaineering (if special climbing equipment is required), free climbing, and recreational and scuba diving;
- Purchase and repair of prostheses, visual aids and hearing aids;
- Acupuncture, fango and massages;
- Need for care or custody;
- psychoanalytic and psychotherapeutic treatment, insofar as this is not covered under clause 5 par 1a, as well as hypnosis;
- Benefits for pregnancy and childbirth if the pregnancy already existed before the start of the insured stay, unless there is an acute and unforeseen deterioration in the health of the mother and/or child;
- medical examinations, studies, treatments, consultations and complications related to sterility, sterilisation, sexual dysfunction, contraception, including the insertion or removal of contraceptives, induced termination of pregnancy, except in the case of a medically necessary termination of pregnancy

performed in accordance with local legislation.

(2) If a medical treatment or other measure for which benefits have been agreed exceed what is medically necessary, the insurer may reduce its benefits to a reasonable amount. If the expenses for the medical treatment or other services are noticeably disproportionate to the services provided, the insurer is not obliged to pay benefits in this respect.

(3) If compensation can be claimed from another insurance contract in the event of an insured event, the other contract takes precedence. This also applies if subordinate liability has also been agreed in one of these insurance contracts, regardless of when the other insurance contract was concluded. If the insured event is first reported to us, we will make an advance payment and contact the other insurer directly for the purpose of cost sharing. We waive cost sharing with a private health insurance company if this would result in disadvantages for the insured person (e.g. premium refund).

7. Payment of benefits

(1) The insurer is only liable to provide benefits if the evidence requested by the insurer has been provided; such evidence becomes the property of the insurer.

(2) The expenses are allocated to the calendar year in which the treatment took place or the funds were received. The expenses must be proven by the original invoices or by copies of such invoices confirming the benefits provided by other insurers or cost carriers. Medical invoices must contain:

- name of the treated person;
- designation of all diseases;
- specification of individual medical services with reference to the items of the applied scale of fees;
- treatment data.

The evidence is to be submitted no later than 31 March of the year following the medical treatment.

(3) In all other respects, the requirements for the insurer's benefits becoming due are set out in section 14 of the German Insurance Contract Act (VVG) (see annex).

(4) Costs incurred in a foreign currency are converted into euros at the current exchange rate on the day the receipts are received by the insurer. The rate of the day is the official euro exchange rate of the European Central Bank. For non-traded currencies for which no reference rates have been fixed, the rate according to the "Exchange Rate Statistics" published by the Deutsche Bundesbank, Frankfurt/Main, applies according to the latest status, unless the insured person proves by means of a bank receipt that he/she has acquired the foreign currencies necessary to pay the invoices at a less favourable rate.

(5) Translation costs are not deducted from the benefits. Costs for bank transfer of insurance benefits will be deducted from the benefits only if they are incurred because the insurer makes bank transfers abroad at the main insured person's request or chooses special forms of transfer.

(6) Claims to insurance benefits may neither be assigned nor pledged. Non-assignment in accordance with sentence 1 does not apply to contracts concluded on or after 1 October 2021; statutory non-assignment clauses remain unaffected.

(7) If an insurance card has been issued on the basis of which it is possible to bill a service provider directly, the non-assignment clause does not apply in this respect.

8. Set-off

Setting off Barmenia premium claims against the insured person is not permitted. Section 35 of the German Insurance Contract Act (VVG) is waived.

9. Informing the insured persons

(1) The policyholder must adequately inform the insured persons about their insurance coverage and the essential provisions of this contract.

(2) The policyholder undertakes to notify all insured persons immediately if the contract is terminated – in whole or in part – under this agreement and that insurance benefits will no longer be paid.

10. Withdrawal from group insurance

(1) The insurance coverage of the individual insured person ends – also for pending insured events –

- with the termination of the stay abroad or with the return to their home country;
- when the requirements according to clause 1 and clause 2 par. 3 of this contract cease to apply;

- with the death of the insured person;
- after a return transport to the home country;
- with the transfer of the policyholder's registered office to a state that is not a member state of the European Union or a contracting state to the Agreement on the European Economic Area;
- upon the termination of the group insurance contract by the policyholder taking effect;
- upon termination of the group insurance contract by the insurer taking effect.

The policyholder will immediately inform the insurer about the reasons for termination specified in a) to e) (cf. clause 2 par. 1).

11. Declarations of intent and notifications

Declarations of intent and notifications to the insurer must be made in writing.

12. Place of jurisdiction

(1) The place of jurisdiction is Wuppertal.

(2) For legal actions arising from the insurance relationship against the policyholder, the court of the place where the policyholder has its registered office is competent.

(3) Legal actions against the insurer may be brought before the court at the registered office of the policyholder or before the court at the registered office of the insurer.

(4) If, after conclusion of the contract, the policyholder relocates its registered office to a country that is not a member state of the European Union or a contracting state to the Agreement on the European Economic Area, or its registered office is unknown at the time the action is brought, the court at the insurer's registered office is competent.

13. Contract language / Applicable law

(1) The contractual provisions are written in German. Communication during the term of the insurance will also be conducted in German. If documents are provided in English, this is to be understood as a mere service provided by the insurer and has no effect on the agreed contract language.

(2) The insurance relationship is governed by German law.

(3) The insurer cannot guarantee that the contract constitutes a substitutive health insurance within the meaning of any compulsory local health insurance requirement that may exist. It is not the insurer's responsibility to check whether this group insurance is suitable as a substitute. The insurer is not obliged to ensure compliance with all relevant provisions and regulations related to the posting for all insured persons covered by the insurance contract.

(4) With regard to the compulsory insurance requirement in Germany pursuant to section 193 number 3 sentence 1 of the German Insurance Contract Act (VVG), the insurer expressly points out that the group insurance is not a substitutive health insurance within the meaning of section 146 of the German Insurance Supervision Act (VAG) and is therefore not suitable for fulfilling the compulsory insurance requirement.

14. Amendment to the group insurance contract

(1) If a provision in this contract has been declared invalid by a supreme court decision or by a final administrative act, the insurer may replace it with a new provision if this is necessary for the continuation of the contract or if adhering to the contract without a new provision would constitute an unreasonable hardship for one of the contracting parties, also taking into account the interests of the other contracting party.

(2) The new provision is only effective if it adequately takes into account the policyholder's interests while preserving the objective of the contract. The new provision will become integral part of the contract two weeks after the new provision and the relevant reasons for it have been communicated to the policyholder.

15. Declaration regarding the insured person's entitlement to receive benefits

The policyholder hereby irrevocably designates all persons insured under this group insurance contract as authorised recipients for the respective insurance benefits relating to them. Barmenia Krankenversicherung AG is then entitled to pay the said insurance benefits directly to the individual insured person as the claimholder or to a third party authorised by the insured person to receive the benefit. (Note: Debt-discharging payments to third parties, e.g. hospitals, doctors, etc., who submit invoices for reimbursement and wish to collect the insurance benefit directly, are only possible if the third party submits a written direct debit authorisation or declaration of assignment signed by the insured person together with the reimbursement request.)

—Reference to the consumer arbitration board Ombudsman Private Health and Longe-Term Care Insurance

(Ombudsmann Private Kranken- und Pflegeversicherung)

Policyholders who are dissatisfied with decisions made by their insurer or whose negotiations with the insurer have not led to the desired outcome can contact the Ombudsman Private Health and Long-Term Care Insurance.

Ombudsmann Private Kranken- und Pflegeversicherung

Postfach 06 02 22

10052 Berlin

Internet: www.pkv-ombudsmann.de

The Ombudsman Private Health and Long-Term Care Insurance is an independent arbitration body that provides its services free of charge to consumers. The insurer has undertaken to participate in the arbitration procedure. Consumers who have concluded their contract online (e.g. via a website) can also submit their complaint online to the platform <http://ec.europa.eu/consumers/odr/>. Their complaint will then be forwarded to the Ombudsman Private Health and Long-Term Care Insurance via this platform.

Please note: The Ombudsman Private Health and Long-Term Care Insurance is not a mediation body and cannot make binding decisions on individual disputes.

Reference to the insurance supervision

If policyholders are dissatisfied with the support provided by the insurer or if disagreements arise during the processing of the contract, they can also contact the supervisory authority responsible for the insurer. As an insurance company, the insurer is subject to supervision by the Federal Financial Supervisory Authority (Bundesanstalt für Finanzdienstleistungsaufsicht).

Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin)

Sektor Versicherungsaufsicht

Graurheindorfer Straße 108

53117 Bonn

E-Mail: poststelle@bafin.de

Note: The Federal Financial Supervisory Authority is not a mediation body and cannot make binding decisions on individual disputes.

Reference to legal recourse

Regardless of the option to contact the consumer arbitration board or the insurance supervisory authority, the policyholder is entitled to take legal action.

Health insurance security fund

In agreement with the Federal Financial Supervisory Authority, Medicator AG, Gustav-Heinemann-Ufer 74 c, 50968 Cologne, Germany, protects policyholders against the consequences of the insolvency of a health insurance company.

General Liability Insurance Conditions of Dialog Versicherung AG (AHB 2008)

Scope of insurance

1. Subject matter of the insurance, insured event

1.1 Insurance cover is provided within the frame of the insured risk if a third party makes a claim for damages against the policyholder in accordance with statutory liability provisions under private law and because of the occurrence of a loss event (insured event) that caused personal injury, property damage or a resulting financial loss while the insurance policy was in effect. Loss event is an event directly causing damage to a third party. The exact point in time, however, when the damage leading to the loss event was caused is not relevant in this context.

1.2 There is no insurance cover for claims, even if they are statutory claims,

1.2.1 for fulfillment of contracts, subsequent performance, for self-remedy of defects, rescission, reduction, for compensation instead of performance;

1.2.2 because of damages that are caused in order to carry out the subsequent performance;

1.2.3 because of the failure to use the subject matter of the contract or because of the absence of the success owed under the contract;

1.2.4 for compensation of unsuccessful expenses in reliance on proper fulfillment of contract;

1.2.5 for compensation of a financial loss caused by late performance;

1.2.6 because of other compensations replacing the fulfillment of contract.

2. Financial loss, loss of property

By means of a special agreement, this insurance cover can be extended to the policyholder's legal liability under private law because of

2.1 financial loss neither caused by personal injury nor property damages;

2.2 damages because of loss of property; such a case is governed by the conditions on property damage.

3. Insured risk

3.1 The insurance cover includes the legal liability

3.1.1 from the policyholder's risks stipulated in the insurance policy and its addendums,

3.1.2 from increases or extensions of the risks stipulated in the insurance policy and its addendums. This applies neither for risks from ownership or use of motor vehicles, aircraft or watercraft that are subject to insurance nor for other risks subject to compulsory insurance or the duty to provide for sufficient cover,

3.1.3 from risks that will newly arise for the policyholder after conclusion of the insurance contract (automatic extension of cover) and which are regulated in detail in clause 4.

3.2 The insurance cover also includes an increase of the insured risk as a result of a change in the existing legal regulations or the enactment of new ones. The insurer can, however, cancel the insurance contract in accordance with the requirements of clause 21.

4. Automatic extension of cover

4.1 Risks that newly arise after the conclusion of the insurance contract are covered within the existing contract with immediate effect.

4.1.1 The policyholder is obliged, at the insurer's request, to inform the insurer about every new risk within one month. This request can also be made together with the premium statement. If the policyholder fails to inform the insurer on time, the insurance cover will be retrospectively cancelled for the new risk starting at the point when it arose. If the insured event takes place before the policyholder informed the insurer about the new risk, the policyholder will have to prove that the new risk did not arise prior to conclusion of the insurance and was added at a point where the notification period had not yet expired.

4.1.2 The insurer shall be entitled to demand an appropriate premium for the new risk. If there is no agreement on the amount of the premium within one month after the policyholder informed the insurer about the new risk, the insurance cover will be retrospectively cancelled for the new risk starting at the point when it arose.

4.2 From the point when new risks arise until an agreement is made in accordance with clause 4.1.2, the insurance cover for new risks will be limited to € 500,000 for personal injury and € 150,000 for property damage.

4.3 Automatic extension of cover does not apply for risks

4.3.1 arising from ownership, possession, keeping or operation of motor vehicles, aircraft or watercraft, insofar as these vehicles require a driver's license and are subject to approval and insurance;

4.3.2 arising from ownership, possession, operation or driving of trains;

4.3.3 that are subject to compulsory insurance or the duty to provide for sufficient cover;

4.3.4 that will be in place for less than a year and therefore need to be covered within short-term insurance contracts.

5. Insurance benefits / insurer's power of attorney

5.1 The insurance cover includes determination of liability, the defense against unjustified claims for compensation and the policyholder's release from justified claims for compensation. Claims for compensation are justified if the policyholder is obliged under law, final judgment, acknowledgement or settlement to pay compensation and if the insurer is bound to this. Acknowledgements and settlements that the policyholder made or accepted without the insurer's consent are only binding for the insurer insofar as the claim would also have been valid without an acknowledgement or settlement. If the policyholder's liability for damages has been determined with binding effect on the insurer, the latter has to release the policyholder from the third party's claim within two weeks.

5.2 The insurer is authorized to provide any statement on the policyholder's behalf he deems necessary to settle or defend against claims for compensation. In case of a dispute about claims for compensation against the policyholder within an insured event, the insurer is authorized to conduct the case on behalf of the policyholder and at the insurer's expense.

5.3 If the appointment of a defense counsel for the policyholder is desired or approved by the insurer in criminal proceedings because of a loss event that might cause a liability claim under the insurance cover, the insurer will bear the costs of the defense counsel in accordance with the fees regulations or the separately arranged additional costs.

5.4 If the policyholder or a co-insured person gains the right to demand the cancellation or reduction of a payable annuity, the insurer is authorized to exercise this right.

6. Benefit limitations

6.1 The insurer's compensations are limited for every insured event to the agreed sums insured. This shall also apply if the insurance cover includes several persons obliged to pay compensations.

6.2 Unless otherwise agreed, the insurer's compensations are limited for all insured events within an insurance year to twice the amount of the agreed sums insured.

6.3 Several insured events taking place during the validity of the insurance policy are deemed as a single insured event that occurred during the first of these insured events if they are based on

- the same cause,
- the same causes and if there was an internal, in particular material and temporal, coherence or
- the delivery of goods with the same defects.

6.4 Where separately agreed, the policyholder will contribute to the compensation in every insured event with an amount stipulated in the insurance policy and its addendums (deductible). Unless otherwise agreed, the insurer is also obliged in these cases to carry out the defense against unjustified claims for compensation.

6.5 The insurer's expenses for costs incurred will not be set off against the sums insured.

6.6 If the justified liability claims from one insured event exceed the sum insured, the insurer will bear the legal costs in the relation the sum insured has to the total amount of these claims.

6.7 If the policyholder has to pay annuity to the injured party and if the capital value of the annuity exceeds the

sum insured or the rest of the sum insured after deduction of other benefits from the insured event, the insurer will only reimburse the payable annuity in the relation the sum insured or its rest has to the capital value of the annuity. The calculation of the annuity will take place in accordance with the regulation on the insurance cover in vehicle liability insurance in its version valid at the time of the insured event. When calculating the amount the policyholder needs to contribute to ongoing annuity payments, if the capital value of the annuity exceeds the sum insured or the rest of the sum insured after deduction of other benefits from the insured event, any other benefits will be set off against the sum insured in full.

6.8 Where the insurer requests the handling of a liability claim by acknowledgement, satisfaction or settlement and the claim cannot be handled because of the policyholder's behavior, the insurer is not obliged to pay for the additional expenses in the form of compensations, interest and costs resulting from the insured person's refusal.

7. Exclusions

Unless otherwise agreed in the policy and its addendums, the insurance policy comes with the following exclusions:

7.1 Insurance claims of all persons who intentionally caused the damage.

7.2 Insurance claims of all persons who caused the damage by

- placing goods on the market or
- carrying out works or other services

in knowledge of their defectiveness or harmfulness.

7.3 Liability claims that exceed the scope of the policyholder's statutory liability because of a contract or pledge.

7.4 Liability claims

7.4.1 of the policyholder or of the persons listed in clause 7.5 against co-insured persons,

7.4.2 between several policyholders of the same insurance contract,

7.4.3 between several additional insured persons of the same insurance contract. The above listed exclusions also extend to liability claims by relatives of the persons cited therein if they live in a joint household.

7.5 Liability claims against the policyholder

7.5.1 from claims of the policyholder's relatives who live with the policyholder in cohabitation or are co-insured persons as named in the insurance contract. Relatives are spouses, life partners in accordance with the Law on Civil Partnership or similar partnerships in accordance with the laws of other countries, parents and children, adoptive parents and children, parents-in-law and children-in-law, stepparents and stepchildren, grandparents and grandchildren, siblings as well as foster parents and children (persons connected by a family-like relationship set out for the long term such as parents and children);

7.5.2 of the policyholder's legal representatives or advisers if the policyholder is a legally incompetent person, a person with limited legal capacity or a person under care;

7.5.3 of the policyholder's legal representatives if the policyholder is a legal entity under private or public law or an association without legal capacity;

7.5.4 of the policyholder's partners with unlimited personal liability if the policyholder is a partnership, limited partnership or civil partnership;

7.5.5 of the policyholder's partners if the policyholder is a registered professional partnership;

7.5.6 of the policyholder's liquidators, receivers and insolvency administrators.

7.5.7 The exclusions under clause 7.5.2 to 7.5.6 also include liability claims of relatives of the persons mentioned therein and living in cohabitation with them.

7.6 Liability claims for damage to third-party property and any resulting financial loss where the policyholder rented, leased or borrowed the property or acquired the property through unlawful interference or if they are the matter of a separate deposit contract.

If the requirements for the exclusions are met in the person of the policyholder's salaried employees, workers, servants, authorized agents or representatives, the insurance cover shall likewise cease for both the policyholder and for other co-insured persons under the insurance contract.

7.7 Liability claims for damage to third-party property and any resulting financial loss if

7.7.1 the damage is a result of the policyholder's commercial or professional work with said property (processing, repair, transport, inspection and the like); in case of immovable property this exclusion only applies if the property or parts thereof were immediately affected by the activity;

7.7.2 the damage was caused because the policyholder used the property to enable his / her commercial or professional activities (as a tool, aid, storage surface for material and the like); in case of immovable property this exclusion only applies if the property or parts thereof were immediately affected by the use;

7.7.3 the damage was caused by the policyholder's commercial or professional activity and if the property or – in the case of immovable property – parts thereof were situated in the area directly affected by the activity; this exclusion shall not apply if the policyholder can prove that, at the time of the activity, he / she had taken necessary protective measures to prevent damages.

If the requirements for the above exclusions are met in the person of the policyholder's salaried employees, workers, servants, authorized agents or representatives, the insurance cover shall likewise cease for both the policyholder and for other co-insured persons under the insurance contract.

7.8 Liability claims for damage to goods, works or other services produced, provided or delivered by the policyholder as a result of their production, delivery or service and any resulting financial loss. This shall also apply if the damage was caused by a defective part of the object or by a defective partial performance resulting in the object or service being damaged or destroyed. This exclusion is also applied if a third party produced or delivered the objects or carried out the works or other services on the policyholder's behalf and for the policyholder's account.

7.9 Liability claims from loss events happening abroad; claims in accordance with § 110 Social Code VII are also covered.

7.10 Liability claims for damages from environmental effects. This also includes damage caused by fire and / or explosion. This exclusion shall not apply

- a) within insurance of personal liability risks;
- b) to damages arising from products manufactured or supplied by the policyholder (including waste), or from work or other services following performance of the service or completion of the work (product liability).

There is, however, no insurance cover for damages from environmental effects as a result of planning, production, delivery, assembly, dismantling, repair or maintenance of

- installations intended for the production, processing, storage, depositing, conveying or disposal of substances harmful to waterways (Waterways Act [WHG] installations);
- installations in accordance with appendix 1 or 2 to the Environment Liability Law (UmweltHG installations);
- installations for the purpose of environmental protection that need to be authorized or notified in accordance with environmental protection regulations;
- waste water installations or parts which are evidently intended for such installations.

7.11 Liability claims for damages from asbestos or substances or products containing asbestos.

7.12 Liability claims for damages directly or indirectly connected to energy-rich ionizing radiation (e. g. radiation emitted from radioactive substances or X-ray radiation).

7.13 Liability claims for damages from

7.13.1 genetic engineering,

7.13.2 genetically modified organisms (GMOs),

7.13.3 products that

- contain parts of GMOs,
- were produced from or with the aid of GMOs.

7.14 Liability claims from property damage caused by

7.14.1 sewage, insofar as domestic sewage is not involved,

7.14.2 subsidence of land or landslides,

7.14.3 flooding caused by standing or flowing water.

7.15 Liability claims for damages arising from the exchange, transmission or provision of electronic data, where such damages result from

7.15.1 deletion, suppression, spoiling or alteration of data,

7.15.2 failure to capture or faulty storage of data,

7.15.3 disruption of access to electronic data interchange,

7.15.4 transmission of confidential data or information.

7.16 Liability claims for damages arising from violations of personal rights or name rights.

7.17 Liability claims for damages due to hostility, vexatious harassment, unequal treatment or other discrimination.

7.18 Liability claims for personal injury arising from the transmission of a disease by the policyholder. The same applies for property damage arising from the illness of animals the policyholder owns, keeps or sells. In both cases, insurance cover is provided if the policyholder proves that he / she did not act with intent or gross negligence.

Start of insurance cover / Payment of premium

8. Start of insurance cover / Premium and insurance tax

The insurance cover starts on the date stipulated in the insurance policy if the policyholder pays the first or single premium on time in accordance with clause 9.1. All invoiced premiums include insurance tax, the amount of which being stipulated by law and payable by the policyholder.

9. Payment and consequences of late payment / First or single premium

9.1 The first or single premium is due immediately on taking out the insurance policy, but not prior to the start of insurance cover. If payment of the annual premium in installments was agreed, only the first installment of the first annual premium shall be deemed to be the first premium.

9.2 If the policyholder fails to pay the first or single premium on time but pays at a later point in time, the insurance cover only starts from this later point in time. This shall not apply if the policyholder proves that he / she was not responsible for non-payment. In case of insured events that occur prior to payment of the premium, the insurer is only exempt from his liability to pay if he informed the policyholder about this legal consequence of non-payment of the premium by separate written notification or by placing a prominent notice in the insurance policy.

9.3 If the policyholder fails to pay the first or single premium on time, the insurer is authorized to withdraw from the contract until the policyholder makes the payment. The insurer is not allowed to withdraw if the policyholder proves that he / she is not responsible for non-payment.

9.4 If the first premium is not paid on time, the policyholder is considered to be in default 30 days after the expiry of the revocation period of 14 days as set out in the insurance certificate and after receipt of a request for payment, unless the policyholder is not responsible for the delayed payment. The insurer is entitled to request compensation for the loss incurred through the delay.

10. Payment and consequences of late payment / Renewal premium

10.1 If not otherwise agreed, the renewal premiums are due on the first day of the month of the agreed premium period. The payment shall be considered to be made on time if it is made at the point in time stipulated in the insurance policy or the premium statement.

10.2 Failure to pay a renewal premium on time shall constitute default without reminder unless the policyholder is not responsible for the late payment.

The insurer will send the policyholder a written request for payment with a set payment period of at least two weeks. Failure to pay a renewal premium on time authorizes the insurer to set a payment period of at least two weeks in text form and at the policyholder's expense. This provision is only valid if it provides details on the backlog of payments consisting of premium, interest and costs and informs about the legal consequences of expiry of the period in accordance with clause 10.3 and 10.4. The insurer is entitled to request compensation for the loss incurred through the delay.

10.3 If the policyholder is still in default of payment after expiry of the deadline, there will be no insurance cover from this point until payment is received, provided that the insurer informed the policyholder respectively in his request for payment according to clause 10.2 par. 2.

10.4 If the policyholder is still in default of payment after expiry of the deadline, the insurer can cancel the contract without notice provided that he informed the policyholder respectively in his request for payment according to clause 10.2 par. 2. Cancellation can also be announced when determining the payment deadline. In this case, the cancellation takes effect on expiry of the payment period if the policyholder is still in default with the payment at this time. This must be pointed out to the policyholder in the request for payment in accordance with clause 10.2 par. 2.

If the insurer has cancelled the contract and the policyholder pays the requested amount within one month after the cancellation, the contract remains in effect. There is, however, no insurance cover for insured events that occurred between the receipt of the cancellation and the payment.

11. Timeliness of payment in case of a direct debit mandate

Where the policyholder has issued a direct debit mandate, the payment shall be deemed on time if the premium can be collected on the due date and if the policyholder does not object to a justified debit. Where the insurer cannot collect the due premium through no fault of the policyholder, the payment shall also be deemed on time if it is made immediately after the insurer has sent the policyholder a written request for payment. Where the insurer cannot collect a due premium because the policyholder has revoked the direct debit mandate or if he / she is otherwise responsible that the premium could not be collected, the insurer is authorized to demand future payments be made outside the direct debiting system. The policyholder is only obliged to pay the premium when the insurer has sent him / her a written request for payment.

12. Partial payment and consequences of late payment

Where payment of the annual premium in installments has been agreed, any outstanding installments are due immediately if the policyholder is in default with the payment of an installment. The insurer may also require the premium to be paid annually in the future.

13. Premium adjustment

13.1 At the insurer's request, the policyholder is obliged to tell the insurer whether and what changes have been made to the insured risk compared with earlier information. This request may also be made by means of a note on the premium statement. The information must be provided within one month after the request was received, with proof being furnished should the insurer so require. Where incorrect information is given to the insurer's disadvantage, he shall be entitled to demand from the policyholder a contractual penalty of three times the amount of the difference in premium ascertained. This shall not apply where the policyholder proves that he/she is not responsible for the information being incorrect.

13.2 The premium shall be corrected from the time of the change (premium adjustment) on the basis of the policyholder's change notice or other findings; where insured risks cease to exist, however, the premium will only be adjusted from the time when the insurer receives the notification. The resulting adjusted premium may not fall below the contractually agreed minimum premium. Any increases and reductions in the minimum premium occurring in accordance with clause 15.1 after conclusion of the insurance contract shall be taken into account.

13.3 Should the policyholder fail to issue the notification on time, then for the period for which the information was to be given the insurer may demand an additional payment amounting to the premium already charged for that period. Where the policyholder subsequently provides the information, a premium adjustment shall take place. Any premium that the policyholder has overpaid shall only be reimbursed if the information was supplied within two months following receipt of the notification about the increased premium.

13.4 The above provisions shall also apply to insurance policies for which the premium is paid in advance for several years.

14. Premium in case of early contract cancellation

Where the contract is cancelled early, unless otherwise provided by law, the insurer shall be entitled to only that portion of the premium corresponding to the period during which insurance cover was in force.

15. Premium rate adjustment

15.1 Insurance premiums are subject to premium rate adjustment. Where premiums are calculated on the basis of payroll, contract price or amount of turnover, there shall be no premium rate adjustment. Regardless of the way in which premiums are calculated, minimum premiums shall be subject to premium rate adjustment.

15.2 An independent trustee shall determine each year, with effect for the premiums due from July 1, the percentage by which the average of the claims payments made in the past calendar year by all insurers licensed

to transact general liability insurance has increased or decreased compared to the previous year. The trustee shall round down the percentage determined to the next lower whole number divisible by five. Where an individual loss leads to special expenses being incurred in order to determine the basis and amount of indemnity, such expenses shall also be deemed to be claims payments. The average of the claims payments made in any one calendar year shall be the sum of the claims payments made in that year, divided by the number of new loss events reported over the same period.

15.3 In the event of an increase the insurer shall be entitled – and in the event of a reduction obliged – to adjust the premium for the following year by the percentage obtained from clause 15.2 (premium rate adjustment). The policyholder will be notified of the change to the premium for the following year with the next premium statement. Where the average level of the insurer's claims payments has increased in each of the last five calendar years by a lower percentage than that determined by the trustee for any of these years in accordance with clause 15.2, the insurer may increase the premium for the following year only by the percentage by which the average of the insurer's claims payments has increased in the last calendar year based on his own company figures; this increase may not exceed the one that would result under the previous paragraph.

15.4 Where the change in accordance with clauses 15.2 or 15.3 is less than five percent, there shall be no premium rate adjustment. Such change shall, however, be taken into account in subsequent years.

Duration and end of contract / Cancellation

16. Duration and end of contract

16.1 The contract is concluded for the period stipulated in the insurance policy.

16.2 Where a policy period of at least one year is agreed, the policy shall be renewed after expiry of the agreed period for a further year in each case unless the contract partner has received a cancellation at least three months prior to the expiry of the respective insurance year.

16.3 Where a policy period of less than one year is agreed, the policy shall end at the stipulated time without any notice of cancellation being required.

16.4 Where a policy period of more than three years is agreed, the contract may already be cancelled at expiry of the third year or of any subsequent year; the notice of cancellation must reach the contract partner at least three months prior to the expiry of the respective insurance year.

17. Cessation of the insured risk

Where risks cease to exist in part, in full or permanently, the respective insurance shall cease to apply. In this case, the insurer shall be entitled to the premium that he could have charged if insurance of these risks had been applied for only up to the time when the insurer became aware of their cessation.

18. Cancellation after a premium rate adjustment

Where the premium increases as a result of the premium rate adjustment in accordance with clause 15.3, without a change in the insurance cover, the policyholder may cancel the policy within one month of receiving the insurer's notification. The cancellation shall be effective immediately, but at the earliest from the time that the premium increase should have taken effect.

The insurer is obliged to inform the policyholder in the notification about the right of cancellation. The notification must reach the policyholder at least one month before the premium increase takes effect. An increase in insurance tax shall not establish any right of cancellation.

19. Cancellation following an insured event

19.1 The insurance contract may be cancelled where

- the insurer has made a compensation payment or
- the policyholder – in case of compulsory insurance the insurer – is served a legal writ in respect of a liability claim falling under the cover. The notice of cancellation must have reached the contract partner in text form at least one month after the compensation payment or the service of the writ.

19.2 If the policyholder cancels the insurance contract, his / her cancellation will take effect immediately after the insurer receives it. The policyholder may, however, stipulate that the cancellation shall take effect at a later date, though no later than the end of the current insurance period. If the insurer cancels the insurance contract, his cancellation shall take effect one month after the policyholder receives it.

20. Cancellation after sale of insured companies

20.1 Where a company for which liability insurance exists is sold to a third party, that party shall for the duration of its ownership be subrogated in the policyholder's place to the rights and obligations arising from the insurance contract. This shall also apply where a company is taken over by a third party as a result of a beneficial interest, lease agreement or similar relationship.

20.2 In this case, the insurance contract may be cancelled in text form

- by the insurer vis-à-vis the third party, subject to one month's notice,
- by the third party vis-à-vis the insurer, with immediate effect or at the end of the current insurance period.

20.3 The right of cancellation shall lapse when

- the insurer fails to exercise it within one month from the time he learns of the transfer to the third party;
- the third party fails to exercise it within one month following the transfer, with the right of cancellation continuing to exist for one month from the time when the third party becomes aware of the insurance.

20.4 Where the transfer to the third party happens during the current insurance period and the insurance contract is not cancelled, the previous policyholder and the third party shall be jointly and severally liable for the insurance premium for this period.

20.5 Where a company is transferred, the existing policyholder or the third party must notify the insurer of this immediately. Where the duty of disclosure is culpably breached, no cover shall apply in cases where an insured event occurs more than one month after the time when the insurer ought to have received the notification and the insurer would not have concluded with the purchaser the contract that existed with the seller.

The insurance cover shall be reinstated and shall apply for all insured events occurring no earlier than one month after the time when the insurer became aware of the sale. This shall apply only where the insurer has not made use of his right of cancellation in that month.

The insurance cover shall not cease, despite breach of the duty of disclosure, in cases where the insurer was aware of the sale at the time when he ought to have received the notification.

21. Cancellation after increase in risk as a result of a change in the existing legal regulations or the enactment of new ones

Where there is an increase in the insured risk as a result of a change in the existing legal regulations or the enactment of new ones, the insurer shall be entitled to cancel the insurance contract subject to a period of notice of one month. The right of cancellation shall cease if it is not exercised within one month from the time when the insurer becomes aware of the increase.

22. Multiple insurance

22.1 Multiple insurance exists where the risk is covered under several insurance contracts.

22.2 Where multiple insurance has come about without the policyholder's knowledge, he / she can ask for cancellation of the policy that was later arranged.

22.3 The right to cancel shall cease if the policyholder fails to assert it within one month of learning of the multiple insurance. The cancellation shall take effect when the insurer receives the declaration in which it is requested.

Obligations of the policyholder

23. Pre-contractual duties of disclosure of the policyholder

23.1 Providing complete and true information about risk-related circumstances

The policyholder is obliged, by the time he / she issues his / her contract statement, to provide complete and true information about all risk-related circumstances known to him / her about which the insurer has asked him / her in text form and which are material to the insurer's decision to arrange the policy with the agreed content. If the insurer asks questions within the meaning of the first sentence of this paragraph in text form after the policyholder's contract statement has been issued but before the contract has been accepted, the policyholder shall also be obliged to answer them. Risk-related circumstances are those circumstances that are material to the insurer's decision to arrange the policy at all or with the agreed content. Where a representative is acting for the policyholder and is aware of the risk-related circumstances, the policyholder shall be treated as if he / she himself / herself had known about it or had fraudulently concealed the fact.

23.2 Withdrawal

23.2.1 Where incomplete and incorrect information about risk-related circumstances is given, the insurer shall be entitled to withdraw from the insurance contract. This shall also apply if no information or incorrect information was given on a fact because the policyholder fraudulently concealed knowledge of the truth. Withdrawal can only take place within one month. The deadline begins at the time the insurer becomes aware of the breach of the duty of disclosure. Withdrawal takes place by way of a declaration vis-à-vis the policyholder.

23.2.2 The insurer has no right of withdrawal if the policyholder proves that he / she or his / her representative neither acted with intent nor with gross negligence when providing incorrect or incomplete information. The insurer has no right of withdrawal due to a grossly negligent breach of the duty of disclosure if the policyholder proves that the insurer would also have concluded the contract, although with different terms and conditions, had he known about the non-disclosed circumstances.

23.2.3 There will be no insurance cover in case of withdrawal. Where the insurer withdraws from the contract after the occurrence of an insured event, he is obliged to provide insurance cover if the policyholder proves that the circumstance about which he / she provided incorrect or incomplete information was not the reason for either the occurrence of the insured event or the ascertainment or extent of the benefits. There will be, however, no insurance cover in such a case if the policyholder fraudulently breached the duty of disclosure. The insurer is entitled to the part of the premium that relates to the contract period before the notice of withdrawal entered into effect.

23.3 Premium adjustment or right of cancellation

Where the insurer has no right of withdrawal because a breach of the duty of disclosure was caused neither by intent nor by gross negligence, the insurer shall be entitled to cancel the insurance contract in text form subject to a period of notice of one month. The insurer has no right of cancellation if the policyholder proves that the insurer would also have concluded the contract, although with different terms and conditions, had he known about the non-disclosed circumstances.

Where the insurer cannot withdraw from the contract or cancel the contract because he would also have concluded the contract, although with different terms and conditions, had he known about the non-disclosed circumstances, the remaining terms and conditions retrospectively become part of the contract at the insurer's request. If the policyholder is not responsible for the breach of obligation, the remaining terms and conditions become part of the contract from the current insurance period on.

If the insurer increases the premium by more than 10 % due to alteration of the contract or if he excludes cover for the non-disclosed circumstance, the policyholder may cancel the contract in text form and without notice within one month after he / she received our notification.

The insurer has to assert his rights in accordance with clause 23.2 and 23.3 within one month in text form.

The period starts when the insurer becomes aware of the breach of the duty of disclosure that justifies his asserted right. The insurer is obliged to state the circumstances his statement is based on; within one month, the insurer can also subsequently state other circumstances to justify his statement.

The insurer is only entitled to the rights in accordance with clause 23.2 and 23.3 if he has drawn the policyholder's attention to the consequences of a breach of the duty of disclosure in text form by means of a separate notification. The insurer cannot invoke the rights stipulated in clause 23.2 and 23.3, if he was aware of the non-disclosed risk-related circumstance or the incorrectness of the disclosed information.

23.4 Cessation of rights of the insurer

The rights of the insurer in accordance with clause 23.2 and 23.3 cease with expiry of a period of five years after conclusion of the contract; this does not apply for insured events that occurred prior to the expiry of this period. The period has a duration of ten years if the policyholder or his / her representative intentionally or fraudulently breached the duty of disclosure.

23.5 Rescission

The insurer's right to rescind the contract due to fraudulent misrepresentation remains unaffected. In case of rescission, the insurer is entitled to the part of the premium that relates to the contract period before the declaration of rescission entered into effect.

24. Obligations prior to occurrence of the insured event

At the insurer's request, the policyholder must eliminate any particularly risk-related circumstances within a reasonable period of time. This shall not apply where, considering the parties' interests, elimination would be unreasonable. A circumstance that has led to a loss shall automatically be deemed to be particularly risk-related.

25. Obligations after occurrence of the insured event

25.1 The policyholder is obliged to notify the insurer immediately about every insured event, even if no claims for compensation have yet been made.

25.2 The policyholder must take steps to avert and minimize loss wherever possible. The policyholder must follow the insurer's instructions in this respect insofar as it is reasonable for him / her to do so. The policyholder is obliged to provide the insurer with detailed, truthful loss reports and assist the insurer with claims assessment and settlement. The insurer must be notified of all circumstances that in his view are important for processing the claim and any documents requested for this purpose must be forwarded.

25.3 The policyholder must likewise notify the insurer immediately if a liability claim is made against him / her, public prosecution, official or judicial proceedings are instituted against him / her, a summary notice to pay is issued, or a third party legal notice is served on the policyholder.

25.4 The policyholder must object to any summary notice to pay or any compensation order issued by the administrative authorities within the time specified, or lodge any other appeals that may be necessary. No instructions from the insurer will be required for this.

25.5 Where a liability claim is asserted against the policyholder through court action, he / she must leave the conduct of the case to the insurer. The insurer will engage a lawyer on the policyholder's behalf. The policyholder must grant the lawyer power of attorney and provide him with all necessary information and make the requested documents available to him.

26. Legal consequences in case of breach of obligations

26.1 Where the policyholder breaches an obligation arising from this contract that he / she has to fulfill prior to the occurrence of the insured event, the insurer may cancel the contract without notice and within one month after becoming aware of the breach of obligation. The insurer has no right of cancellation if the policyholder proves that the breach of obligation was neither caused by intent nor by gross negligence.

26.2 Where the policyholder intentionally breaches an obligation arising from this contract, he / she will lose his / her insurance cover. In case of a grossly negligent breach of obligations, the insurer is entitled to reduce his benefits according to the severity of the policyholder's fault.

For the policyholder to lose the insurance cover in full or in part when the breach of the obligation to provide information happened after the occurrence of the insured event, it is necessary that the insurer informed the policyholder about this legal consequence by separate written notification.

Where the policyholder proves that he / she did not breach the obligation with gross negligence, the insurance cover will continue. Insurance cover will also continue if the policyholder provides evidence that the breach of obligation was neither the cause for the occurrence or determination of the insured event nor for the determination or scope of the benefits the insurer is obliged to pay. This shall not apply if the policyholder fraudulently breached the obligation. The above conditions apply irrespective of the question if the insurer makes use of the right of cancellation that he is entitled to in accordance with clause 26.1.

Further provisions

27. Co-insured persons

27.1 Where the insurance also extends to liability claims against persons other than the policyholder, all provisions applying to the policyholder shall also be applicable to those insured persons accordingly. The provisions on automatic extension of cover (clause 4) shall not apply where the new risk arises only for a co-insured person.

27.2 The policyholder alone shall be entitled to exercise the rights arising from the insurance contract. The policyholder shall remain responsible along with the co-insured persons for fulfilling the obligations.

28. Non-assignment

Without the insurer's consent, the right of indemnity may be neither assigned nor pledged before it has been finally determined. Assignment to the injured third party is permissible.

29. Notifications, declarations of intent, change of address

29.1 All notifications and declarations intended for the insurer are to be directed to the insurer's head office or to the responsible branch office as stipulated in the insurance policy or its addendums.

29.2 Where the policyholder has failed to notify the insurer of a change in his / her address, the posting of a registered letter to the last address known to the insurer under the last name known to the insurer shall suffice for the purposes of submitting any declaration of intent to the policyholder. The declaration shall be deemed received three days after the letter is sent. The same shall apply in case of a change of the policyholder's name.

29.3 Where the policyholder has purchased insurance for his / her business establishment, clause 29.2 shall apply analogously to any relocation of the business establishment.

30. Statute of limitations

30.1 Any claims arising from the insurance contract are subject to a limitation period of three years. The period is calculated in accordance with the general conditions of the German Civil Code (BGB).

30.2 Where the policyholder has reported a claim under the insurance contract to the insurer, the limitation period shall be suspended from the report up to the time when the claimant receives the insurer's decision in text form.

31. Competent court

31.1 For actions against the insurer arising from the insurance contract, the competent court depends on the insurer's head office or branch office responsible for the insurance contract. Where the policyholder is a natural person, local responsibility also lies with the court in whose district the policyholder has his / her residence or, in the absence of such, his / her habitual residence at the time the action is brought.

31.2 Where the policyholder is a natural person, actions against the policyholder arising from the insurance contract need to be brought before the court responsible for his / her residence or, in the absence of such, his / her habitual residence. Where the policyholder is a legal entity, the competent court shall also be determined by the registered office or branch office of the policyholder. The same shall apply if the policyholder is a partnership, limited partnership, civil partnership or registered partner company.

31.3 Where the policyholder's residence or habitual residence is unknown at the time the action is brought, the competent court for actions arising from the insurance contract against the policyholder depends on the registered office of the insurer or its branch office responsible for the insurance contract.

32. Applicable law

German law applies to this contract.

33. Sanction clause

Irrespective of the other contractual provisions, insurance cover only exists if and as long as there are no economic, trade or financial sanctions or embargoes of the European Union or the Federal Republic of Germany that are directly applicable to the contracting parties.

This also applies to economic, trade or financial sanctions or embargoes by the United States of America, provided they do not conflict with the legal provisions of the European Union or the Federal Republic of Germany.

General Accident Insurance Conditions of Dialog Versicherung AG (AUB 2008)

§ 1 Insured event

I. The insurer provides insurance cover for accidents of insured persons during the validity of the contract. The types of benefits which can be insured are set out in § 7; the application and insurance certificate each show which types of benefits can be agreed in the policy.

II. The insurance policy covers accidents all around the world.

III. An accident shall be deemed to have occurred when the insured person has involuntarily suffered damage to his / her health due to an event (an accident) having a sudden effect on his / her body from the outside.

IV. An accident shall also be deemed to have occurred when, as a consequence of increased physical exertion to limbs or extremities or the spine,

1. a joint is dislocated or
2. muscles, tendons, ligaments or capsules are stretched, strained or torn.

§ 2 Exclusions

The following is not covered by the insurance:

I.

1. Accidents caused by mental illness or cognitive disorders, including those due to drunkenness, and strokes or seizures, epileptic fits or other spasmodic fits affecting the whole body of the insured person. Cover shall be granted, however, if such disorders, derangement, fits or paroxysms were caused by an accident under this policy.

2. Accidents that befall the insured person as a consequence of the insured person intentionally carrying out or attempting to carry out a criminal offense.

3. Accidents directly or indirectly caused by war or civil war. There is, however, insurance cover if the insured person faces sudden and unexpected war or civil war during his / her journeys abroad. Such insurance cover expires at the end of the 14th day after the outbreak of war or civil war in the country where the insured person stays.

This expansion of cover does, however, not apply to trips in or through countries on whose territory war or civil war is already underway when the trip begins. It also does not apply to active participation in the war or civil war or to accidents caused by ABC weapons (atomic, biological or chemical weapons) and in connection with war or warlike events between the following countries: China, Germany, France, United Kingdom, Japan, Russia or USA. In case of acts of terror committed outside the territories of warring parties, the insurer will not invoke this exclusion.

Accidents due to unrest if the policyholder participated on the side of those instigating the unrest.

4. Accidents suffered by the insured person

a) as the pilot of an aircraft (including recreational aircraft) to the extent that this activity requires a permit under German law and as a member of the crew of an aircraft;

b) during professional activities for which an aircraft is necessary;

c) when using spacecraft.

5. Accidents suffered by the insured person as a result of taking part in driving events, including the corresponding practice runs, with the aim of achieving high speeds as a driver, co-driver or passenger of a motor vehicle.

6. Accidents caused directly or indirectly by nuclear power.

II.

1. Health damage caused by radiation.

2. Health damage caused by therapeutic treatments or surgery, which the policyholder carries out or has carried out on his / her body. However, this exclusion does not apply if therapeutic treatments or surgery, including radiodiagnostic and radio-therapeutic treatment or surgery, is carried out as the result of an accident covered by this insurance.

3. Infections

Insurance cover is provided if the disease pathogens entered the body through an accident injury covered by this policy. Accident injuries do not include skin or mucous membrane injuries, which are minor as such, and via which disease pathogens immediately or subsequently enter the body; this restriction does not apply to rabies and tetanus. For infections caused by treatment measures, clause 2. par. 2 applies accordingly.

4. Poisoning as a result of taking solid or liquid substances via the gullet.

III.

1. Stomach or lower abdominal hernias.

However, insurance cover is provided if they have occurred through a violent external effect covered by this policy.

2. Damage to spinal discs as well as bleeding from internal organs and cerebral hemorrhage unless directly caused by an accident event covered by this insurance in accordance with § 1 III.

IV.

Pathological disorders as a result of psychological reactions, irrespective of their cause.

§ 3 Uninsurable persons

I. Persons are uninsurable if their independence or abilities are restricted due to medical reasons so that they are permanently in need of care by others. These requirements are met by persons who at least classify as long-term care level 3 in accordance with German compulsory long-term care insurance (§ 15 par. 1 no. 2 German Social Code (SGB) XI in its version of 21 December 2015) due to a physical, mental or cognitive impairment with disabling effects. Even if a premium has been paid, the above mentioned group of people is not insured.

II. Insurance cover ceases as soon as an insured person is no longer insured according to § 3 section I. The insurance ends at the same time.

III. Any premium that was paid for uninsurable persons since the contract was concluded or since the persons started to be uninsurable shall be reimbursed.

§ 3a Pre-contractual duties of disclosure of the policyholder or his / her representative prior to conclusion of the contract

I.

1. The policyholder is obliged, by the time he / she issues his / her contract statement, to provide complete and true information about all risk-related circumstances known to the policyholder about which the insurer has asked him / her in text form and which are material to the insurer's decision to arrange the policy with the agreed content. If the insurer asks questions within the meaning of the first sentence of this paragraph in text form after the policyholder's contract statement has been issued but before the contract has been accepted, the policyholder shall also be obliged to answer them. Risk-related circumstances are those circumstances that are material to the insurer's decision to arrange the policy at all or with the agreed content.

2. If another person is to be insured, he / she is also obliged to provide complete and true information about all risk-related circumstances and to also answer the questions he / she is asked by the insurer.

3. Where a representative of the policyholder concludes the contract and is aware of the risk-related circumstance, the policyholder shall be treated as if he / she himself / herself had known about it or had fraudulently concealed the fact.

II.

1. Where incomplete and incorrect information about the risk-related circumstances is given, the insurer shall be entitled to withdraw from the insurance contract. The insurer has to assert his right of withdrawal within one month in text form to the policyholder. In doing so, the insurer has to name the circumstances his statement is based on. The period starts when the insurer becomes aware of the breach of the duty of disclosure that justifies his right of withdrawal.

2. The insurer has no right of withdrawal if

- a) the policyholder proves that he / she or his / her representative neither acted with intent nor with gross negligence when providing incorrect or incomplete information;
- b) the policyholder – in case of a grossly negligent breach of the duty of disclosure – proves that the insurer would also have concluded the contract, although with different terms and conditions, had he known about the non-disclosed circumstances.

3. There will be no insurance cover in case of withdrawal. Where the insurer withdraws from the contract after the occurrence of an insured event, he is obliged to provide insurance cover if the policyholder proves that the circumstance about which he / she provided incorrect or incomplete information was not the reason for either the occurrence of the insured event or the ascertainment or the extent of the benefits. There will be, however, no insurance cover in such a case if the policyholder fraudulently breached the duty of disclosure. The insurer is entitled to the part of the premium that relates to the contract period before the notice of withdrawal entered into effect.

III.

1. Where the insurer has no right of withdrawal because the policyholder's breach of the duty of disclosure was caused neither by intent nor by gross negligence, the insurer shall be entitled to cancel the insurance contract in text form subject to a period of notice of one month. In doing so, the insurer has to name the circumstances his statement is based on. The period starts when the insurer becomes aware of the breach of the duty of disclosure.

2. The insurer has no right of withdrawal if the policyholder proves that the insurer would also have concluded the contract, although with different terms and conditions, had he known about the non-disclosed circumstances.

IV. Where the insurer cannot withdraw from the contract or cancel the contract because he would also have concluded the contract, although with different terms and conditions, had he known about the non-disclosed circumstances, the remaining terms and conditions retrospectively become part of the contract at the insurer's request. If the policyholder is not responsible for the breach of obligation, the remaining terms and conditions become part of the contract from the current insurance period. If the insurer increases the premium by more than 10% due to alteration of the contract or if he excludes cover for the non-disclosed circumstance, the policyholder may cancel the contract in text form and without notice within one month after he/she received our notification.

V.

1. The insurer has to assert his rights in accordance with clause II. to IV. within one month in text form. The period starts when the insurer becomes aware of the breach of the duty of disclosure that entitles him to adjust the contract. In doing so, the insurer has to name the circumstances his statement is based on. Within one month, the insurer can also subsequently state other circumstances to justify his statement.

2. The insurer is only entitled to his rights in accordance with clause II. to IV. if he has drawn the policyholder's attention to the consequences of a breach of the duty of disclosure by means of a separate written notification.

3. The insurer cannot invoke his rights in accordance with clause II. to IV. if he was aware of the non-disclosed risk-related circumstance or the incorrectness of the disclosed information.

VI. The insurer's right to rescind the contract due to fraudulent misrepresentation remains unaffected. In case of rescission, the insurer is entitled to the part of the premium that relates to the contract period before the declaration of rescission entered into effect.

VII. The rights of the insurer in accordance with clause II. to IV. cease with expiry of a period of five years after conclusion of the contract. The period has a duration of ten years if the policyholder or his / her representative intentionally or fraudulently breached the duty of disclosure.

§ 4 Start and end of insurance cover / Right to alter a legal relationship

I. The insurance cover starts on the date stipulated in the insurance policy when the policyholder pays the first or single premium immediately after it is due in accordance with § 5 I.

II. The policy can be ended through notification in text form by one of the contracting parties

1. on expiry of the agreed period.

The notice of cancellation must be received at least 3 months before expiry; otherwise the policy is renewed for a year each time.

2. at the end of the third or each following year if a policy is taken out for the duration of more than three years. The notice of cancellation must be received by the contracting party at least three months before the expiry of the third or appropriate following year.

3. if the insurer has made a payment in accordance with § 7 or a claim has been made against him for such a payment. The notice of cancellation must be received at least one month after the payment – or, in the event of a legal dispute, after withdrawal of the claim, acceptance, settlement or legal enforcement of the decision. If the policyholder cancels the contract, his notice of cancellation comes into effect immediately after being received by the insurer. The policyholder can, however, determine that the notice of cancellation comes into effect at a later point in time, but not later than at the end of the current insurance year. A notice of cancellation by the insurer comes into effect one month after being received by the policyholder.

III. The policy ends without notice at the date stipulated in the insurance certificate if the agreed duration is less than one year.

IV. The insurance cover shall be suspended for the insured person when he / she fulfills his / her service in a military or likewise formation that participates in war or warlike operations between the countries China, Germany, France, United Kingdom, Japan, Russia or USA. The insurance cover will continue to apply as soon as the insurer receives the notification about the end of such service.

§ 5 Premiums, due date and default

I. The premiums include the relevant insurance tax and agreed additional costs. Unless otherwise agreed, the first or single premium is due immediately on taking out the insurance policy, but not prior to the start of insurance cover. If payment of the annual premium in installments was agreed, only the first installment of the first annual premium shall be deemed to be the first premium. If not otherwise agreed, the renewal premiums are due on the first day of the due month. The payment shall be considered to be made on time if it is made at the point in time stipulated in the insurance policy or the premium statement.

II. Where the policyholder has issued a direct debit mandate, the payment shall be deemed on time if the premium can be collected on the due date and if the policyholder does not object to a justified debit. Where the insurer cannot collect the due premium through no fault of the policyholder, the payment shall also be deemed on time if it is made immediately after the insurer has sent the policyholder a written request for payment. Where the insurer cannot collect a due premium because the policyholder has revoked the direct debit mandate or if he / she is otherwise responsible that the premium could not be collected, the insurer is authorized to demand future payments be made outside the direct debiting system. The policyholder is only obliged to pay the premium when the insurer has sent him / her a written request for payment.

III.

1. In the event of payment not being made on time, the provisions of §§ 37 and 38 of the German Insurance Contract Act (VVG) apply.

2. Failure to pay the first or single premium on time shall constitute default of the policyholder 30 days after expiry of the revocation period of two weeks stipulated in the insurance policy and after receipt of a request for payment, unless he / she is not responsible for the delay of payment.

3. If the policyholder fails to pay the first or single premium on time but pays at a later point in time, the insurance cover only starts from this later point in time. This shall not apply if the policyholder proves that he / she was not responsible for non-payment. In case of insured events that occur prior to payment of the premium, the insurer is only exempt from his liability to pay if he informed the policyholder about this legal consequence of non-payment of the premium by separate written notification or by placing a prominent notice in the insurance policy.

4. If the policyholder does not pay the first or single premium on time, the insurer is authorized to withdraw from the contract until the policyholder makes the payment. The insurer is not allowed to withdraw if the policyholder proves that he / she is not responsible for non-payment.

5. Failure to pay a renewal premium on time shall constitute default without reminder unless the policyholder is not responsible for the late payment.

Failure to pay a renewal premium on time authorizes the insurer to set a payment period of at least two weeks in text form and at the policyholder's expense. This provision is only valid if it provides details on the backlog of payments consisting of premium, interest and costs and informs about the legal consequences of expiry of the period.

If the policyholder is still in default of payment after expiry of the deadline, there will be no insurance cover from this point until payment is received, provided that the insurer informed the policyholder respectively in his request for payment according to clause § 5 III. No. 5 par. 2.

6. Where payment of the annual premium in installments has been agreed, any outstanding installments are due immediately if the policyholder is in default with the payment of an installment. The insurer may also require the premium to be paid annually in future.

7. In case of default, the insurer is entitled to claim compensation for the loss incurred through the default of payment.

8. If the policyholder is still in default of payment after expiry of the deadline, the insurer can cancel the contract without notice provided that he informed the policyholder respectively in his request for payment according to § 5 III. No. 5 par. 2. Cancellation may already be given at the determination of a deadline. In this case, it becomes effective upon expiry of the deadline if the policyholder is still in default of payment at this point in time. The policyholder must be explicitly informed about this provision in case of cancellation in accordance with § 5 III. No. 5 par. 2.

IV. Where the contract is cancelled early, the insurer shall be entitled to only that portion of the premium corresponding to the period during which insurance cover was in force.

V. In case of § 4 IV. (military activities), the obligation to pay premiums is suspended.

§ 6 Change of job or occupation, military service

I. The amount of the sums insured or of the premium mainly depends on the job or occupation of the insured person. The basis for calculating the sums insured as well as the premiums is the prevailing occupational classification of the insurer (for details on the classification criteria, see application documents). The policyholder is therefore obliged to inform the insurer about any change of the insured person's profession or occupation immediately. Compulsory military service, civilian service or military reserve training are not considered to be changes.

II.

1. If the policyholder's new job or occupation results in a lower premium in accordance with the insurer's rates applicable at the time of the change, these lower sums insured will be valid after the expiry of one month after the change.

2. If the calculation, however, provides higher sums insured and unchanged premiums, these shall apply as soon as the insurer becomes aware of the change, but no later than one month after the change.

3. On the policyholder's request, the insurer will continue the contract with the previous sums insured and with increased or reduced premiums, as soon as the insurer becomes aware of the change.

4. If the insurer does not offer insurance cover for a new job or occupation of the insured person, the insurer can cancel the policy within one month after becoming aware of the change. The cancellation becomes effective one month after receipt.

§ 7 Types of benefits

The agreed types of benefits and their amount (sums insured) are set out in the policy. The following conditions apply for the arising of the claim and the assessment of the benefits.

I. Disability benefit

1. If the physical or mental fitness of the insured person is permanently impaired due to an accident (disability), a claim for disability benefit from the sum insured in case of disability arises. Impairment is deemed permanent if it can be expected to last more than three years and when a change of the insured person's condition cannot be expected. Disability needs to have occurred within one year after the accident. The diagnosis thereof by a physician needs to be made and the claim thereof to be asserted to the insurer before the expiry of a deadline of another three months.

2. The benefit amount is determined by the degree of disability.

a) The following fixed degrees of disability apply – without evidence of greater or lesser disability – in the event of loss or functional incapacity of

- an arm 70 %
- an arm up until the upper part of the elbow joint 65 %
- an arm below the elbow joint 60 %

- a hand 55 %
- a thumb 20 %
- an index finger 10 %
- another finger 5 %
- a leg above the mid-thigh 70 %
- a leg up to the mid-thigh 60 %
- a leg below the knee 50 %
- a leg up to the middle of the lower leg 45 %
- a foot 40 %
- a big toe 5 %
- other toes 2 %
- an eye 50 %
- hearing in one ear 30 %
- sense of smell 10 %
- sense of taste 5 %

b) Upon partial loss or partial loss of use of any of these parts of the body or sensory organs, the corresponding proportion of the percentage in accordance with a) is assumed.

c) If through the accident parts of the body or sensory organs are affected, the loss or functional impairment of which is not set out in a) or b), the decisive aspect is the extent to which normal physical or mental performance is impaired from an exclusively medical point of view.

d) If through the accident several physical or mental functions are impaired, the degrees of disability in accordance with 2. are added together. However, more than 100 % is not accepted.

3. If through the accident a physical or mental function is affected, which was already permanently impaired prior to the accident, a deduction in accordance with the degree of this pre-existing disability is made. This is assessed in accordance with 2.

4. If death occurs within one year of the accident as a result of the accident, disability benefits cannot be claimed.

5. If the policyholder dies within one year after the accident from causes unrelated to the accident – irrespective of what caused the death – and if a claim for disability benefits in accordance with 1. had arisen, payment is made in accordance with the degree of disability that could have been anticipated on the basis of the most recent medical findings.

II. Transition payment

If after the end of a period of six months of the accident and without the joint effect of illnesses or disabilities there is still accident-related impairment of the normal physical or mental performance both at work and outside work of more than 50 percent and if this impairment has existed until then without interruption, the transition payment agreed in the policy is paid. Appropriate claims can be asserted in accordance with § 9 VI.

III. Daily allowance

1. If the accident leads to impairment of the ability to work, a daily allowance is paid for the duration of medical treatment. The daily allowance is graded in accordance with the degree of impairment. Assessment of the degree of impairment depends on the job or occupation of the policyholder.

2. The allowance is paid for a maximum of one year, calculated from the day of the accident.

IV. Daily hospital allowance

1. A daily hospital allowance is paid for each calendar day the policyholder is receiving medically necessary inpatient treatment at a hospital, but only for a maximum of two years calculated as of the day of the accident.

2. Daily hospital allowance is not paid for stays in sanitariums, rehabilitation centers or health resorts.

V. Convalescence allowance

1. For the same number of calendar days for which the policyholder has received accident-related daily hospital allowance, he / she receives convalescence allowance amounting to the insured daily hospital allowance, but for a maximum duration of 4 weeks per accident.

2. Several full admissions to a hospital as a result of the same accident count as one uninterrupted stay at a hospital.

3. Convalescence allowance can be claimed on discharge from hospital.

VI. Death benefits

If the accident results in death within one year, payment of the sum insured in the event of death can be claimed. Appropriate claims can be asserted in accordance with § 9 VI.

§ 8 Benefit restrictions

If illnesses or disabilities have also contributed to the health damage brought about by an accident or to the consequences thereof, the payment is reduced in accordance with the proportion of the illness or disability if this proportion is at least 25 %.

§ 9 Obligations after the occurrence of an accident

I. After an accident which is expected to result in a claim a physician must be consulted immediately and the insurer must be informed immediately. The insured person must observe the physician's directions and must also help to reduce the consequences of the accident if possible.

II. The accident report form forwarded by the insurer must be completed truthfully and returned to the insurer immediately. Any other information requested in relation to the matter must also be provided immediately.

III. The insured person must allow himself / herself to be examined by the physicians appointed by the insurer. The costs of this, including the resulting loss of earnings, shall be borne by the insurer.

IV. The physicians who have examined or treated the insured person (also for other reasons), other insurers, insurance carriers and authorities must be empowered to provide all required information.

V. The policyholder shall be obliged to claim the transition payment at the latest seven months after the occurrence of the accident and substantiate it with a medical report.

VI. If the accident results in death, this must be notified within 48 hours, even if the accident has already been reported. The insurer must be granted the right to have a post-mortem carried out by a physician appointed by the insurer.

§ 10 Consequences of a breach of obligations

An intentional breach of an obligation to be fulfilled after the occurrence of an accident or of an obligation in accordance with § 9 or one of the obligations mentioned in the Special Conditions will result in loss of insurance cover for the policyholder. In case of a grossly negligent breach of obligations, the insurer is entitled to reduce his benefits according to the severity of the policyholder's fault.

Where the policyholder breaches an obligation to provide information, which has been in place after an insured event takes place, the insurer is only exempt from performance in full or in part if he provided the policyholder with a separate written notification about this legal consequence. Where the policyholder proves that he / she did not breach the obligation with gross negligence, the insurance cover will continue.

Insurance cover will also continue if the policyholder proves that the breach of obligation was neither the cause for the occurrence or determination of the insured event nor for the determination or scope of the benefits. This shall not apply if the policyholder fraudulently breached the obligation. The above conditions apply irrespective of the question if the insurer makes use of the right of cancellation that he is entitled to due to the breach of a pre-contractual duty of disclosure.

§ 11 Due date of payment

I. As soon as the insurer has received the documents which the policyholder must provide as evidence of occurrence of the accident and the consequences of the accident as well as of completion of the treatment necessary for assessing disability, the insurer is obliged to declare in text form within one month – or within three

months in the case of disability claims – whether and to which extent he accepts a claim. The medical charges incurred by the policyholder as evidence of the right to receive benefits are assumed by the insurer

- in the event of disability up to 1% of the sum insured,
- in the case of transition payment up to 1% of the sum insured,
- in the case of daily allowance up to one daily allowance payment,
- in the case of daily hospital allowance up to one daily hospital allowance payment.

The insurer will not pay for any further costs.

II. If the insurer accepts the claim or if policyholder and insurer have agreed on the basis and amount, the insurer makes the payment within two weeks. Before completion of treatment, disability benefits can only be claimed within one year of the accident if and insofar as death benefits have been insured.

III. If the liability to pay has only been accepted in principle, the insurer makes appropriate advance payments at the request of the policyholder.

IV. Policyholder and insurer are entitled to have the degree of disability medically re-assessed on an annual basis, for at most up to three years after the accident. However, on the part of the insurer, this right must be exercised submitting a declaration in accordance with clause I. and on the part of the policyholder prior to expiry of the respective period. If the final assessment results in higher disability benefits than already paid by the insurer, annual interest of 5 percent is payable on the additional sum.

§ 12 Legal relationships of persons involved in the policy

I. If the policy has been taken out for accidents that happen to others (insurance for the benefit of third parties), it is not the insured person but the policyholder who is entitled to exercise the rights in accordance with the policy. In addition to the insured person, the policyholder is responsible for fulfilling the obligations.

II. All provisions applying to the policyholder are applicable accordingly to his / her legal successors and other claimants.

III. Without the permission of the insurer, the insurance claims cannot be transferred or pledged before they are due.

§ 13 Notifications and declaration of intent

I. All notifications and declarations intended for the insurer are to be directed to the insurer's head office or to the responsible branch office as stipulated in the insurance policy or its addendums.

II. Where the policyholder has failed to notify the insurer of a change in his / her address, the posting of a registered letter to the last address known to the insurer under the last name known to the insurer shall suffice for the purposes of submitting any declaration of intent to the policyholder. The declaration shall be deemed received three days after the letter is sent. The same shall apply in case of a change of the policyholder's name.

III. Where the policyholder has purchased insurance for his / her business establishment, clause II. shall apply analogously to any relocation of the business establishment.

§ 14 Statute of limitations

I. Any claims arising from the insurance contract are subject to a limitation period of three years. The period is calculated in accordance with the general conditions of the German Civil Code (BGB).

II. Where the policyholder has reported a claim under the insurance contract to the insurer, the limitation period shall be suspended from the report up to the time when the claimant receives the insurer's decision in text form.

§ 15 Competent courts

I. For actions against the insurer arising from the insurance contract, the competent court depends on the insurer's head office or branch office responsible for the insurance contract. Where the policyholder is a natural person, local responsibility also lies with the court in whose district the policyholder has his / her residence or, in the absence of such, his / her habitual residence at the time the action is brought.

II. Where the policyholder is a natural person, actions against the policyholder arising from the insurance contract need to be brought before the court responsible for his / her residence or, in the absence of such, his / her habitual residence. Where the policyholder is a legal entity, the competent court shall also be determined by

the registered office or branch office of the policyholder. The same shall apply if the policyholder is a partnership, limited partnership, civil partnership or registered partner company.

III. Where the policyholder's residence or habitual residence is unknown at the time the action is brought, the competent court for actions arising from the insurance contract against the policyholder depends on the registered office of the insurer or its branch office responsible for the insurance contract.

IV. German law applies to this contract.

§ 16 Sanction clause

Irrespective of the other contractual provisions, insurance cover only exists if and as long as there are no economic, trade or financial sanctions or embargoes of the European Union or the Federal Republic of Germany that are directly applicable to the contracting parties.

This also applies to economic, trade or financial sanctions or embargoes by the United States of America, provided they do not conflict with the legal provisions of the European Union or the Federal Republic of Germany.

Additional Conditions for Group Accident Insurance

§ 1 Insurance without giving a name

1. Insurance cover is provided for persons that are part of the group mentioned in the contract.
2. The persons to be insured must be named and recorded by the policyholder so that in the event of an insurance claim there can be no doubt that the injured belongs to the insured group of people.
3. At the end of the period of time for which the annual premium is proportionally paid, the insurer requests the policyholder to indicate the number of persons who were insured during this period. These details must be given by month and the highest number per month is to be indicated. Averaging is not permitted.
4. Based on the stated numbers, the insurer calculates the premium to be paid for the elapsed period of time. The policyholder receives a premium statement about the calculated numbers.
5. Insurance cover for individual people will end if their current employment or membership ends.

§ 2 Insurance with disclosure of names

1. Insurance cover is provided for the persons mentioned by name.
2. Uninsured persons can be registered for insurance at any time if their job or occupation and the sums insured are the same as that of the already insured persons. Insurance cover for the newly added persons is provided within the agreed scope as soon as the insurer receives their application.
3. Persons in other jobs or other occupations or with higher sums insured are only considered as insured after agreement on the sums insured and the premiums.
4. The insurer is entitled to decline the insurance of individuals due to a risk assessment. In the event of rejection, insurance cover ends one month after the date of rejection.
5. Insurance cover ends for insured persons intended to no longer be part of the contract at the earliest when we receive notification thereof.

§ 3 Contract period (Addition to § 4 of the General Accident Insurance Conditions)

1. The contract partners can end insurance cover of insured individuals by written notification if – after an accident – the insurer paid benefits to the policyholder or if the policyholder made a claim for benefits against the insurer. The notification must have been received in text form no later than one month after the payment of benefit or – in the event of a legal dispute – after the discontinuance of the action, the acknowledgement, the settlement or the final judgment by the court. Insurance cover expires one month after the notification is received.
2. The insurance policy ends if the company or association is ceased. A transfer of undertakings does not constitute a cessation of a business.
3. The insurer is entitled to cancel the insurance policy with one month's notice if insolvency proceedings have been opened over the policyholder's assets or if the application to institute such proceedings has been rejected for lack of assets.

Limitation of sums insured

1. Air passenger risk

1.1 Insurance cover for air passenger risk (see also § 2 I. 4. of the General Accident Insurance Conditions (AUB)) is provided per insured person in accordance with the agreed sums insured, but not exceeding the following sums insured:

- in the event of death € 1,000,000
- in the event of disability (max. compensation in the case of 100 % disability) € 2,000,000
- daily allowance € 250
- for daily hospital allowance / convalescence allowance € 250
- for treatment costs € 10,000
- for transition payment € 50,000

1.2 If several persons insured by this group accident insurance are traveling in the same aircraft and if the sums insured in accordance with this policy for these persons exceed in total

- in the event of death € 10,000,000
- in the event of disability (max. compensation in the case of 100 % disability) € 20,000,000
- for daily allowance € 2,500
- for daily hospital allowance / convalescence allowance € 2,500
- for treatment costs € 100,000
- for transition payment € 500,000

these sums are considered as maximum sums insured for the persons and the sums insured for each person are reduced accordingly.

In the case of all other accidents, the following applies: If several insured persons are affected by the same accident, the maximum payment by the insurer for all the insured persons is limited to € 10,000,000.

Expansions of AUB 88 Version 2008 of Dialog Versicherung AG

Special conditions for the insurance against poisoning as a result of vapors and gases

§ 1 III. of the agreed General Accident Insurance Conditions is expanded as follows:

In the event of poisoning as a result of the sudden escape of gases or vapors, the suddenness of the event is also assumed if the insured person was involuntarily exposed to the effects of gases and vapors for several hours due to extraordinary circumstances. Occupational and industrial illnesses are, however, excluded.

Special conditions for the insurance of typical diving injuries as part of accident insurance

In addition to § 1 III. of the agreed General Accident Insurance Conditions, the insurer also provides insurance cover for

- typical diving injuries such as decompression sickness (DCS) or eardrum injuries, as well as
- for death by drowning or suffocation under water, even if no accident has occurred.

Special conditions for accidents as a result of heart attack, stroke or medication

By way of derogation from § 2 I. 1. of the agreed General Accident Insurance Conditions, insurance cover is provided for accidents as a result of mental illness or cognitive disorders if they were caused by heart attack, stroke or prescribed medication. Damages as a direct result of heart attack, stroke or prescribed medication are excluded from insurance cover.

Special conditions for accidents as a result of epileptic fits

By way of derogation from § 2 I. 1. of the agreed General Accident Insurance Conditions, insurance cover is provided for accidents if they were caused by epileptic fits.

Special conditions for the insurance of an alcohol-induced cognitive disorder

By way of derogation from § 2 I. 1. of the agreed General Accident Insurance Conditions, insurance cover is provided for accidents as a result of an alcohol-induced cognitive disorder; in case of operation of motor vehicles, however, this shall only apply if the blood alcohol level was below 1.5 ‰ at the time of the accident.

Special conditions for the insurance of accidents as a result of unrest / violent conflicts

§ 2 I. 3. of the agreed General Accident Insurance Conditions is altered as follows:

Accidents as a result of unrest or other violent conflicts are covered if the insured person did not actively participate in the acts of violence or, if he / she did actively participate but not on the side of those instigating the unrest.

Special conditions for co-insurance of passive war risk in accident insurance (BB Kriegsrisiko 92)

1. In amendment of § 2 I. 3. of the agreed General Accident Insurance Conditions (AUB 88), the insurance cover extends to accidents suffered by the insured person through war-related events without him / her belonging to the active participants in the war or civil war (passive war risk).

An active participant is also a person who supplies, transports or otherwise handles certain installations, equipment, devices, vehicles, weapons or other materials intended for waging war on behalf of a warring party. Co-insured are accidents through terrorist attacks causally connected to a war or civil war and carried out outside the territories of the warring parties.

2. The following are excluded from the insurance cover:

- accidents if the insured person travels to the war zone after the outbreak of the war or civil war;
- accidents if the insured person travels to the crisis area in anticipation of a possible outbreak of war for professional reasons (journalist, cameraman);

- accidents as a result of the use of ABC weapons (atomic, biological or chemical weapons);
- accidents in connection with a war or warlike situation between world powers (China, France, Great Britain, Japan, Russia, USA);
- accidents in connection with a war or civil war if the state in which the insured person is domiciled or normally resides is involved as a warring party or if the war is conducted on the territory of this state.

3. Insurance cover in accordance with these Special Conditions only applies for a maximum duration of 14 days as of midnight of the day when the hostilities started.

Special conditions for the insurance of accidents as a result of taking part in unlicensed motor sport events

In amendment of § 2 I. 5. of the agreed General Accident Insurance Conditions, the following is agreed:

Accidents as a result of actively taking part in authorized driving events with motor vehicles with the aim of achieving high speeds are covered by the policy if said events require no license (e. g. in case of occasional runs with rented carts at an indoor track). This expansion of the policy only applies within Europe and only for persons who have attained the age of 18 years.

Accidents as a result of radiation

In amendment of § 2 I. 1. of the agreed General Accident Insurance Conditions (AUB), insurance cover is provided in the event of damages to health as a result of radiation if the damages were the result of an accident covered by the insurance policy. The exclusion of § 2 I. 6. AUB (nuclear power) remains unaffected by this and is applied in its original form.

Special conditions for the insurance of infections caused by ticks

In amendment of § 2 I. 3. of the agreed General Accident Insurance Conditions (AUB), insurance cover is also provided for the consequences of the infectious diseases tick-borne encephalitis (TBE) and Lyme borreliosis caused by tick bites. Insured event is the first-time infection with the causative agent of these infectious diseases. By way of derogation from § 9 AUB, the insurer is to be immediately informed when a first-time infection has been diagnosed by a physician.

By way of derogation from § 4 I. AUB, insurance cover for these infections only starts after a waiting period of one month after the start / date of change stipulated in the insurance policy. For insured events that occurred prior to the waiting period, there is no liability to pay. For the insurer to pay benefits, it is required that the evidence for the occurrence of infectious diseases is provided in the form of an objective medical report together with the appropriate laboratory results in accordance with latest medical knowledge.

Special conditions for the insurance of infections in the event of minor skin injuries

By way of derogation from § 2 II. 3. of the agreed General Accident Insurance Conditions, the policy also covers infections in the case of which it is clear from the case history, findings or nature of the illness that the causative agents must have entered the body through injury to the skin, whereby at least the outer layer of the skin must have been penetrated. This expansion does not include influenza or AIDS.

Special conditions for the insurance of poisoning as a result of the ingestion of liquid or solid substances

§ 2 II. 4. of the agreed General Accident Insurance Conditions is altered as follows:

Poisoning as a result of the accidental ingestion of hazardous substances is covered if said substances are not food.

Special conditions for the insurance of food poisoning

By way of derogation from § 2 II. 4. of the agreed General Accident Insurance Conditions, the consequences of food poisoning are covered. The policy does not cover alcohol poisoning. This does not apply, however, for children who were under the age of 10 at the time the accident occurred.

Psychological reactions

In amendment of § 2 IV. of the agreed General Accident Insurance Conditions, it is deemed agreed that insurance cover is provided for the consequences of mental and nervous disorders following an accident if and insofar as

such disorders are the result of an organic disease of the nervous system or of an epilepsy caused by an accident covered by the policy.

Special conditions for asserting a claim for disability benefits

By way of derogation from § 7 I. 1. of the agreed General Accident Insurance Conditions, disability needs

- to have occurred within 15 months after the accident; and
- to be diagnosed in text form by a physician at the latest prior to expiry of a period of another 6 months and to be asserted by the policyholder or the insured person.

Special conditions for improved disability benefits

§ 7 I. 2. a) of the agreed General Accident Insurance Conditions and, insofar as agreed, clause 1 of the Special Conditions for the Insurance of Accident Disability Benefits are altered as follows:

The following fixed degrees of disability apply – without evidence of greater or lesser disability – in the event of loss or functional incapacity of

- an arm 80 %
- an arm up until the upper part of the elbow joint 75 %
- an arm below the elbow joint 70 %
- a hand 70 %
- a thumb 28 %
- an index finger 20 %
- another finger 15 % (in the event of loss of all fingers of one hand, a maximum of 70 % is reimbursed)
- a leg above the mid-thigh 80 %
- a leg up to the mid-thigh 70 %
- a leg below the knee 60 %
- a leg up to the middle of the lower leg 55 %
- a foot 50 %
- a big toe 15 %
- other toes 8 %
- an eye 50 %
- in the event of loss of the other eye prior to the accident 70 %
- hearing in one ear 30 %
- in the event of loss of hearing in the other ear prior to the accident 45 %
- sense of smell 20 %
- sense of taste 15 %
- a kidney if the other kidney remains unaffected 20 %
- the spleen 10 %
- the ability to speak 100 %

Upon partial loss or partial loss of use, the corresponding proportion of the relevant percentage is assumed.

Payment of disability benefits following diagnosis

By way of partial derogation from § 7 I. of the agreed General Accident Insurance Conditions, the insurer will pay disability benefits amounting to the stated degree of disability immediately after a diagnosis has been made in the following cases:

Diagnosis	Share of the value of the agreed schedule of compensation
Cruciate ligament rupture	1 / 10 of the value for the leg above the mid-thigh
Calcaneus fracture	2 / 10 of the value for the foot
Ankle joint fracture	1 / 20 of the value for the leg above the mid-thigh
Tibia fracture	1 / 7 of the value for the leg above the mid-thigh
Patella fracture	1 / 7 of the value for the leg above the mid-thigh
Femoral neck fracture	1 / 7 of the value for the leg above the mid-thigh
Colles fracture or radial head fracture	1 / 10 of the value for the arm
Humeral head fracture	1 / 7 of the value for the arm
Compression fracture of a vertebral body	10 % of the agreed basic sum insured for disability

The insured person's right to provide evidence for a greater degree of disability in the form of a medical opinion remains unaffected by this condition.

Special conditions for improved transition payment

§ 7 II. of the agreed General Accident Insurance Conditions is expanded as follows:

If there is still accident-related impairment of the normal physical or mental performance of the insured person both at work and outside work and if this impairment has existed until then without interruption, the insurer will pay

- a) after 3 months and 100 % impairment 50 % of the agreed sum insured and
- b) after 6 months and an at least 50 % impairment 100 % of the agreed sum insured minus the payment made in accordance with a). The transition payment needs to be asserted by the policyholder or the insured person at the latest 1 month after expiry of the period stipulated under a) or b) and together with the provision of a medical certificate.

Special conditions for daily hospital allowance in the event of a treatment in medical facilities that offer both treatment and rehabilitation

In amendment of § 7 IV. of the agreed General Accident Insurance Conditions, the following is agreed:

If inpatient treatment takes place in a facility that offers treatment as well as rehabilitation services, the entitlement to daily hospital allowance continues to apply

- in the event of an emergency hospitalization;

or

- if the medical institution is the only hospital in the vicinity of the insured person's place of residence.

Special conditions for daily hospital and convalescence allowance in the event of an outpatient operation

By way of derogation from § 7 IV. of the agreed General Accident Insurance Conditions, the insurer will pay the agreed daily hospital and convalescence allowance also according to the following conditions:

1. Benefit requirements:

The insured person undergoes an operation on at least a full limb under general or regional anesthesia as a result

of an accident.

2. Benefit amount:

2.1 The agreed daily hospital and convalescence allowance is paid for at least 3 days.

2.2 The insurer will also pay if the accident-related operation in accordance with clause 1 is carried out as an outpatient operation, thereby preventing the need for a hospital stay.

Special conditions for extended daily hospital allowance

In amendment of § 7 IV. 1. of the agreed General Accident Insurance Conditions, the daily hospital allowance for accident-related inpatient hospital stays is paid within 5 years from the day of the accident, but no longer than for a maximum period of two years for the sum of all inpatient hospital stays necessary as a result of the accident.

Special conditions for the inclusion of a combination of rooming-in allowance and school absence allowance

In amendment of § 7 of the agreed General Accident Insurance Conditions (AUB) and in accordance with the following conditions, the insurer will pay a

Rooming-in allowance

1. Benefit requirements:

The insured child

- is under the age of 8 at the time of the accident;
- is in medically necessary inpatient treatment as a result of the accident;

and

- a parent or legal guardian stays overnight at the hospital together with the insured child (rooming-in).

The policyholder needs to prove that these requirements have been fulfilled by providing a medical certificate. Stays at a health resort or sanitarium do not constitute medically necessary treatment.

2. Benefit amount and duration:

The insurer will pay the rooming-in allowance for a maximum period of 1 year from the day of the accident and amounting to a sum insured of € 40 for each night a parent or legal guardian spends at the hospital. The conditions of § 8 AUB are taken into account.

School absence allowance

1. Benefit requirements:

The insured child

- is under the age of 8 at the time of the accident;
- cannot attend a school providing general education or a similar institution for more than 6 weeks as a result of the accident; several absences from school as a result of the same accident are considered as one uninterrupted period of absence from school.

The policyholder needs to prove that these requirements have been fulfilled by providing a medical certificate and a respective statement by the school. School holidays or temporary closing of the school do not constitute school absence.

2. Benefit amount and duration:

The insurer will pay the school absence allowance from week 7 of school absence for every school day and up to a maximum period of 1 year from the day of the accident; the allowance amounts to € 40 (daily rate). The conditions of § 8 AUB are taken into account.

Special conditions for the insurance against robbery or hostage-taking

In amendment of § 7 of the agreed General Accident Insurance Conditions, the insurer will pay if the insured person has become the victim of robbery or hostage-taking, even if the insured person was not injured in the process.

1. Benefit requirements:

The robbery or hostage-taking has been reported to and recorded by the police as a criminal act.

2. Benefit amount:

Benefits are paid up to the amount of € 3,000.

Special conditions for the insurance of assistance in the event of severe injury

In amendment of § 7 of the agreed General Accident Insurance Conditions, the insurer will pay benefits in the event of severe injury in accordance with the following conditions:

After an accident and in accordance with the following conditions, the insurer pays an advance payment for any of the following severe injuries:

- paraplegia as a result of spinal cord injuries;
- amputation of at least an entire foot or of an entire hand;
- craniocerebral injuries after an unequivocally established cerebral contusion or cerebral hemorrhage;
- severe multiple injuries / polytrauma;
- fracture of two long bones in different parts of the body (e. g. leg and arm fracture) or
- damages to two inner organs resulting in destroyed tissue or
- combination of at least two of the following injuries: fracture of a long bone, fractured pelvis, spinal fracture, damage to an inner organ resulting in destroyed tissue;
- 2nd and 3rd degree burns of more than 30 % of the body surface;
- loss of sight or severe visual impairment of both eyes; in the event of visual impairment: visual acuity of not more than 1 / 20.

The right to benefits arises after the occurrence of the accident. The policyholder is required to provide evidence for a severe injury by means of a medical certificate. The right to benefits ceases if such claims are not asserted within one year from the day of the accident. If the insured person has several accident insurance policies with the same insurer, the respective benefits can only be claimed from one of these policies.

Benefit amount

Benefits are paid up to the amount of € 5,000.

Special conditions for the insurance of rehabilitation allowance within accident insurance

In amendment of § 7 of the agreed General Accident Insurance Conditions (AUB), the insurer will pay rehabilitation allowance in accordance with the following conditions:

1. Benefit requirements:

1.1 The insured person has undergone

- a medically necessary inpatient rehabilitation measure
- as a result of an accident subject to compensation in accordance with § 1 AUB
- because of the health damage or its consequences suffered through the accident
- within three years from the date of accident
- for a continuous period of at least three weeks.

The fulfillment of these requirements shall be proven by the policyholder or the insured person by providing a medical certificate.

1.2 Inpatient treatment with a focus on medical treatment of the consequences of the accident is not considered to be a rehabilitation measure.

2. Benefit amount:

Rehabilitation allowance of € 3,000 is paid once per accident in accordance with § 8 AUB.

Where the insured person is covered through several accident insurance policies with the same insurer, this benefit can only be claimed for one of these policies.

Special conditions for the insurance of plastic surgery costs within accident insurance

In amendment of § 7 of the agreed General Accident Insurance Conditions, the insurer will reimburse plastic surgery costs as a result of an accident in accordance with the following conditions:

1. Benefit requirements:

1.1 The insured person has undergone plastic surgery after an accident. Plastic surgery is defined herein as a separate medical treatment after the end of the regular remedial treatment with the objective to repair an impairment of the insured person's physical appearance that was a result of the accident.

1.2 Plastic surgery shall take place within three years after the accident; in case of an accident suffered by an underage person, surgery must take place before the person reaches the age of 21.

1.3 A third party is not liable to pay or denies its liability to pay.

2. Benefit type and amount:

The insurer pays up to € 10,000 in compensation for proven

- physicians' fees and other surgery expenses,
- necessary costs for accommodation and catering in a hospital.

The insurer will also reimburse proven costs for dental treatment and dentures because of full or partial loss of incisors and canines as a result of the accident.

Where the insured person is covered through several accident insurance policies with the same insurer, this benefit can only be claimed for one of these policies.

Special conditions for the insurance of rescue costs within accident insurance

In amendment of § 7 of the agreed General Accident Insurance Conditions, the insurer will reimburse rescue costs in accordance with the following conditions:

1. Benefit type:

1.1 The insurer will reimburse the costs for search, rescue, or recovery operations of rescue services organized in accordance with public law or private law insofar as fees are normally charged for this. The costs will also be reimbursed by the insurer if the accident was immediately threatening or to be expected due to the specific circumstances.

1.2 The insurer will reimburse the costs for transport of the injured person to the nearest hospital or to a special clinic, insofar as this is medically necessary and has been ordered by a physician.

1.3 The insurer will reimburse the additional expenses in connection with the return of the injured person to the location of his / her permanent residence, insofar as the additional costs arise from what has been ordered by a physician or were unavoidable because of the nature of the injury.

1.4 In case of a fatal accident, the insurer will reimburse the costs for transport of mortal remains of the insured person to his / her last permanent residence.

2. Benefit amount:

The benefit amount is limited to a total of € 25,000. Insofar as a third party (e. g. motor vehicle liability insurer, social insurance agency) is liable to pay in case of an insured event or where compensation can be claimed from

other insurance contracts, such liabilities shall prevail. Where the policyholder can claim compensation from other insurance contracts, he / she is free to choose to which insurer he / she wants to report the insured event. If the policyholder reports the damage to Dialog Versicherung AG, the latter will make an advance payment in accordance with the present conditions.

Where another party denies its liability for damages, the policyholder or the insured person can contact the insurer directly. In this case, potential claims against other parties liable for damages have to be assigned to the insurer. Where the insured person is covered through several accident insurance policies with the same insurer, this benefit can only be claimed for one of these policies.

Special conditions for the joint effect of illnesses or ailments

By way of derogation from § 8 of the General Accident Insurance Conditions, the degree of disability or the benefit will not be reduced if the joint effect of illnesses or ailments is less than 45 %.

Special conditions for family insurance within accident insurance

In accordance with the following provision, the insurer offers family insurance without the need to pay an extra premium:

1. Benefit type:

Insurance cover is provided for the below listed joining relatives of the insured person for a duration of 15 months during the validity of the present contract:

- the spouse from the date of civil marriage or the civil partner from the starting date of civil partnership,
- the natural children from their date of birth.

Insurance cover is provided within family insurance exclusively for disability benefits and – insofar as one of these types of benefit was agreed for the insured person and / or the other parent – for death benefits and daily hospital allowance.

2. Benefit amount:

The sums insured in case of disability and death as well as for daily hospital allowance are

- for the spouse 50 % of the insured person's sum insured up to a maximum of € 25,000 for disability (basic sum insured) or death and a maximum of € 20 for daily hospital allowance,
- for the natural children 50 % of the insured person's sum insured and the sum insured of the co-insured other parent, insofar as the co-insurance of this parent is not a result of this family insurance, up to a maximum of € 25,000 for disability (basic sum insured) and € 5,000 for death and a daily hospital allowance of € 20.

Special conditions for the evidence of the right to receive benefits

§ 11 I. of the General Accident Insurance Conditions is altered as follows:

The medical charges incurred by the policyholder as evidence of the right to receive benefits are assumed in full by the insurer.

Special conditions for chemists, disinfection personnel and members of the medical professions

I. Inclusion of infections in accident insurance

Insured persons who work / are

- as chemists or disinfection personnel,
- as physicians, dentists, dental technicians, non-medical practitioners, (male) midwives, veterinaries,
- in nursing care (male or female nurses, children's nurses, nurse assistants),
- students in the field of medicine, dentistry or veterinary science

are, by way of derogation from § 2 II. 3. of the agreed General Accident Insurance Conditions (AUB), provided with the following insurance cover:

1. Benefit requirements:

1.1 The insured person became infected while performing his / her occupation as stipulated in the contract.

1.2 From

- the patient's medical records,
- medical findings or
- the nature of the illness

it is clear that the causative agents have entered the body in one of the ways described in clause 1.3.

1.3 The causative agents have entered the body either

- through injury to the skin, whereby at least the outer layer of the skin must have been severed, or
- through the injection of infectious substances into the eye, mouth or nose.

Being breathed on, sneezed at or coughed at are not deemed as injection. Insured persons who work in medical professions are insured, however, against diphtheria and tuberculosis.

1.4 For insured persons who work as chemists or disinfection personnel cover does not include gradually occurring harm caused by their normal work with chemicals (occupational diseases).

2. Extended cover in case of disability:

By way of derogation from § 7 I. 1. AUB, disability claims can still be made where disability as a result of an infection and in accordance with the present Special Conditions

- has occurred within three years after the accident and
- has been diagnosed by a physician in text form within this period and where the insured person have asserted this claim against the insurer within another three months.

II. Inclusion of health damage through X-ray and laser radiation in accident insurance

Insured persons who work / are

- as chemists or disinfection personnel,
- as physicians, dentists, dental technicians, non-medical practitioners, (male) midwives, veterinaries,
- in nursing care (male or female nurses, children's nurses, nurse assistants),
- students in the field of medicine, dentistry or veterinary science

are, by way of derogation from § 2 II. 1. of the agreed General Accident Insurance Conditions (AUB), provided with the following insurance cover:

The insurance cover includes health damage through X-ray and laser radiation as well as artificially generated ultraviolet radiation. Excluded from the cover are damages as a result of the normal handling of radiation generating equipment.

Special conditions for increased benefits in case of simultaneously valid motor vehicle liability insurance

Where the insured person suffers an accident as operator or passenger of a motor vehicle covered under liability insurance by Dialog Versicherung AG, the potential benefits from accident insurance increase by 25 %.

This only applies for the following benefit types:

- disability,
- accident benefits,
- daily hospital allowance,

- convalescence allowance,
- daily allowance,
- transition payment,
- damages for pain and suffering in case of bone fractures,
- fatal accident,

insofar as they are actually agreed on.

Errors and omissions clause

In addition to § 10 of the General Accident Insurance Conditions, the following condition shall apply:

Where the policyholder fails to make a required notification or to fulfill any other obligation, the insurer is not exempt from his liability to pay when the policyholder or the insured person proves that his / her failure was the result of an error or omission and that he / she immediately made up for it.

In case of notification of a situation that results in the payment of an additional premium, such premium must be paid retrospectively for the period during which this situation occurred.

General Insurance Conditions for the Insurance of Assistance Services (PROTRIP-WORLD Additional Assistance 2014) of Europ Assistance SA, Niederlassung für Deutschland

I. Assistance in case of loss of means of payment

1. Where the insured person finds himself / herself in a financial emergency during a trip abroad as a result of theft, robbery or other loss of his / her travel funds, the insurer will establish contact to the insured person's main bank.

If contacting the main bank is not successful within 24 hours after the working day following the notice of claim, the insured person can take out a loan with the insurer up to € 1,600 per insured event.

2. Loan payment will only be made on submission of a written unconditional letter of commitment of the insured person to the insurer to pay back the loan at the latest 30 days after receiving it.

3. Any loss in case of a suspected criminal act must be reported immediately to the responsible police department; the insured person needs to have his / her notification confirmed by the police. In any case, inquiries need to be made with and confirmed by the lost property office.

II. Assistance in case of loss of documents

1. Where the insured person finds himself / herself in an emergency situation during a trip abroad as a result of theft, robbery or other loss of his / her travel documents, the insurer will provide him / her with information about the responsible authorities and documents required to issue the necessary replacement documents for finishing the trip.

2. The insurer will reimburse the costs for obtaining the replacement documents required abroad to finish the trip. Any costs incurred by issuing replacement documents after the end of the trip are not covered.

3. Any loss in case of a suspected criminal act must be reported immediately to the responsible police department; the insured person needs to have his / her notification confirmed by the police. In any case, inquiries need to be made with and confirmed by the lost property office.

III. Assistance in case of criminal prosecution

1. Where the insured person is arrested or threatened to be arrested, the insurer will provide help in finding a lawyer and an interpreter.

2. The insured person can take out a loan with the insurer of up to € 12,000 for the payment of court, lawyer and interpreter fees or for the payment of a bail.

3. Loan payment will only be made on submission of a written unconditional letter of commitment of the insured person to the insurer to pay back the loan at the latest 30 days after receiving it.

IV. Return trip in case of an emergency

1. In the event of death, severe injury or unexpected serious illness of a relative, the insurer will organize the return trip from abroad and reimburse the additional expenses for traveling by train or plane (economy class).

Relatives of the insured person according to the policy are spouses, children, parents, partners (cohabitation), life partners (in accordance with Law on Civil Partnership (LPartG)), stepparents, stepchildren, grandparents, grandchildren, siblings, parents-in-law, children-in-law, brothers-in-law and sisters-in-law.

2. In the event of damage to property of the insured person as a result of fire, acts of God or criminal acts of a third party, the insurer will organize the return trip from abroad and reimburse the additional expenses for traveling by train or plane (economy class).

Precondition for the payment of the claim: the damage is substantial with regard to the financial situation and personal assets of the damaged party or the presence of the insured person is required for damage assessment.

3. Travel services that were not made use of will not be reimbursed. For every insurance year, the insurer will provide payment for a maximum of two insured events of this kind.

V. Arrival of a person in a position of trust in case of an emergency

1. Where the insured person undergoes inpatient treatment for more than five days during a trip abroad due to severe injuries as a result of an accident or due to unexpected serious illness, the insurer will, at the request of the insured person, organize the arrival and departure of a person in a position of trust to the hospital and from there back to his / her home; the insurer will further pay his / her travel expenses by train or plane (economy class) as well as the costs for simple accommodation. Benefits are paid per insured event up to a maximum amount of € 4,000.

VI. Special exclusions

No insurance cover is provided for benefits under IV. and V.

1. insofar as the illness is a psychological reaction to war, unrest, an act of terror, a plane crash or the fear of war, unrest or acts of terror;
2. in case of chronic mental illnesses, also if they occur in phases, and in case of addiction.

VII. Obligations after occurrence of the insured event

1. The insured person has to submit the following documents to the insurer:

- a) proof of insurance, booking records and invoices;
- b) in case of severe injuries as a result of an accident and unexpected serious illness: a medical certificate; in case of mental illness: a certificate from a psychiatry specialist;
- c) death certificate in case of death;
- d) appropriate proof in case of damages to property and in case of fire or acts of God during the journey (e. g. police records);
- e) in case of loss of means of payment or loss of documents: a certificate of the lost property office and (if necessary) evidence that the loss was reported to the police;
- f) evidence for imminent or actual criminal prosecution.

2. As evidence for the insured event, the insured person is further obliged to grant the insurer the right (if requested) to verify any severe injuries as a result of an accident or any unexpected serious illness by means of a certificate of a medical specialist.

3. If one of these obligations is intentionally breached, EA is exempt from its liability to pay. In case of a grossly negligent breach of the obligation, EA is entitled to reduce its benefits according to the severity of the fault of the insured person. The policyholder must prove that he / she did not act with gross negligence. EA remains liable to pay if the breach had no influence on either the ascertainment or the extent of EA's liability to pay, unless the insured person acted fraudulently.

General Insurance Conditions for the Insurance of Baggage (AVB Reisegepäck 2008) of Dialog Versicherung AG

1 Insured objects and people

1.1 The insurance policy covers your entire baggage as well as the baggage of your family members traveling with you and of your partner and his / her children listed in the insurance policy, as long as these individuals live with you in a joint household (insured persons).

Persons living in a joint household with you and undertaking travel alone or separately in accordance with paragraph 1 shall only be covered by the policy if a special agreement has been made.

1.2 All objects pertaining to personal travel necessities taken on a trip, carried on the body or in clothing, or conveyed by a conventional means of transportation shall be deemed to be baggage. Gifts and souvenirs acquired on the trip shall also be considered to be baggage. Objects that are usually only carried for professional purposes shall only be insured if a special agreement has been made. Objects that are permanently kept in a place that is not your principal residence (e. g. in second homes, boats, caravans) shall only be deemed to be baggage in the event that they are taken from this place on trips, journeys or walks.

1.3 Collapsible boats, inflatables, and other sports equipment, including their accessories, shall only be covered while they are not being put to their intended use. Outboard motors are always excluded regardless of the situation.

1.4 Furs, jewelry, objects made of precious metals, photographic and film equipment and portable video systems, including their accessories, shall only be insured – notwithstanding the compensation limit specified in clause 4.1 – if they

1.4.1 are carried / used properly or

1.4.2 are carried securely in personal safekeeping or

1.4.3 are handed over to a hotel or other form of lodging for safekeeping or

1.4.4 are located in a properly locked room of a building, passenger ship, or guarded check room; however, this shall only apply to jewelry and objects made of precious metals if, in addition, they are accommodated in a sealed container, which offers an increased level of security that also protects against removal of the container itself.

Furs, photographic and film equipment and portable video systems, including their accessories, shall also be covered if they are placed in a properly sealed container, which does not allow the contents to be seen from outside, belonging to a transport company or baggage room / checkroom.

1.5 Excluded from cover are: money, securities, tickets, certificates and documents of any kind, objects of predominantly artistic or sentimental value, contact lenses, prostheses of any kind, as well as land, air, and water vehicles, including their accessories, including bicycles, hang-gliders and windsurfing equipment (see clause 1.3 regarding collapsible boats and inflatables). However, the insurance does cover identification papers (clause 11.1.4).

2 Insured risks and damages

Insurance cover shall apply:

2.1 if insured objects are lost, destroyed or damaged while the baggage is in the safekeeping of a transport company, a hotel or other form of lodging, a porter, or a baggage room / check room;

2.2 during the remainder of the journey for damages listed in clause 2.1 caused by:

2.2.1 theft, burglary, robbery, extortion with robbery, willful destruction or maliciousness on the part of third parties (intentional damage to property);

2.2.2 loss – not including leaving something behind – up to the limit of compensation stipulated in clause 4.2;

2.2.3 an accident involving a means of transportation or an accident of an insured party;

2.2.4 the non-intentional effects of water, including rain and snow;

2.2.5 storms, fires, lightning strikes, or explosions;

2.2.6 force majeure;

2.3 if baggage is not handed over in due time (if baggage does not reach the destination on the same day as you or other insured persons). The proven expenses for replacement purchases up to 10 % of the sum insured shall be reimbursed up to a maximum of € 400 per insured event.

3 Excluded risks and damages

3.1 The following risks are excluded:

3.1.1 war, civil war or warlike events and such risks and damages that (irrespective of the state of war) result from the hostile use of instruments of war and from the existence of instruments of war as a consequence of one of the above mentioned risks;

3.1.2 strike, lockout, industrial unrest, terrorist or political violence, irrespective of the number of participating persons, riots or other civil unrest;

3.1.3 confiscation, deprivation of possession or other acts of authorities;

3.1.4 use of chemical, biological, biochemical substances or electromagnetic waves as weapons that are a danger to public safety, regardless of other contributing causes;

3.1.5 nuclear energy or other ionizing radiation.*)

*) In the Federal Republic of Germany, compensation for loss or damage resulting from nuclear energy is governed by the Atomic Energy Act. Operators of nuclear facilities are obliged to provide cover and conclude (among other things) liability insurance policies for this purpose.

3.2 We will not compensate for damages that

3.2.1 were caused by the natural or deficient properties of the insured objects, or by wear and tear;

3.2.2 occur during camping within the area utilized for this purpose.

4 Objects and damages subject to limited liability for damages

4.1 Damage to furs, jewelry, objects made of precious metals, photographic and film equipment and portable video systems, including their accessories (clause 1.4), are covered up to a maximum of 50 % of the sum insured per insured event. The clauses 5.1.3 and 5.2 sentence 2 remain unaffected.

4.2 Damage

4.2.1 as a result of loss (clause 2.2.2),

4.2.2 to gifts and souvenirs acquired on the trip is in each case covered up to 10 % of the sum insured, up to a maximum of € 400 per insured event.

5 Insurance cover for motor vehicles and recreational watercraft

5.1 Cover is only provided against theft or burglary from motor vehicles or trailers parked without supervision on condition that the baggage is located in a fully enclosed and properly locked interior or trunk.

5.1.1 We shall only be liable for the full sum insured if it can be proven that

5.1.1.1 the damage occurred during the day, i. e. between 6am and 10pm, or

5.1.1.2 the motor vehicle or trailer was parked in a locked garage (parking lots and underground car parks for public use are not sufficient), or

5.1.1.3 the damage occurred during a break in the journey of no longer than two hours.

5.1.2 If you and the other insured persons are unable to prove any of the conditions of clause 5.1.1, then compensation shall be limited to € 250 per insured event.

5.1.3 Furs, jewelry, objects made of precious metals, photographic and film equipment and portable video systems, including their accessories, are not insured in motor vehicles or trailers parked without supervision.

5.2 With regard to unsupervised recreational watercraft, the policy only covers theft, burglary, and willful destruction or maliciousness on the part of third parties (malicious damage to property) if the objects are located in a fully enclosed interior of the watercraft, which is secured with a security lock (cabin, box, or similar). Furs, jewelry, objects made of precious metals, photographic and film equipment and portable video systems, including their accessories, are not covered in unsupervised recreational watercraft.

5.3 Supervision shall only be deemed your constant presence or that of another insured person or a person in a position of trust appointed by you or another insured person with the object to be safeguarded, but not, for example, the guarding of a place that is open to general public use or a similar situation.

5.4 Should you or another insured person breach one of the above obligations, the legal consequences are stipulated in clause 14.4.

6 Duty of disclosure – what are the obligations to notify upon contract conclusion and the consequences of non-disclosure?

6.1 Correctness and completeness of the information about risk-related circumstances

You are obliged, by the time you issue your contract statement, to disclose completely and truthfully all risk-related circumstances known to you about which we asked in text form and which are material to our decision to arrange the policy with the agreed content. If we ask questions within the meaning of the first sentence of this paragraph in text form after your contract statement has been issued but before the contract has been accepted, you shall also be obliged to answer them. Risk-related circumstances are those circumstances that are material to our decision to arrange the policy at all or with the agreed content.

If the contract is concluded by your representative and if he / she is aware of the risk-related circumstances, you shall be treated as if you yourself had known about it or had fraudulently concealed your knowledge about it.

6.2 Withdrawal

6.2.1 Requirements for withdrawal

Where incomplete and incorrect information about the risk-related circumstances is given, we shall be entitled to withdraw from the insurance contract.

6.2.2 Exclusion of the right of withdrawal

We have no right of withdrawal if you or another insured person prove that you or the other insured person neither acted with intent nor with gross negligence when providing incorrect or incomplete information. We have no right of withdrawal due to a grossly negligent breach of the duty of disclosure if you prove that we would also have concluded the contract, although with different terms and conditions, had we known about the non-disclosed circumstances.

6.2.3 Consequences of withdrawal

There will be no insurance cover in case of withdrawal. Where we withdraw from the contract after the occurrence of an insured event, we are obliged to provide insurance cover if you or another insured person prove that the circumstance about which incorrect or incomplete information was provided was not the reason for either the occurrence of the insured event or the ascertainment or the extent of the benefit.

There will be, however, no insurance cover in such a case if you fraudulently breached the duty of disclosure. We are entitled to the part of the premium that relates to the contract period before the notice of withdrawal entered into effect.

6.3 Cancellation

Where we have no right of withdrawal because the breach of the duty of disclosure was caused neither by intent nor by gross negligence, we shall be entitled to cancel the insurance contract subject to a period of notice of one month. We have no right of cancellation if you or another insured person prove that we would also have concluded the contract, although with different terms and conditions, had we known about the non-disclosed circumstances.

6.4 Retrospective policy adjustment

Where we cannot withdraw from the contract or cancel the contract because we would also have concluded the contract, although with different terms and conditions, had we known about the non-disclosed circumstances, such different terms and conditions retrospectively become part of the contract at our request. If neither you nor another insured person is responsible for the breach of obligation, the remaining terms and conditions become part of the contract from the current insurance period on.

If the premium increases by more than 10 % due to adjustment of the policy or if we exclude cover for the non-disclosed circumstance, you may cancel the contract in text form and without notice within one month after you received our notification. We have to draw your attention to this right of cancellation in our notification.

6.5 Exercising our rights

We need to assert our rights under clause 6.2 to 6.4 within one month in text form. The period starts when we become aware of the breach of the duty of disclosure that justifies our asserted right. We have to name the circumstances our statement is based on. Within one month, we can also subsequently state other circumstances to justify our statement.

We are only entitled to the rights under clause 6.2 to 6.4 if we have drawn your attention to the consequences of a breach of the duty of disclosure in text form by means of a separate notification. We cannot claim our rights under clause 6.2 to 6.4 if we were aware of the non-disclosed risk-related circumstance or the incorrectness of the disclosed information.

6.6 Cessation of our rights

Our rights of withdrawal (clause 6.2), cancellation (clause 6.3) and policy adjustment (clause 6.4) cease with expiry of a period of five years after conclusion of the contract. The period has a duration of ten years if you or your representative intentionally or fraudulently breached the duty of disclosure.

6.7 Rescission

Our right to rescind the contract due to fraudulent misrepresentation remains unaffected.

7 What to do in the event of an increase in risk

7.1 Increase in risk – definition:

7.1.1 An increase in risk occurs when, after you issued your contract statement, the actual circumstances are altered in a way that makes a claim or an increase in damage or unjustified claims against us more likely.

7.1.2 An increase in risk occurs in particular – but not limited to a situation – when there is a change to a risk-related circumstance we asked you about prior to the conclusion of the contract in text form.

7.1.3 No increase in risk in accordance with clause 7.1.1 occurs, when there has only been an immaterial change in the risk or if the risk is to be deemed as included in the policy according to the situation.

7.2 Your obligations and obligations of other insured persons

7.2.1 After issuing your contract statement, neither you nor any other insured person shall be allowed to increase a risk or allow a third party to increase a risk without our prior consent.

7.2.2 Where you or another insured person retrospectively become aware of the fact that a risk has been increased or allowed to increase without our prior consent, either you or another insured person are obliged to inform us immediately about this increase in risk.

7.2.3 You or another insured person need to inform us immediately about any increase in risk that occurs after you issued your contract statement and that is beyond your control, after you or another insured person have become aware of the respective situation.

7.3 Cancellation or adjustment of policy through us

7.3.1 Our right of cancellation

Where you or another insured person breach an obligation under clause 7.2.1, we may cancel the contract without notice if you or another insured person acted with intent or gross negligence when breaching the obligation.

If the breach is based on simple negligence, we can cancel the contract by giving one month's notice. If we become aware of an increase in risk in the cases stipulated in clauses 7.2.2 and 7.2.3, we can cancel the contract by giving one month's notice.

7.3.2 Policy adjustment

Instead of cancelling the policy, we can demand an appropriately raised premium in accordance with our business principles or exclude cover for the increased risk from the time of the increase in risk. If the premium increases by more than 10 % in such a case or if we exclude cover for the increased risk, you may cancel the

contract without notice within one month after you received our notification. We have to draw your attention to this right of cancellation in our notification.

7.4 Cessation of our rights

Our rights of cancellation or policy adjustment under clause 7.3 cease if we do not assert them within one month from the date we become aware of the increase in risk or if the condition prior to the increase in risk is restored.

7.5 Exemption from liability to pay due to increase in risk

7.5.1 If an insured event occurs after an increase in risk, we are not liable to pay if you or another insured person intentionally breached the obligations stipulated in clause 7.2.1. In case of a grossly negligent breach of these obligations by you or another insured person, we are entitled to reduce our benefits according to the severity of your or the other insured person's fault. You or another insured person must prove that you or he / she did not act with gross negligence.

7.5.2 In the event of an increase in risk in accordance with clauses 7.2.2 and 7.2.3, we are not liable to pay in case of a grossly negligent breach of your obligations, if the insured event occurs later than one month after we should have received the notification. In case of a grossly negligent breach of the obligations by you or another insured person, clause 7.5.1 sentences 2 and 3 apply accordingly. Our liability to pay continues to apply if we were aware of the increase in risk at the point in time stipulated in sentence 1.

7.5.3 Our liability to pay also continues to apply

7.5.3.1 if you or another insured person prove that the increase in risk was not the reason for the occurrence of the insured event or the extent of the liability to pay; or

7.5.3.2 if at the time of the insured event our period of notice had expired and we did not cancel the policy; or

7.5.3.3 if we, instead of cancelling the policy, demanded an appropriately raised premium in accordance with our business principles from the time of the increase in risk.

8 Start, end and area of validity of cover

8.1 Within the agreed contract period, cover starts at the point at which insured objects are removed from your permanent residence for the purpose of immediately embarking on the journey and ends as soon as the insured objects are returned to said permanent residence. If, in the event of a trip taken by motor vehicle, the baggage is not unloaded immediately upon arrival at the permanent residence, then cover shall end upon said arrival.

8.2 In the case of insurance agreements of less than one year's duration, cover shall be extended beyond the agreed contract period up until the end of the journey if the journey is delayed for reasons that are beyond your or another insured person's control and if you and the other insured persons are not in a position to apply for a renewal.

8.3 The insurance cover applies to the agreed area of validity.

8.4 Trips, walks and stays within your permanent place of residence are not deemed as journeys.

9 How to calculate the sum insured; definition of the insured value

9.1 The sum insured shall correspond to the insured value of the entire insured baggage according to clause 1. Gifts and souvenirs acquired on the journey are not taken into consideration.

9.2 The insured value shall be the amount that is generally required to procure new items of the same type and quality at your permanent residence minus an appropriate amount to reflect the condition (age, wear, use, etc.) of the insured objects (current value).

10 Payment of premiums and duration of contract

10.1 Start of insurance cover

The insurance cover starts on the date stipulated in the insurance policy when you pay the first or single premium immediately after it is due in accordance with clause 10.2.1.

10.2 Payment and consequences of late payment of the first or single premium

10.2.1 The first or single premium is due immediately on taking out the insurance policy, but not prior to the start of insurance cover. If payment of the annual premium in installments was agreed, only the first installment of the first annual premium shall be deemed to be the first premium.

10.2.2 Default

If you do not pay the first or single premium on time, you are considered to be in default 30 days after the expiry of the period stipulated in clause 10.2.1 and after receipt of a request for payment, unless you are not responsible for the delayed payment.

10.2.3 Later start of insurance cover

If neither you nor another insured person pay the first or single premium on time but at a later point in time, the insurance cover only starts from this later point in time if you were informed about this legal consequence by separate written notification or by a prominent notice in the insurance policy. This shall not apply if you prove that you were not responsible for non-payment.

10.2.4 Withdrawal

If neither you nor another insured person pay the first or single premium on time, we are authorized to withdraw from the contract until the payment is made. We are not allowed to withdraw if you prove that you are not responsible for non-payment.

10.3 Due date and consequences of late payment of a renewal premium

10.3.1 Due date and timeliness of payment

A renewal premium is due on the agreed date of the respective insurance period. Payment shall be deemed on time if it is made within the period stipulated in the insurance policy or premium statement. Failure to pay a renewal premium on time shall constitute default without reminder unless you are not responsible for the late payment. We are entitled to request compensation for the loss incurred through the delay.

10.3.2 Request for payment

Failure to pay a renewal premium on time authorizes us to send you a request for payment and set a payment period of at least two weeks in text form and at your expense (reminder). The reminder is only valid if we provide details on the backlog of payments consisting of premium, interest and costs and inform you about the legal consequences – exemption from liability to pay and right of cancellation – of a failure to pay on time.

10.3.3 Loss of insurance cover

If you are still in default of payment after expiry of the deadline, there will be no insurance cover from this point until payment is received (exemption from liability to pay), provided that we informed you respectively in our request for payment according to clause 10.3.2.

10.3.4 Cancellation

If you are still in default of payment after expiry of the deadline, we can cancel the contract without notice provided that we informed you respectively in our request for payment according to clause 10.3.2. If we have cancelled the contract and you pay the requested amount within one month after the cancellation, the contract remains in effect. There is, however, no insurance cover for insured events that occurred between the expiry of the deadline stipulated in clause 10.3.2 and the payment.

10.4 Direct debiting

10.4.1 Your obligations

If you gave us a direct debiting authorization, you have to make sure you have sufficient funds in your account on the due date of the premium.

10.4.2 Change of method of payment

If, through your fault, one or several premiums could not be collected despite repeated attempts to do so, we are authorized to cancel the direct debit agreement in text form. In the cancellation, we have to inform you of your obligation to transfer the due premium and future premiums yourself. You can be invoiced for any service fees charged by the banks for failed direct debit attempts.

10.5 Payment by installments

Where payment by installments has been agreed, any outstanding installments shall be deemed deferred until the agreed payment dates. The deferred installments of the current insurance period are due immediately if you are in default of full or partial payment of an installment or if compensation becomes due.

10.6 Contract duration

10.6.1 The contract is concluded for the period stipulated in the insurance policy.

10.6.2 Automatic renewal

Where a policy period of at least one year is agreed, the policy shall be renewed after expiry of the agreed period for a further year in each case unless you or we have received a cancellation in text form at least three months prior to the expiry of the respective insurance year.

10.6.3 End of contract

10.6.3.1 Policy period of less than one year

Where a policy period of less than one year is agreed, the policy shall end at the stipulated time without any notice of cancellation being required.

10.6.3.2 Cancellation of multi-year contracts

Where a policy period of more than three years is agreed, you may cancel the contract at expiry of the third year or of any subsequent year subject to a period of three months. The notice of cancellation in text form must reach us at least three months prior to the expiry of the respective insurance year.

10.6.4 Premium in case of early cancellation

10.6.4.1 General principle

In case of a cancellation of the insurance contract prior to expiry of the insurance period, we are only entitled to the part of the premium that relates to the period during which insurance cover was in effect.

10.6.4.2 Premium in case of revocation

Where you exercise your right to revoke your contract statement within two weeks, we only need to reimburse the part of the premium that relates to the period after receipt of the revocation. Prerequisite for this is that we informed you in the notice on the right of revocation about the legal consequences of revocation and about the payable premium and that you agreed that insurance cover will start prior to the end of the revocation period.

If we fail to inform you as stipulated in sentence 2 of this clause, we are obliged to also reimburse the premium paid for the first insurance year; this shall not apply, however, if you made use of benefits under the insurance contract.

10.6.4.3 Premium or fee for out-of-court work in case of revocation and withdrawal

If the insurance contract ends as a result of withdrawal because of a breach of a duty of disclosure (clause 6.2) or if we rescind the contract because of fraudulent misrepresentation (clause 6.7), we are entitled to the premium for the period before the notice of withdrawal or rescission entered into effect.

If we withdraw from contract in accordance with clause 10.2.4 due to delayed payment of the first or single premium, we are entitled to an appropriate fee for out-of-court work.

11 Compensation and underinsurance

11.1 We reimburse

11.1.1 the insured value of destroyed and lost objects at the time the damage occurred;

11.1.2 required repair costs and, if applicable, the remaining reduction in value, to a maximum of the insured value, for damaged objects that can be repaired;

11.1.3 only the value of the materials for films, image media, sound media and data media;

11.1.4 the official charges for the replacement of identity cards, passports, motor vehicle documents and other identification documents.

11.2 Consequential financial loss shall not be reimbursed.

11.3 If the sum insured in accordance with clause 9 is lower than the insured value at the time of the insured event (underinsurance), we shall only be liable in accordance with the proportional relationship between the sum insured and the insured value.

12 Occurrence of overinsurance and what to do in such a case

12.1 If the sum insured exceeds the value of the insured objects, both you and we can demand that the sum insured is reduced immediately to remove overinsurance.

12.2 From this point on, the premium will depend on the amount we would have demanded had the contract been concluded with its new content right from the start.

12.3 Where you concluded overinsurance with the intention to obtain an unlawful pecuniary advantage, any contract concluded with this intention is void. In such a case, we are entitled to the premium up to the date when we became aware of the circumstances that caused the contract to be void. Our potential claims for compensation remain unaffected.

13 Multiple insurance

13.1 Multiple insurance exists where the same risk is covered under several insurance contracts and where either the total sums insured exceed the insured value or where, for other reasons, the sum of compensation payments, which would have to be paid by each insurer in case there were no other parallel insurance policies, exceed the total damage.

13.2 Where multiple insurance has come about without your knowledge, you can ask for cancellation of the policy that was later arranged. You can also demand a reduction of the sum insured to the amount that is not covered by the policy arranged earlier. In this case, the premium needs to be reduced accordingly.

13.3 The right of cancellation or reduction shall cease if you fail to assert it within one month of becoming aware of the multiple insurance. The cancellation or reduction shall take effect when we receive the declaration in which it is requested.

13.4 Where you concluded multiple insurance with the intention to obtain an unlawful pecuniary advantage, any contract concluded with this intention is void. In such a case, we are entitled to the premium up to the date when we became aware of the circumstances that caused the contract to be void.

14 Your obligations and obligations of other insured persons; consequences of a breach of such obligations

14.1 You or another insured person have to

14.1.1 inform us immediately about any insured event;

14.1.2 avert and minimize damage wherever possible, submit claims for compensation against third parties (e. g. railway companies, post offices, shipping firms, airlines, hotel proprietors) properly and in due time or otherwise secure such claims and have to follow our instructions;

14.1.3 do everything in your / his / her power that could help clarify and resolve the matter. All documents that substantiate the reason for and level of the claim for compensation must be submitted by you or another insured person to the extent that the procurement of said documents can reasonably be expected of you or the other insured person. At request, you or the insured person shall also submit a list of all the objects insured according to clause 1 at the time the damage occurred.

14.2 Damage which occurred in the safekeeping of a transport company (including damage resulting from failure to deliver items in due time according to clause 2.3) or of a hotel or other form of lodging must be immediately reported by you or another insured person to said transport company, hotel or other form of lodging. Certification of this shall be submitted to us. In the case of damage that is not visible externally, the transport company shall be requested to view the damage and certify it immediately after its discovery. The relevant deadlines for making complaints in each case shall be observed.

14.3 Damage resulting from criminal acts (e. g. theft, robbery, intentional damage to property) must also be immediately reported by you or another insured person to the responsible police department, including submission of a list of all the objects lost. Your or another insured person need to have your / his / her notification confirmed by the police. In the case of damage resulting from loss (clause 2.2.2), you or another insured person shall make inquiries at the lost property office.

14.4 If you or another insured person intentionally breach an obligation that needs to be fulfilled in the event of a claim, we shall be exempt from the liability to pay. In case of a grossly negligent breach of obligations, we are entitled to reduce our benefits according to the severity of the fault. You must prove that you did not act with gross negligence.

14.5 Except for a case of fraudulent intent, we are obliged to pay if you or another insured person prove that the breach of obligation was neither the cause for the occurrence or determination of the insured event nor for the determination or scope of our liability to pay.

14.6 If you or another insured person breach the duty of disclosure or to provide information after the occurrence of an insured event, we are only exempt from our liability to pay in full or in part if we informed you about this legal consequence in text form by means of a separate notification.

15 Further cases of cessation of the liability for compensation

15.1 Where you or another insured person intentionally caused the damage, we are exempt from our liability for compensation.

15.2 Where you or another insured person act with gross negligence in causing the damage, we are entitled to reduce our benefits according to the severity of the fault.

15.3 Where you or another insured person act with fraudulent misrepresentation in trying to deceive us about facts that are relevant for the cause and amount of compensation, we are exempt from our liability for compensation.

16 Due date for payment of compensation and interest

16.1 Due date for payment of compensation

Compensation becomes due when our assessment regarding cause and amount of the claim is complete.

You can claim the minimum payable amount according to the respective circumstances as an installment one month after reporting the damage.

16.2 Interest

The following conditions apply for the payment of interest, unless there is any further obligation to pay interest in accordance with current legislation:

16.2.1 Interest on the compensation amount is to be paid from the time the damage is reported, unless compensation is paid within one month after notification of the damage.

16.2.2 The interest rate is 4 %.

16.2.3 Interest is to be paid together with the compensation.

16.3 Suspension

When calculating the deadlines in accordance with clause 16.2, the period during which the compensation could not be assessed or paid due to your fault or the fault of another insured person is not to be taken into account.

16.4 Deferment of payment

We can defer the payment as long as

16.4.1 there are doubts as to your authorization to receive the payment;

16.4.2 any regulatory or criminal proceedings against you or another insured person arising from this insured event are not yet completed.

17 Details on date and method of cancelling the contract following an insured event

17.1 Both parties may cancel the contract upon the occurrence of an insured event. Cancellation must be submitted in text form. It must be received by the other contracting party no later than one month after payment or denial of the compensation.

17.2 Cancellation by you

Where you cancel the contract, your cancellation will take effect immediately after being received by us. You may, however, determine that the cancellation shall take effect at a later point in time but not later than at the end of the current insurance period.

17.3 Cancellation by us

Our cancellation shall take effect one month after being received by you.

18 Statute of limitations for claims arising from the contract

18.1 Any claims arising from the insurance contract are subject to a limitation period of three years.

18.2 The period is calculated in accordance with the general conditions of the German Civil Code (BGB).

18.3 Where you have reported a claim under the insurance contract to us, the period from the start of the limitation period until you or another claimant receive our decision in text form is not included in the calculation of the limitation period.

19 Subrogation of claims for compensation

19.1 Subrogation of claims for compensation

Where you have a claim for compensation against a third party, we are subrogated to this claim if we compensate the damage. This subrogation cannot be asserted to your disadvantage. If your claim for compensation is against a person with whom you lived in cohabitation when the damage occurred, the subrogation cannot be asserted unless this person has intentionally caused the damage.

19.2 Obligations to secure claims for compensation

You have to assert your claim for compensation or any right to secure this claim properly and in due time and assist us, as far as necessary, in enforcing such claim for compensation after its subrogation by us. Where you breach this obligation intentionally, we are exempt from our liability to pay insofar as we can consequently not claim compensation from the third party. In case of a grossly negligent breach of obligations, we are entitled to reduce our benefits according to the severity of your fault. You must prove that you did not act with gross negligence.

20 Handing over of statements and payments between you and our agent

20.1 Regarding your statements

The insurance agent (broker) is authorized to receive your statements on:

20.1.1 conclusion or revocation of an insurance contract,

20.1.2 an existing insurance contract including the cancellation of such contract,

20.1.3 duties of disclosure and to provide information prior to signing the contract and during the validity of the insurance contract.

20.2 Regarding our statements

The insurance agent is authorized to forward to you the insurance policies or their addendums issued by us.

20.3 Payments to the insurance agent

The insurance agent is authorized to accept payments made by you with regard to the procurement or the conclusion of an insurance contract. You only need to accept restrictions to this authorization if you were aware of the restriction at the time of the payment or if you were not aware of the restriction as a result of gross negligence.

21 Notifications to us and consequences of failure to provide information about a change of name or address

21.1 Form

If written form is not requested by law and unless otherwise stipulated in the present contract, all notifications and declarations intended for us and affecting the insurance contract and directly addressed to us are to be made in text form. All notifications and declarations intended for us are to be directed to our head office or to the responsible branch office as stipulated in the insurance policy or its addendums. Any legal provisions on the receipt of notifications and declarations remain unaffected.

21.2 Failure to notify us about a change of name or address

Where you failed to notify us of a change in your address, the posting of a registered letter to the last address and last name known to us shall suffice for the purposes of submitting any declaration of intent to you. The same applies in case you failed to notify us of a change of your name. The declaration shall be deemed received three days after the letter is sent.

22 Competent court

22.1 Actions against us

For actions against us arising from the insurance contract, the competent court depends on our head office or branch office responsible for the insurance contract. Where you are a natural person, local responsibility also lies with the court in whose district you have your residence or, in the absence of such, your habitual residence at the time the action is brought.

22.2 Actions against you

Where you are a natural person, actions against you arising from the insurance contract need to be brought before the court responsible for your residence or, in the absence of such, your habitual residence. Where the policyholder is a legal entity, the competent court shall also be determined by the registered office or branch office of such entity. The same shall apply if the policyholder is a partnership, limited partnership, civil partnership or registered partner company.

22.3 Unknown residence or residence outside the European Union, Iceland, Norway or Switzerland

Where your residence or habitual residence is unknown at the time the action is brought, the competent court for actions arising from the insurance contract against you depends on our registered office or branch office responsible for the insurance contract. If you move your residence to a country outside the European Union, Iceland, Norway or Switzerland, responsibility lies with the courts of the country where we have our office.

23 Applicable law

German law applies to this contract.

24 Sanction clause

Irrespective of the other contractual provisions, insurance cover only exists if and as long as there are no economic, trade or financial sanctions or embargoes of the European Union or the Federal Republic of Germany that are directly applicable to the contracting parties.

This also applies to economic, trade or financial sanctions or embargoes by the United States of America, provided they do not conflict with the legal provisions of the European Union or the Federal Republic of Germany.

Special conditions for personal liability, baggage and accident insurance of Dialog Versicherung AG PROTRIP-WORLD (2014)

By way of derogation from or in addition to the General Insurance Conditions, the following Special Insurance Conditions apply for the additional package of the product PROTRIP-WORLD:

I. General information

1. Insured persons

Insurance cover can be provided to all persons who are not older than 69 years of age at the start of insurance and who are on a temporary stay abroad.

2. Area of validity

Abroad / foreign country /-ies means all countries except the country where the insured person has his / her permanent residence. In case of an interruption of the stay abroad during the contract period for reasons of a temporary stay in the country where the insured person has his / her permanent residence, benefits are provided for immediately occurring claims on site if the insurance contract was concluded for a period of at least 3 months and if the temporary stay in the country of permanent residence, the start of which needs to be proven by the policyholder in the event of a claim, has not yet exceeded a duration of 6 weeks.

3. Conclusion of the contract

- a) The insurance contract comes into effect upon receipt of the correctly completed application form (e. g. by handing out the insurance policy).
- b) If insurance is applied for in the valid application form issued by the insurer for this purpose and if the premium is paid, the contract is already valid (subject to receipt of the correctly completed form by the insurer) on the date of payment or transfer of the premium (date of the postmark or date on the receipt slip of the bank). The copy of the application form remaining with the applicant is deemed as the insurance policy.
- c) If insurance is applied for in the valid application form issued by the insurer for this purpose and if the intended direct debit mandate is given, the contract is already valid (subject to receipt of the correctly completed form by the insurer) on the date the application is sent (date of the postmark). The copy of the application form remaining with the applicant is deemed as the insurance policy.
- d) If insurance is applied for electronically through the provided online form and if the direct debit mandate is given, the contract is already valid (subject to receipt of the completed online form by the insurer) on the date the application is sent (sending date of the email). The insurance certificate electronically sent to the applicant is deemed as the insurance policy.

The following conditions apply for points a) to d): The insurance contract only comes into final effect if you made no use of your right of revocation within the revocation period. For persons who are not insurable, no insurance contract comes into effect even in case of payment or receipt of the premium. If the premium is paid for an uninsurable person nonetheless, the premium is available to the sender (less the expenses of the insurer).

4. Payment and due dates of the premiums

The premium is a single premium and is due for the entire term of the insurance after receipt of the insurance policy and after expiry of the revocation period. In case of a term of the insurance of more than one month, the parties can agree on premium payment in monthly installments; such installments are in each case deemed deferred until they are due. The first installment of the premium shall be due at the start of insurance, the subsequent installments at the start of the following month. Any deferred installments are due immediately if the policyholder is in default with the payment of an installment.

5. Contract period

The insurance contract is concluded for the single journey. The minimum term of insurance is one month, the maximum term of insurance is five years. The exact duration of the insurance can be found on the insurance policy.

6. Cancellation right of the policyholder

After expiry of the term of insurance applied for, insurance cover will end automatically. Please inform us

immediately if the insured person returns in advance from his / her trip. It only takes one call. You will then only have to pay the monthly premiums for the period prior to our receipt of this notification. The direct debit mandate will be stopped and we will pay back any overpaid premiums immediately in full and you do not need to pay any service fees. Where you change your au pair or host family, we will calculate the premium based exactly on the actual number of days spent in the respective family. You only need pay for the actual insurance period and not for the full month. Reimbursement starts from a minimum reimbursement amount of € 10. No service fees will be charged for reimbursement.

II. Accident insurance

1. Scope of services

The insurance policy covers occupational and non-occupational accidents worldwide (24-hour cover)

2. Sums insured

The sums insured per person are:

- € 10,000 death benefit,
- € 30,000 disability benefit,
- progression (increase in the sum insured in proportion to the degree of disability) of 350 %,
- € 25,000 for rescue costs,
- € 10,000 for plastic surgery.

3. Disability classification

Special conditions for accident insurance with a progressive disability classification of 350 % – if agreed

In amendment of clause 3 § 7 of the agreed General Accident Insurance Conditions, disability benefits will be paid based on the following table:

Degree of disability in % / Payment in % of the basic disability benefits

1 bis 25 / 1 bis 25	44 / 82	63 / 165	82 / 260
26 / 28	45 / 85	64 / 170	83 / 265
27 / 31	46 / 88	65 / 175	84 / 270
28 / 34	47 / 91	66 / 180	85 / 275
29 / 37	48 / 94	67 / 185	86 / 280
30 / 40	49 / 97	68 / 190	87 / 285
31 / 43	50 / 100	69 / 195	88 / 290
32 / 46	51 / 105	70 / 200	89 / 295
33 / 49	52 / 110	71 / 205	90 / 300
34 / 52	53 / 115	72 / 210	91 / 305
35 / 55	54 / 120	73 / 215	92 / 310
36 / 58	55 / 125	74 / 220	93 / 315
37 / 61	56 / 130	75 / 225	94 / 320
38 / 64	57 / 135	76 / 230	95 / 325
39 / 67	58 / 140	77 / 235	96 / 330
40 / 70	59 / 145	78 / 240	97 / 335
41 / 73	60 / 150	79 / 245	98 / 340

42 / 76	61 / 155	80 / 250	99 / 345
43 / 79	62 / 160	81 / 255	100 / 350

III. Baggage insurance

1. Scope of services

With this baggage insurance, the insurer provides you with protection against financial loss in the event of loss of or damage to the insured baggage. This protection is valid for the entire duration of your journey.

2. Sums insured

The sum insured per person is € 2,000. Insurance cover is only provided for the person stated in the insurance policy but not for family members, life partners or persons living in cohabitation with the insured person. In the event of damage to furs, jewelry, objects made of precious metals, laptops, photographic and film equipment and portable video systems, including their accessories, the liability for damages per insured event is limited to a maximum of 50 % of the sum insured. The deductible for all damages to baggage is € 50 per insured event.

3. Laptops

Laptops are covered within the maximum insurance limits.

4. Camping

4.1. By way of derogation from clause 3.2.2 AVB Reisegepäck 2008, insurance cover is also provided for damages that occur during camping on an official camping site (run by authorities, associations or private enterprises).

4.2. Where things are left in the tent or caravan without supervision, insurance cover is only provided for damage as a result of theft, burglary as well as malice or intent by third parties (intentional damage to property) if

4.2.1 in case of tents:

the damage does not occur during nighttime. Nighttime is considered to be the time between 10pm and 6am. The tent must at least be closed with a zipper or buttons;

4.2.2 in case of a caravan:

it is properly secured by being locked.

4.2.3 Furs, jewelry and objects made of precious metals (clause 1.4 AVB Reisegepäck 2008) are not covered if they were kept without supervision in a tent or caravan.

4.2.4 Supervision shall only be deemed as being your constant presence with the object to be safeguarded or the presence of a person of trust appointed by you or another insured person, but not, however, the guarding of a place that is open to general public use or a similar situation.

4.3 Photographic and film equipment and portable video systems, including their accessories, watches, optical devices, hunting weapons, radio and television equipment, sound recording and reproducing devices, including their accessories, are only insured as long as they

4.3.1 are carried securely in personal safekeeping or

4.3.2 are placed with the administration of an official camping site for safekeeping or

4.3.3 are placed in a caravan properly secured by being locked or in a fully enclosed and properly locked motor vehicle on an official camping site.

4.4. Where a camping site other than an official one (see clause 4.1) is used, damages as a result of theft, burglary, robbery, extortion as well as malice or intent by third parties (intentional damage to property) are excluded from cover.

4.5. Where you or another insured person breach an obligation arising from this contract and required to be fulfilled prior to the occurrence of an insured event, we may cancel the contract without notice within one month of becoming aware of the breach of obligation. We have no right of cancellation if you prove that the breach of obligation was neither caused by intent nor by gross negligence. Where an obligation arising from this contract is intentionally breached, you and the other insured persons will lose your / their insurance cover. In case of a

grossly negligent breach of obligations, we are entitled to reduce our benefits according to the severity of the fault.

Full or partial loss of insurance cover in case of a breach of a duty of disclosure and to provide information after occurrence of an insured event requires that we provided you or the other insured persons with a separate written notification about this legal consequence. Where you or another insured person prove that the obligation was not breached with gross negligence, insurance cover continues. Insurance cover will also continue if you or another insured person prove that the breach of obligation was neither the cause for the occurrence or determination of the insured event nor for the determination or scope of the benefits we are obliged to pay. This shall not apply if you or another insured person fraudulently breached the obligation.

5. Bicycles

5.1. By way of derogation from clause 1.5 AVB Reisegepäck, bicycles shall only be covered while they are not being put to their intended use.

5.2. In case of theft, insurance cover shall only apply if the bicycle was secured with a cable lock or a lock with similar security value (this does regularly not include frame locks) at the time of theft. Clause 2.1 AVB Reisegepäck remains unaffected. Where you or another insured person breach an obligation arising from this contract and required to be fulfilled prior to the occurrence of an insured event, we may cancel the contract without notice within one month of becoming aware of the breach of obligation. We have no right of cancellation if you prove that the breach of obligation was neither caused by intent nor by gross negligence.

Where an obligation arising from this contract is intentionally breached, you and the other insured persons will lose your / their insurance cover. In case of a grossly negligent breach of obligations, we are entitled to reduce our benefits according to the severity of the fault. Full or partial loss of insurance cover in case of a breach of a duty of disclosure and to provide information after occurrence of an insured event requires that we provided you or the other insured persons with a separate written notification about this legal consequence. Where you or another insured person prove that the obligation was not breached with gross negligence, insurance cover continues. Insurance cover will also continue if you or another insured person prove that the breach of obligation was neither the cause for the occurrence or determination of the insured event nor for the determination or scope of the benefits we are obliged to pay. This shall not apply if you or another insured person fraudulently breached the obligation.

5.3. We will only pay compensation for damages to things loosely attached to the bicycle and regularly used for its operation if they were stolen along with the bicycle.

5.4. The compensation per insured event is limited to € 250 if the theft takes place during nighttime. Nighttime is generally considered to be the time between 10pm and 6am.

5.5. You or another insured person have to acquire and keep documents about manufacturer, brand and frame number of the insured bicycles. Where you or another insured person breach this condition, you can only claim compensation if you are otherwise able to provide evidence for these features of the bicycle.

IV. Personal liability insurance – Standard

1. Sums insured and scope of services

The total sum of benefits paid by the insurer for all insured events in one insurance year within personal liability insurance per insured person is twice the amount of the following sums insured:

- € 1,000,000 lump sum for personal injury and property damage;
- € 100,000 for damage to rented property;
- € 10,000 for damage caused during activities carried out as an intern.

Damages to a host family's immovable property are covered.

The deductible for all liability losses is € 100 per insured event.

2. Special conditions for personal liability insurance

2.1 Insured risk

2.1.1 Within the agreed General Liability Insurance Conditions (AHB) and the following terms and conditions, the insurance policy covers your compulsory personal liability arising from the dangers of everyday life.

2.1.2 Excluded are the risks

2.1.2.1 of your own or an external business or commerce, profession, service or post (including honorary posts). This does not apply to a job-specific internship as part of a degree course;

2.1.2.2 of a responsible position in associations of any kind;

2.1.2.3 of unusual or dangerous activities.

2.2 Family, household and sports

The policy covers your compulsory liability

2.2.1 as head of family and household (e. g. responsibility for minors);

2.2.2 as employer of persons working in your household;

2.2.3 from the use of bicycles;

2.2.4 from practicing sports, except for hunting and taking part in horse, bicycle or motor vehicle racing and the respective preparations (training).

2.3 Vehicles, aircraft or watercraft

No cover is provided for your liability as the owner, proprietor, holder or operator of motor vehicles, aircraft or watercraft as well as trailers and resulting from damages caused by the use of such vehicle / trailer.

3. Special conditions for the insurance of au pair activities

Insurance cover includes the compulsory liability of au pairs (professional liability insurance) from activities which the insured person is allowed to carry out due to his / her level of training. This protection also applies for language travelers who live in families with children and carry out activities similar to those of an au pair. The cover also includes personal injuries of the host parents and their children culpably caused by the au pair. Depending on the selected insurance tariff, the policy might also cover damage to immovable property of the host family.

4. Inclusion of damage to rented property

4.1 By way of derogation from clause 7.6 of the agreed General Liability Insurance Conditions, the cover includes your compulsory liability for property damage and all resulting financial losses to rented buildings, residential property and other rooms in buildings rented for private use.

4.2 No cover is provided for

4.2.1 liability claims arising from

- wear and tear as well as excessive use;
- damage to heating installations, machinery, boiler plants and water heating systems, and to electrical and gas appliances as well as all resulting financial losses;
- damage to glass insofar as you are able to take out a separate policy for this purpose;
- damage caused by mold;

4.2.2 rights of recourse that fall under the waiver of recourse in accordance with the agreement of fire insurers for overall insurance claims.

4.3 The maximum compensation per loss event is stipulated in the insurance policy and amounts to twice the amount of this sum for all insured events of an insurance year. The compensation for damage to rented property is set off against the sum insured for property damage.

5. Subsidiary cover

Where the insured persons are covered by other personal or professional liability insurance policies, insurance cover is only provided if and insofar as the other insurer is not liable to pay.

Law excerpts

GERMAN INSURANCE CONTRACT ACT (VVG)

§ 8 Policyholder's right of revocation

(1) The policyholder may revoke his contractual agreement within 14 days. The policyholder shall declare his revocation to the insurer in writing, but need not state any reason; timely dispatch shall suffice for compliance with the time limit.

(2) The revocation period shall begin at such time as the policyholder receives the following documents in writing:

1. the insurance policy and the terms of contract, including the general terms and conditions of insurance, as well as the other information in accordance with section 7 (1) and (2), and

2. a clearly worded instruction regarding the right of revocation and the legal consequences of the revocation which makes clear to the policyholder his rights commensurate with the requirements of the means of communication employed, and the names of the person to whom the revocation is to be declared, with an address at which documents may be served, as well as a note making reference to the commencement of the revocation period and to the rules set out in subsection (1), second sentence.

(3) The right of revocation shall not apply

1. to contracts of insurance with a term of less than one month,

2. to contracts of insurance for provisional cover, unless they are distance contracts within the meaning of section 312b (1) and (2) of the German Civil Code,

[...]

§ 14 Due date of the payment

(1) Payments of the insurer are due after the end of the assessment required to determine the occurrence of an insured event and the amount of compensation payable by the insurer.

(2) If such assessment is not finished after expiry of one month since the notification of the insured event, the policyholder can request payment by installments amounting to the minimum that the insurer can be expected to be required to pay. The period shall be suspended as long as the assessment cannot be finished due to a fault of the policyholder.

(3) Any agreement under which the insurer is exempt from his obligation to pay default interest shall be invalid.

§ 19 Duty of disclosure

(1) The policyholder shall disclose to the insurer before making his contractual acceptance the risk factors known to him which are relevant to the insurer's decision to conclude the contract with the agreed content and which the insurer has requested in writing. If, after receiving the policyholder's contractual acceptance and before accepting the contract, the insurer asks such questions as are referred to in the first sentence, the policyholder shall also be under the duty of disclosure as regards these questions.

(2) If the policyholder breaches his duty of disclosure under subsection (1), the insurer may withdraw from the contract.

[...]

§ 28 Breach of a contractual obligation

(1) In case of a breach of a contractual obligation towards the insurer that the policyholder needs to fulfill prior to the occurrence of the insured event, the insurer may cancel the contract without notice within one month from the time he becomes aware of the breach, unless the breach is not the result of intention or gross negligence.

(2) Where the contract stipulates that the insurer is exempt from its liability to pay in case of a breach of a contractual obligation that the policyholder needs to fulfill, the insurer is only exempt from its liability to pay if the policyholder has deliberately breached the obligation. In the event of a grossly negligent breach of the obligation, the insurer shall be entitled to reduce his benefits according to the severity of the fault of the policyholder; the burden of proof for the non-existence of a grossly negligent behavior lies with the policyholder.

(3) By way of derogation from paragraph 2, the insurer is obliged to pay if the breach of the obligation was neither

the cause for the occurrence or determination of the insured event nor for the determination or scope of the insurer's liability to pay. Sentence 1 shall not apply if the policyholder has fraudulently breached the obligation.

(4) Where an obligation to provide information is breached after the occurrence of the insured event, the insurer's full or partial exemption from performance according to paragraph 2 requires that the insurer has informed the policyholder in writing by separate notification about this legal consequence.

(5) An agreement based on which the insurer is entitled to withdraw from the contract in the event of the non-observance of an incidental obligation shall be void.

§ 37 Delayed payment of first insurance premium

(1) If the single premium or the first premium is not paid in good time, the insurer shall be entitled to withdraw from the contract as long as the payment has not been made, unless the policyholder is not responsible for the non-payment.

(2) If the single premium or first premium has not been paid when the insured event occurs, the insurer shall not be obligated to effect payment, unless the policyholder is not responsible for the non-payment. The insurer shall only be released from liability if he had informed the policyholder of the legal consequence of non-payment of the premium in writing in a separate communication or by means of a conspicuous note in the insurance policy.

§ 38 Delayed payment of subsequent premium

(1) If a subsequent premium is not paid in good time, the insurer may set the policyholder a payment deadline of no less than two weeks at his expense and in writing. The setting of the deadline shall only be effective if it details the individual amounts of the premium which are in arrears, the interest and costs, as well as quoting the legal consequences associated in accordance with subsections (2) and (3) with expiry of the time limit; in the case of consolidated contracts, the amounts must be quoted separately.

(2) If the insured event occurs after the deadline expires, and if the policyholder is in arrears as regards the payment of the premium or of the interest or costs, the insurer shall not be obligated to effect payment.

(3) The insurer may, after the deadline expires, terminate the contract without prior notice insofar as the policyholder is in arrears as regards the payment of the due amounts. The termination can be linked to the setting of the payment deadline in such a way that it becomes effective once the deadline expires if the policyholder is in arrears as regards the payment at that point in time; the policyholder must be explicitly informed of this in the termination. The termination shall become void if the policyholder makes the payment within one month after the contract has been terminated or, if it has been linked to the setting of a deadline, within one month after the deadline expires; subsection (2) shall remain unaffected.

§ 86 Subrogation of claims for compensation

(1) Where the policyholder has a claim for compensation against a third party, the insurer is subrogated to this claim if he compensates the damage. This subrogation cannot be asserted to the policyholder's disadvantage.

(2) The policyholder has to assert his / her claim for compensation or any right to secure this claim properly and in due time and assist the insurer, as far as necessary, in enforcing such claim for compensation. Where the policyholder breaches this obligation intentionally, the insurer is exempt from his liability to pay insofar as he can consequently not claim compensation from the third party. In case of a grossly negligent breach of obligations, the insurer is entitled to reduce his benefits according to the severity of the policyholder's fault. The burden of proof for the non-existence of a grossly negligent behavior lies with the policyholder.

(3) If the policyholder's claim for compensation is against a person with whom he / she lived in cohabitation when the damage occurred, the subrogation in accordance with paragraph 1 cannot be asserted unless this person has intentionally caused the damage.

§ 193 Insured person; obligatory insurance

(1) The health insurance may be taken out for the policyholder or for another person. The insured person shall be that person for whom the insurance is taken out.

(2) Where the knowledge and the conduct of the policyholder are of legal significance under this Act, in the case of insurance for another person, account shall also be taken of the knowledge and conduct of that person.

(3) Each person with a place of residence in Germany shall be obligated to conclude and maintain with an insurance company licensed to operate in Germany for himself and for the persons legally represented by him, insofar as they are not themselves able to conclude contracts, a cost-of-illness insurance which comprises at least a cost refund for outpatient and inpatient treatment and in which the absolute and percentage excesses for outpatient and inpatient treatment which have been agreed for services covered by the respective tariff for each

person to be insured are limited to an amount of Euro 5,000 per calendar year; for persons entitled to medical expenses assistance, the possible excesses emerge through the analogous application of the percentage not covered by the rate of medical expenses assistance to the maximum amount of Euro 5,000. The obligation in accordance with the first sentence shall not apply to persons who

1. are insured or subject to obligatory insurance in statutory health insurance, or
2. have a right to free treatment, to medical expenses assistance or to comparable rights to the extent of the respective entitlement, or
3. have a right to benefits in accordance with the Asylum-Seekers Benefits Act, or
4. are recipients of recurrent benefits in accordance with the Third, Fourth and Seventh Chapters of Social Code Book XII, and recipients of benefits in accordance with Part 2 of Social Code Book IX, for the duration of the receipt of such benefits and during periods of an interruption of the receipt of benefits of less than one month if the receipt of benefits commenced prior to 1 January 2009.

A cost-of-illness insurance contract agreed prior to 1 April 2007 shall be deemed to meet the requirements of the first sentence.

§ 194 Applicable provisions

(1) Insofar as the insurance cover is granted in accordance with the principles of indemnity insurance, sections 74 to 80 and sections 82 to 87 shall apply. Sections 23 to 27 and section 29 shall not apply to health insurance. Section 19 (4) shall not apply to health insurance if the policyholder is not responsible for the breach of the duty of disclosure. Notwithstanding section 21 (3), first sentence, the time limit for asserting the insurer's rights shall be three years.

(2) If the policyholder or an insured person is entitled to the repayment of remuneration paid without legal basis to the provider of services for which the insurer has paid compensation on the basis of the contract of insurance, section 86 (1) and (2) shall apply mutatis mutandis.

(3) Sections 43 to 48 shall apply to health insurance with the proviso that only the insured person may demand payment of the insurance benefit if the policyholder has designated him in writing to the insurer as the beneficiary of the insurance benefit; such designation may be revocable or irrevocable. Where this condition is not met, only the policyholder may demand payment of the insurance benefit. The insurance policy need not be presented.

§ 195 Period of insurance

(1) Health insurance which may wholly or partially substitute for health and long-term nursing care insurance cover provided for in the statutory social insurance system (substitutive health insurance) shall be for an indefinite period, unless subsections (2) and (3) and sections 196 to 199 provide otherwise. Where the non-substitutive health insurance cover is provided in the manner of life insurance, the first sentence shall apply mutatis mutandis.

(2) In the case of vocational training, overseas, travel and residual debt health insurance, a period of contract may be agreed.

(3) In the case of health insurance for a person with a temporary residence permit for Germany, agreement may be reached to the effect that the insurance will expire after five years at the latest. If a shorter term has been agreed, a similar new contract may only be concluded with a maximum term that does not exceed five years when added to the term of the expired contract; this shall also apply if the new contract is concluded with another insurer.

§ 205 Termination of the contract by the policyholder

(3) If the contract of insurance provides that when the policyholder reaches a certain age or when other preconditions referred to therein are met the premium for another age or another age group applies or the premium is calculated taking old age reserves into account, the policyholder may terminate the insurance agreement with regard to the affected insured person within two months after the change with effect from the time it became effective if the premium increases as a result.

(4) If the insurer increases the insurance premium or reduces a benefit on account of an adjustment clause, the policyholder may terminate the insurance policy with regard to the affected insured person within two months after receipt of the communication of the change with effect from such time as the increase in the premium or the reduction of the benefits is to take effect.

§ 213 Collection of personal health data from third parties

(1) The insurer is only allowed to collect personal health data from the following third parties: physicians, any kind of hospitals, nursing homes and staff, other personal insurance providers and providers of compulsory health insurance as well as employers' liability insurance associations and authorities; such collection of data is only allowed if knowledge of said data is necessary to assess the insured risk or the liability to pay and if the affected party has given his / her declaration of consent.

(2) The declaration of consent in accordance with paragraph 1 can be given prior to issuing the contract statement. The affected person must be informed about data collection as stipulated in paragraph 1 and may object to the collection.

(3) The affected person can request at any time that a collection of data is only carried out if he / she gave his / her consent for each individual data collection.

(4) The affected person must be informed about his / her rights, in particular about the right of objection in accordance with paragraph 2 when being informed about data collection.

GERMAN INSURANCE SUPERVISION ACT (VAG)

§ 153 Hardship tariff

(1) Non-payers within the meaning of section 193 (7) of the German Insurance Contract Act form a tariff within the meaning of section 155 (3) sentence 1. The hardship tariff provides for the reimbursement of expenses solely in connection with benefits necessary for the treatment of serious illness and pain and those associated with pregnancy and maternity. By way of derogation from the above provision, expenses for insured children and young persons, in particular expenses for preventive medical examinations aimed at the early discovery of illnesses under statutory programmes and for immunisation recommended by the German Standing Committee on Vaccination (Ständige Impfkommision – STIKO) at the Robert Koch Institute under section 20 (2) of the German Protection against Infection Act (Infektionsschutzgesetz – IfSG) must be reimbursed.

(2) A standard premium must be calculated for all insured persons under the hardship tariff; section 146 (1) nos. 1 and 2 applies in all other respects. In the case of insured persons whose insurance contract only provides for the reimbursement of a percentage of the expenses incurred, the hardship tariff provides benefits equivalent to 20, 30 or 50 per cent of the insured treatment costs. Section 152 (3) applies, with the necessary modifications. The calculated premiums under the hardship tariff must not exceed the amount required to cover the claims expenditures under the tariff. Additional expenses that arise in connection with guaranteeing the limitations specified in sentence 3 must be allocated equally to all the insurer's policyholders with an insurance contract that satisfies an obligation under section 193 (3) sentence 1 of the German Insurance Contract Act. The provision for increasing age must be offset against the premium to be paid under the hardship tariff such that up to 25 per cent of the monthly premium is covered by a withdrawal from the provision for increasing age.

GERMAN CRIMINAL CODE (STGB)

§ 218a Exemption from punishment for abortion

(2) A termination which is performed by a physician with the consent of the pregnant woman is not unlawful if, considering the pregnant woman's present and future circumstances, the termination is medically necessary to avert a danger to the life of or the danger of grave impairment to the pregnant woman's physical or mental health and if the danger cannot be averted in another manner which is reasonable for her to accept.

(3) The conditions of subsection (2) are also deemed fulfilled with regard to a termination performed by a physician with the consent of the pregnant woman if, according to medical opinion, an unlawful act under sections 176 to 178 has been committed against the pregnant woman, there are cogent reasons to support the assumption that the pregnancy was caused by the act and no more than 12 weeks have elapsed since conception.

GERMAN CIVIL CODE (BGB)

§ 195 Regular limitation period

The regular limitation period is three years.

Data protection notice

a) Data protection principles of DR-WALTER GmbH (hereinafter referred to as DR-WALTER)

The protection of your privacy and of your personal data is paramount to us. We guarantee that we will always treat your data with the utmost confidentiality. Nowadays, insurance companies can only carry out their tasks with the aid of electronic data processing (EDP). Our state-of-the-art EDP enables us to handle contractual relationships correctly, quickly and in a cost-effective manner.

Both our behavior and our tools are in accordance with the General Data Protection Regulation (GDPR), the Federal Data Protection Act (BDSG) as well as with other specific regulations for online data protection. Our data protection officer ensures that our data protection principles and any relating regulations are fully met.

For further information, please go to <https://www.dr-walter.com/en/data-protection.html>.

b) Information about the use of your data by DR-WALTER

We need your personal data to process your applications and contracts, for claims handling and for individual supervision and consultancy. Collection, processing and use of your data are regulated by law. We have adopted a code of conduct for the handling of personal data that complies with the code of conduct of the German Insurance Association (GDV). Our code of conduct is based on data protection regulations of the German Insurance Contract Act (VVG), the General Data Protection Regulation (GDPR), the Federal Data Protection Act as well as other significant laws but also on further measures to strengthen data protection. For more information, go to <https://www.dr-walter.com/en/data-protection/personal-data.html> to learn about our code of conduct with regard to handling your personal data.

DR-WALTER cooperates with several service providers in the use of health data and other data protected under § 203 German Criminal Code (StGB). At <https://www.dr-walter.com/en/data-protection/list-of-service-providers.html>, we provide you with an overview of the service providers we work with. At your request, we can send you a printed list of the service providers as well as our code of conduct. Please contact:

DR-WALTER GmbH
Eisenerzstr. 34
53819 Neunkirchen-Seelscheid, Germany
P +49 2247 9194 -0
F +49 2247 9194 -40

c) Responsible body

Collection of your personal data is carried out by DR-WALTER GmbH, Eisenerzstr. 34, Germany, 53819 Neunkirchen-Seelscheid (responsible body).

d) Your rights

You have the right to obtain information free of charge about your data stored by us. You also have the right to withdraw any granted consent to the collection, processing and use of your personal data at any time and with future effect as well as the right to correct any incorrect data or to delete or block any impermissible or no longer needed data.

You can assert these rights to the above address directly against DR-WALTER. For further questions with regard to data protection, please contact our data protection officer at DR-WALTER, Eisenerzstr. 34, Germany, 53819 Neunkirchen-Seelscheid, P +49 2247 9194 -0.

Privacy Policy of Barmenia Krankenversicherung AG

Data protection information for interested parties and customers

With this notice, we inform you about the processing of your personal data by the Barmenia company responsible for data collection and your rights under data protection law.

Controller responsible for data processing

Depending on whether the insurance coverage and/or credit you seek or have is provided by Barmenia Versicherungen a. G., Barmenia Krankenversicherung AG, Barmenia Lebensversicherung a. G. or Barmenia Allgemeine Versicherungs-AG, the respective insurance company providing the specific insurance coverage is the entity responsible for processing your personal data. Names and contact details of the above mentioned

Barmenia companies:

Barmenia Versicherungen a. G.
Barmenia Krankenversicherung AG
Barmenia Lebensversicherung a. G.
Barmenia Allgemeine Versicherungs-AG
Barmenia-Allee 1
42119 Wuppertal
Phone: 0049 202 438 -00
Email: info@barmenia.de

You can contact the joint data protection officer of the aforementioned companies by mail at the above address with the addition 'Data Protection Officer' or by email at: datenschutz@barmenia.de

Purpose and legal basis of data processing

We process your personal data in compliance with the EU General Data Protection Regulation (GDPR), the German Federal Data Protection Act (BDSG), the provisions of the German Insurance Contract Act (VVG) relevant to data protection and all other applicable laws. In addition, our company has committed itself to the „Code of Conduct for the Handling of Personal Data by the German Insurance Industry“, which specifies the above-mentioned laws for the insurance industry. You can find them online at datenschutz.barmenia.de.

If you submit an application for the conclusion of an insurance contract in person or via an insurance broker commissioned by you or via one of our self-employed insurance agents, or if you obtain an offer for the conclusion of an insurance contract from us via one of the aforementioned agents, we require your personal data requested in the application form or in the offer screen (including health data for some products) in order to assess the risk to be assumed by us and, if necessary, for the establishment of the insurance contract.

In the event that an application is received/an offer is solicited by an insurance agent, the agent shall initially collect the aforementioned data in order to carry out its brokerage activities. With the official forwarding of your application to us or with the input of your data into the electronic offer screen of our company in case of electronic offer request, the agent transmits said data to us. If we accept your application or if you accept our offer, the requested insurance contract will come into effect and we will process this data and the personal data collected by us during the term of the contract at the same time for the purpose of implementing the contractual relationship, e.g., for invoicing or amending the contract. In the event of a claim, we require further information from you to be able, for example, to check whether an insured event has occurred and to estimate the amount of the loss.

The conclusion or performance of the insurance contract is not possible without the processing of your personal data.

In addition, we need your personal data to compile insurance-specific statistics, e.g., for the development of new tariffs or to meet regulatory requirements. We use the data of all contracts existing with a Barmenia company for a consideration of the entire customer relationship, for example, for advice regarding a contract adjustment, amendment, for decisions out of goodwill, or for comprehensive information provision.

The legal basis for the collection and processing of personal data for pre-contractual purposes and for the performance of the contract to be concluded or already concluded with you is Article 6 par. 1 b GDPR.

If specific categories of personal data (e.g., health data) are required for the conclusion and performance of the contract, we require your consent. If we create statistics with this kind of data, this is done on the basis of Article 9 (2) j GDPR together with Section 27 BDSG.

We also process your data to protect legitimate interests of us or of third parties (Article 6 par. 1 f GDPR). This may be necessary in particular:

- to ensure IT security and IT operations and to carry out IT tests
- to advertise our own insurance products and other products of the companies of the Barmenia Group and their cooperation partners as well as for market and opinion surveys
- to check your ability and willingness to pay
- to prevent, investigate and record criminal offenses; in particular, we use data analysis to identify clues that may point to insurance fraud.

In addition, we process your personal data to fulfill legal obligations, such as regulatory requirements, commercial and tax retention obligations, or our obligation to provide advice. The legal basis for the processing in this case is the respective legal regulations together with Article 6 par. 1 c GDPR.

Should we wish to process your personal data for a purpose not mentioned above, we will inform you of this in advance within the framework of the legal provisions.

Categories of recipients of the personal data**Reinsurers:**

If necessary, we insure risks assumed by us with special insurance companies (reinsurers). For this purpose, it may be necessary to transmit your contract and, if applicable, claims data to a reinsurer so that he can form its own opinion of the risk or the insured event. In addition, it is possible that the reinsurer supports our company due to its special expertise in risk or benefit assessment as well as in the evaluation of procedures. We transmit your data to the reinsurer only to the extent that this is necessary for the performance of our insurance contract with you or to the extent necessary to protect our legitimate interests. For more information on the reinsurer commissioned, please go datenschutz.barmenia.de. You can also request the information using the contact information above.

Distributor/intermediary:

Insofar as you are serviced by a distributor/intermediary with regard to your insurance contracts, your distributor/intermediary processes the application, contract and benefit data required for the conclusion and performance of the contract. Our company also transmits this data, insofar as it has been communicated to it directly by you or a third party, to the distributor/intermediary who manages your contract, insofar as the distributor/intermediary requires the information for your support and advice in insurance and financial services matters.

Data processing in the group of companies:

The insurance companies in the Barmenia group perform certain data processing tasks for the companies affiliated in the group. For example, your data may be processed for the central administration of address data, for telephone service, for billing purposes or for joint mail processing in a common program for all companies in the group. In our list of service providers, you will find the companies that participate in centralized data processing.

External service providers:

In some cases, we use external service providers to fulfill our contractual and legal obligations.

A list of the contractors and service providers we use and with whom we have more than a temporary business relationship can be found in the overview in the application/attachment and in the current version on our website at datenschutz.barmenia.de.

Further recipients:

In addition, we may transfer your personal data to other recipients, such as authorities for the fulfillment of legal notification obligations (e.g., law enforcement agencies, tax authorities or social insurance agencies).

Duration of data storage

We will delete your personal data as soon as they are no longer required for the above-mentioned purposes. In this context, personal data may be retained for the period during which claims can be asserted by us or against our company (statutory limitation period of three or up to thirty years). In addition, we store your personal data insofar as we are legally obligated to do so. Corresponding obligations to provide evidence and to retain records result, among other things, from the German Commercial Code (HGB) and the German Fiscal Code (AO). The storage periods are then up to ten years.

Right of access

You can request access to the data stored about you at the above address. In addition, under certain conditions, you can request the correction or deletion of your data. You may also have a right to restrict the processing of your data and a right to receive the data you have provided in a structured, common and machine-readable format.

Right to object

You have the right to object to the processing of your personal data for direct marketing purposes.

If we process your data to protect legitimate interests, you can object to this processing if reasons arise from your particular situation that conflict with the data processing.

Right to lodge a complaint

You have the option of contacting the above-mentioned data protection officer or a data protection supervisory authority with a complaint. The data protection supervisory authority responsible for us is:

Landesbeauftragte für Datenschutz und Informationsfreiheit
Nordrhein-Westfalen Postfach 20 04 44
40102 Düsseldorf

Credit reports

Insofar as it is necessary to protect our legitimate interests, we request information from credit agencies to assess your general payment behavior. For this purpose, we transmit your data (name, address and, if necessary, date of birth) to the credit agency. For more information on credit agencies, go to datenschutz.barmenia.de.

Information system of the insurance industry

If necessary, Barmenia Allgemeine Versicherungs-AG uses the information system (HIS) of informa HIS GmbH in vehicle insurance claims settlement to support risk assessment in the event of a claim, to clarify the facts in the examination of benefits and to combat insurance fraud. This requires an exchange of certain personal data with HIS. For more information on HIS, go to datenschutz.barmenia.de.

Data exchange with your former insurer and other agencies

In order to be able to check the information you provided when concluding the insurance contract (e.g., to carry over a no-claims bonus in motor vehicle liability insurance) or your information when an insured event occurs, personal data may be exchanged to the extent necessary for this purpose, e.g., with the former insurer named by you in the application or the treating physicians notified, as well as with hospitals, nursing homes, etc. If we transfer special categories of personal data (e.g., health data) in our inquiries, e.g., to the previous insurer, and if we collect such special data, we will obtain your consent in advance in each individual case.

Automated individual case decisions

In the context of health insurance benefit settlement, we make fully automated decisions about our obligation to pay benefits based on the information you provide about the insured event and the data stored about your contract. The fully automated decisions are based on rules defined in advance by the company. In doing so, we take into account, for example, the respective classification of the medications or medical treatments to be billed.

List of service providers

Service providers commissioned by DR-WALTER GmbH

In accordance with „Verhaltensregeln für den Umgang mit personenbezogenen Daten durch die deutsche Versicherungswirtschaft“
(Code of Conduct Data Protection)

German insurers have issued a Code of Conduct for the protection of your personal data and your privacy. We, DR-WALTER, comply with this Code of Conduct and would like to provide you with a list of service providers (companies and private individuals) with whom we work together during order processing when it comes to data processing and assignment of functions. The list also includes service providers with whom we cooperate in the use of health data and other data protected under § 203 German Criminal Code (StGB). We also work together with service providers who collect, process and use health data and other data protected under § 203 StGB.

Insurers and reinsurers	
Assigned functions: Collection, processing or use of personal data to establish, carry out or end an insurance contract (e. g. application processing, risk assessment, policy management, determination of the liability to pay)	Involved bodies / organizations: insurers mentioned in the insurance certificate • Generali Deutschland Krankenversicherung AG, • Dialog Versicherung AG, • Würzburger Versicherungs-AG, • HanseMerkur Reiseversicherung AG, • ERGO Reiseversicherung AG, • ERGO Versicherung AG, • Allianz Partners – AWP Health & Life SA, • Inter Krankenversicherung AG, • Hiscox SA, • Barmenia Krankenversicherung AG, • Barmenia Allgemeine Versicherungs-AG, • Techniker Krankenkasse, • BDAE Holding GmbH, • Foyer Santé S.A., • Globality S.A., • BD24 Berlin Direkt Versicherung AG, • Hallesche Krankenversicherung a. G.
Assistance companies	
Assigned functions: Assistance services	Involved bodies / organizations: • MD Medicus Assistance Service GmbH, • GMMI, Inc., • Europ Assistance SA, Niederlassung für Deutschland, • International SOS B.V., • International SOS GmbH, • Global Excel Management Inc.
Doctors, dentists, psychologists, psychiatrists, experts, other healthcare professionals, institutions for medical examinations, hospitals	
Assigned functions: Information on treatment and diseases, expert opinions on medical issues	Involved bodies / organizations: Individual assignments
Banks	
Assigned functions: Premium payments, payments in the event of a claim	Involved bodies / organizations: • Postbank Köln – eine Niederlassung der DB Privat- und Firmenkundenbank AG, • Kreissparkasse Köln, Mündelsichere Anstalt des öffentlichen Rechts, • Revolut Bank UAB

Lawyers	
Assigned functions: Legal advice, collections management, legal representation at court.	Involved bodies / organizations: Individual assignments
Market and opinion researchers	
Assigned functions: Customer satisfaction surveys, market and opinion research	Involved bodies / organizations: • TÜV NORD CERT GmbH, • eKomi Holding GmbH
Consulting companies	
Assigned functions: Support and advice e.g. in claims and billing matters (Germany and abroad), fraud detection, health programs; IT services	Involved bodies / organizations: Individual assignments
IT and telecommunication companies	
Assigned functions: Service providers for IT, network and telephone services	Involved bodies / organizations: • AssFINET AG, • Trevedi IT-Consulting GmbH, • IBExpert GmbH, • NETGO GmbH, • DATEV eG, • i42 Informationsmanagement GmbH, • Air Doctor Ltd., • enthus GmbH, • Telekom Deutschland GmbH, • mySolution Software & Consulting GmbH, • Pipedrive OÜ, • D.F.H.E. ADVISORS, • Calypso Verlag GmbH
Online support	
Assigned functions: Service providers for web hosting, internet portals, online policy procurement, email marketing and live chat	Involved bodies / organizations: • Host Europe GmbH, • 1&1 Internet AG, • JMC Technologieberatung GmbH, • united-domains AG, • STRATO AG, • ALL-INKL.COM, • COREER GmbH, • Einmahl WebSolution GmbH, • emarsys eMarketing Systems GmbH, • Sistrix GmbH, • KCS Internetlösungen Kröger GmbH, • Userlike UG, • aveta David Cürten, • consentmanager GmbH, • SIX Payment Services (Europe) S.A., • OMQ GmbH, • Flixcheck GmbH, • igroup Internetagentur GmbH & Co. KG
Credit bureaus, address brokers	
Assigned functions: Collection of information during the application stage, claims management	Involved bodies / organizations: Individual assignments
Disposal companies	

Assigned functions:	Involved bodies / organizations:
Disposal of files and data media, document destruction	Individual assignments

If required we will send you all contact details of our service providers.

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