TERMS AND CONDITIONS FOR LIMITED SICKNESS DAILY ALLOWANCE COVER OF THE EXPAT-SERIES FOR LONG-TERM JOURNEYS PART II

EXPAT CASH

1.	**INSURANCE COMPANY**	Würzburger Versicherungs-AG, Bahnhofstr. 11, D-97070 Würzburg
2.	**POLICE HOLDER:**	BDAE EXPAT GmbH
3.	**PARTIES ENTITLED TO INSURANCE:**	Corporate bodies and business enterprises, whose members and employees are internationally active.
4.	**INDIVIDUALS INSURABLE:**	Employees of the party entitled to insurance up to an age of 65, if they are insurable according to the conditions of insurance, part I, A, § 1. A contract, which verifies the existing employment contract with the party entitled to insurance or its representative offices, branch offices, subsidiaries, holdings or co-operation partners, must be submitted subsequently on request.
5.	**CONTRACTUAL BASIS:**	Terms and conditions for limited sickness daily allowance cover of the EXPAT-series for long-term journeys part I and part II (EXPAT CASH).
6.	**AREA OF APPLICATION:**	Worldwide. The following terms apply to the Federal Republic of Germany: foreign nationals may only be insured if they are temporarily resident in the Federal Republic of Germany. German nationals may only be insured for the length of the employment contract that they serve abroad. Temporary residence in the Federal Republic of Germany when on leave, or for the fulfilment of demonstrable business objectives, is also covered during this period. Not covered, even in spite of payment of premiums, is the taking up of residence and / or a work position by individuals of German nationality in the Federal Republic of Germany.
7.	**START OF INSURANCE COVER:**	At the time specified in the insurance confirmation document with consideration of conditions of insurance part I, A, § 4.
8.	**INSURANCE YEAR:**	From 1 July of each year respectively to 30 June of the following year.
9.	**DURATION OF INSURANCE RELATIONSHIP:**	The insurance agreement between the party entitled to insurance and policyholder is concluded with acceptance of the insured person into the group insurance policy, initially up to the end of the current insurance year. The agreement is extended for a further year respectively, if it is not terminated by the party entitled to insurance with one month notice to the end of the insurance year. The insurance relationship ends in each case with termination of the framework insurance agreement between insurance company and policyholder.
10.	**TERMINATION OF INSURANCE RELATIONSHIP:**	1. The policyholder is obligated to inform the party entitled to insurance and the insured persons of notice of termination of the framework insurance agreement with two months notice before the termination takes effect. 2. The insurance cover within the insurance agreement can be terminated for individual insured persons with two months notice to the end of the insurance year by the party entitled to insurance or the insured person in regard to the policyholder. 3. If the party entitled to insurance and the insured person are not identical, a notice of termination only becomes effective, if the insured person concerned by the termination has attained knowledge of the termination declaration. The policyholder proves this accordingly to the insurance company at deregistration from the framework insurance agreement. The insured person concerned is in this case entitled to continue the insurance contract under designation of a future party entitled to insurance. An appropriate declaration must be made within two months after receiving the notice of termination.
11.	**PREMIUM PAYMENTS:**	The premium is an annual premium, which is made out in equal monthly instalments. It becomes due for payment in advance by the time of the end of each contractual year.
12.	**DATA ON INSURED PERSONS STATE OF HEALTH:**	None. Please observe the exclusion of benefits in the conditions of insurance.
12.a	**ADDITIONAL STIPULATIONS ON BENEFIT EXCLUSION:**	For employees and members of the party entitled to insurance, who leave their country of residence and / or native country in the scope of personnel deployment at the instance of the party entitled to insurance, the exclusion of benefits according to conditions of insurance part I, A, § 4, para. 2 and § 5, para. 1 and § 6, para. 2a is limited notwithstanding to the following illnesses and insured events existing at the start of insurance: a) HIV-infections / AIDS and their consequences; b) cancer or benign tumours, which required treatment within the last five years before or at start of insurance; c) cardiac and coronary illnesses and their consequences, which were treated within the last 12 months before or at start of insurance.

State: 23.10.2019

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Registered office of the company: Hamburg • HRB 122052 • Local court of Hamburg • Managing Director: Philipp Belau

13.	**BENEFITS:**	**EXPAT CASH**	
		Payment of a daily sickness benefit allowance with medically proved complete (100%) inability to work. The party entitled to insurance can insure the proved income of the insured person, however at the most up to EUR 150 daily.	
13.a	**DURATION OF INSURANCE COVER:**	Benefit will be paid until the insured party is no longer unable to work, at most however for a duration of 546 days (78 weeks), including the selected period of restriction.	
14.	**PERIOD OF RESTRICTION:**	The insurance company's obligation to pay benefit shall begin after expiration of the number of performance-free days agreed according to the selected tariff starting from the point in time of the inability to work as certified by a doctor.	
15.	**MONTHLY PREMIUM:**	Monthly premiums for EUR 5,00 in each case insured sickness benefit daily allowance	Days without benefit (period of restriction)
	EXPAT CASH 14	EUR 7,60	14
	EXPAT CASH 42	EUR 0,90	42
	EXPAT CASH 91	EUR 0,55	91
	EXPAT CASH 183	EUR 0,25	183
16.	**OTHER MATTERS:**	If inability to work should be occasioned by several illnesses or accidents occurring simultaneously, the sickness benefit daily allowance will only be paid once. If several daily sickness benefit insurances have been concluded with one insurance company for the insured person, then the entire benefit from all contracts is limited to a maximum of EUR 150 daily.	

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TERMS AND CONDITIONS FOR LIMITED SICKNESS DAILY ALLOWANCE COVER OF THE EXPAT CASH FOR LONG-TERM JOURNEYS (PART I - WÜRZBURGER VERSICHERUNGS-AG)

PART A - GENERAL PROVISIONS

§ 1 INSURABLE PERSONS AND INSURABILITY

So far as has not been agreed to the contrary, the following shall apply:

1. The application of insured persons in the framework insurance agreement can only be submitted by the party entitled to insurance. Parties entitled to insurance are juridical and natural persons according to the respektive underlying tariff conditions.

2. Natural persons may be insured.

3. Not insurable and despite premium payment not insured are

   a) Persons who are in need of constant care. A person is in need of care if he/she for the most parts needs external help in order to manage the tasks of daily life.

   b) Persons who are constantly excluded from participating in daily life. For this classification, in particular the mental state and the objectiv life circumstances of the person must be considered.

4. No insurance cover is granted for insured persons, who are on a long term domiciled in the Federal Republic of Germany.

5. Natural persons with a limited residence permit for the Federal Republic of Germany may not be insured, if at the time of applying for registration in the framework insurance agreement the entire insurance duration of all health insurance agreements concluded during the visit exceed a period of 5 years.

§ 2 CONCLUSION AND DURATION OF THE INSURANCE CONTRACT

1. The framework insurance contract will be concluded between the insurance company and the policy holder for the duration of a year. The framework insurance contract will be extended by one year if notice of termination is not given with a term of notice of three months to the expiry date.

2. The legal regulations on the extraordinary right to give notice of termination remain unaffected.

3. At termination of the framework insurance agreement, the insurance company will offer the insured persons continuation of the insurance cover.

§ 3 PREMIUM, BENEFIT ADJUSTMENT, INSURANCE YEAR

1. The policyholder is entitled to deregister individual insured persons from the framework insurance agreement because of non-payment of the premium.

2. Insurance company shall be entitled to make changes in the premium level or the extent of the benefits at the beginning of a new insurance year, provided that it notifies the policyholder of this with a term of notice of three months to the end of the agreed tariff insurance year.

3. The insurance year will be defined in the conditions of insurance for sickness daily allowance cover of the EXPAT-series for long-term journeys conditions of insurance part II.

4. The policyholder shall be obliged to give the party entitled to insurance and the insured person written notice of an adjustment of the premium level or of the level of benefits paid within a term of two months to the end of the agreed tariff insurance year.

§ 4 SCOPE, START, DURATION, AND END OF INSURANCE COVER

The insurance company shall offer insurance cover to insured persons, who are resident for a limited time in the context of a limited visit to the agreed tariff area in the context of these conditions of insurance. So far as has not been agreed to the contrary, the following shall apply:

1. The insurance cover starts for the insured person after binding registration into the framework insurance agreement at the time (start of insurance) specified in the insurance confirmation document,

   a) however not before start of the stay of the insured person in the agreed tariff area;

   b) not before effectiveness of the insurability of the insured person according to tariff;

   c) not before payment of the premium;

   d) not before expiration of waiting periods agreed according to tariff.

2. No insurance cover is granted for claims occasioned before or at start of insurance.

3. No benefits will be paid for claims occasioned during the waiting period as agreed in the tariff.

4. The maximum duration of insurance cover for the insured person is defined in terms of the relevant tariff.

5. Insurance cover for individual persons insured comes to an end, even in connection with pending claims, with

   a) end of the insurance relationship of the insured person, at the latest however upon expiration of the maximum duration of insurance of the select ed tariff;

   b) deregistration from the group of persons insured by the party entitled to insurance, taking into account the terms of notice and conditions defined in the tariff;

   c) death of the person insured;

   d) with the ending of the insurability of an insured person according to conditions of insurance part I, A, §1;

   e) at the end of the month following termination of the temporary visit of the insured person in the agreed tariff area or final return of the insured person to their native country;

   f) as soon as the tariff terms on the insurability of an insured person are inapplicable;

   g) with termination of the framework insurance agreement between the insurance company and the policy holder.

§ 5 OBJECT OF INSURANCE COVER AND SCOPE OF INSURANCE BENEFITS

So far as has not been agreed to the contrary, the following shall apply:

1. The insurance company shall offer insurance cover for urgent and unexpected insured events occurring during the stay in the agreed tariff area.

2. The insurance cover results from the insurance confirmation, these conditions of insurance, the selected tariffs, statutory regulations of the Federal Republic of Germany.

§ 6 GENERAL LIMITATIONS OF THE OBLIGATION TO PAY BENEFIT

So far as has not been agreed to the contrary, the following shall apply:

1. Insurance cover is not granted for damage occasioned by active participation in strikes, war, war-like events, civil disturbance, damages by nuclear energy, as well as for such events, resulting from intentional activities of the policyholder,

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the party entitled to insurance or the insured person.

2. There is no obligation to pay benefit:

   a) On account of illnesses and complaints including their consequences existing and known at start of the insurance cover. Furthermore, there is no insurance cover for the consequences of such illnesses and accidents, which have been treated in the last six months before start of insurance.

   b) For spa and sanatorium treatments as well as rehabilitation measures organised by party legally responsible for rehabilitation;

   c) For treatments during a stay in a spa or a health resort, even if this involves a stay in hospital. This limitation shall no longer apply if the person insured has his/her constant place of residence there or if he/she becomes unable to work as a result of a sickness independent of the purpose of his/her visit or as a result of an accident that has occurred there, so long as this results, on medical testimony, in his/her being unable to journey home. This limitation also shall no longer apply if and to the extent that the insurance company has given written consent to benefit being paid before the start of residence abroad.

   d) In consequence of an accommodation occasioned by the need of lingering illness, care or custody;

   e) For the treatment of mental or emotional disturbances, or for hypnosis, psychoanalysis or psychotherapy;

   f) For immunisation measures;

   g) For medical aids;

   h) For treatment of sterility, including in vitro fertilisation well as pertinent preliminary examinations and subsequent treatments;

   i) For preventive medical examinations;

   j) For treatments by spouses, parents, children or persons living together in the immediate domestic circle or persons living together with the insured person within his/her own or guest family. Costs of materials will be reimbursed in keeping with the given tariff.

   k) For treatment on account of such illnesses, including their consequences, or consequences of such accidents as are occasioned through professional participation in sporting competitions organised by sporting federations and associations or prenotory measures related to these, or such as are recognised as war injuries and are not explicitly included in the insurance cover.

   l) On account of withdrawal measures including courses of withdrawal treatment;

   m) On account of such illnesses, including their consequences, which arise as a result of the person's having neglected to obtain the protective inoculations recommended by the World Health Organisation or prescribed by statute, unless there should be medical reasons why protective inoculation cannot be carried out. In this case, the medical reasons are to be proved to the insurance company by the submission of a doctor's certificate.

   n) For treatment of a dependency syndrome and its consequences;

   o) For attempted suicides and their consequences;

   p) For organ donations and their consequences;

   q) For tooth replacement (such as e.g. pivot teeth, insert fillings, crowns, implants) and orthodontic treatment, occlusive overlay aids and gnathologic measures.

Note: Please also regarded the Special Obligations on exclusions in the conditions of insurance, part I, B.

§ 7 OBLIGATIONS AND CONSEQUENCES OF FAILURE TO OBSERVE TO OBLIGATIONS

1. Policyholder, parties entitled to insurance and insured person are obligated, after occurrence of the insured event

   a) To avoid everything that could lead to an unnecessitated increase in costs;

   b) To immediately notify the insurance company or its agent of all damages that could presumably exceed a sum of EUR 1,000.00,

   c) To permit the insurance company or its agent to make all reasonable examinations regarding the cause and amount of its duty to pay benefits, provide all relevant information in this connection, to submit original documents, and submit a death certificate in the case of death.

2. If required by the insurance company, the insured person is obligated to be examined by a doctor assigned by the insurance company.

3. Start and end, as well as an interruption of a stay in the area according to tariff, as well as the presence of the tariff terms concerning insurability must be proved by the insured person on request of the insured company in the case of benefit.

4. If the policy holder, the party entitled to insurance or the person insured wilfully infringes one of the contractually agreed obligations, the insurance company shall be released from its obligation to pay benefits. In the case of a grossly negligent infringement of the obligation, the insurance company is entitled to reduce the benefits by an amount commensurate with the seriousness of the fault of the policyholder, the party entitled to insurance or the person insured. The onus of proving that there has been no gross negligence rests with the policyholder, the party entitled to insurance or the person insured.

5. The party entitled to insurance and the person insured are obligated to immediately communicate changes of address to the policyholder.

§ 8 PAYMENT OF INSURANCE BENEFITS

So far as has not been agreed to the contrary, the following shall apply:

1. The insurance company shall be obliged to pay out benefits only if the following documentary proof is supplied, which then become the property of the insurance company:

   a) Paid original receipts, which must carry the first name, surname and date of birth of the person treated, name and address of the doctor treating the patient, the description of the illness, nature of the services provided by the treating doctor according to type, place and treatment period. If compensation may be claimed under another insurance contract in connection with an insured event and if the claim has first been asserted for the other contract, then duplicates of the invoices will be considered sufficient, provided that the other insurance company has made a note on the document of the benefit paid. The insurer may request translation into German or English, if the original receipts or documents relevant for compensation are submitted in a foreign language.

   b) Prescriptions must be presented together with the doctor's bill, the bill for pharmaceuticals and medical aids together with the prescription.

   c) Proof of the amount of costs, which would have ensued in the case of a regular return journey, if benefits are asserted for a medically necessitated return transport. Furthermore, a doctor's certificate, which should clearly demonstrate the medical necessity of return transport, must be submitted.

   d) For the assertion of claims in connection with conveyance of the body or funeral costs an official death certificate and medical certificate giving the cause of death must additionally be submitted.

2. Costs that have been incurred in a foreign currency will be converted into the currency valid in Germany at the exchange rate of the day on which the receipts are received by the insurance company, unless the foreign currency required for payment of the invoice was acquired at a less favourable rate and that this was caused by a change in the currency valuation.

3. Costs incurred for the payment of insurance benefit by banker's draft to a foreign country, or for special forms of fund transfer which have been agreed on, will be deducted from the benefit paid.

4. Claims to insurance benefit can neither be assigned nor given in pledge.

5. In connection with examining the benefits to be provided, it may be necessitated for the insurance company to obtain personal-related health data within the legally permitted scope. If the party entitled to insurance or insured person fail to consent to this and the examination of benefits is not made possible in other ways, and if the insurance company as a result, is unable finally to determine the amount and scope of its obligation to provide benefits, the benefits are not payable.

6. One month after notification of a claim, the minimum amount which is payable as matters then stand may be claimed as a payment on account. The said period stops running as long as the insurance company's examination of the claim is hindered by fault on the part of the policyholder, the party entitled to insurance, the insured person.

7. Claims under this framework insurance agreement shall become time-barred after three years. The limitation period begins at the end of the year in which the benefit may be demanded.

§ 9 COMPENSATION FROM OTHER INSURANCE CONTRACTS AND CLAIMS AGAINST THIRD PARTIES

1. If compensation may be claimed under another insurance contract in an insured case, the other contract shall take precedence over this contract. This applies likewise, even if a subordinate liability has also been agreed upon in one of these insurance contracts, irrespective of when the other insurance contract was concluded. If the insured event was first communicated to the insurance company via this framework insurance agreement, the insurance company will pay in advance and will contact the other insurance company directly

concerning distribution of costs.

2. Claims of the policyholder, the party entitled to insurance or the insured person against third parties pass to the insurance company to the statutory extent, as far as the insurance company has reimbursed the damage. If necessary, the policyholder, the party entitled to insurance or the insured person is obligated to provide a statement of assignment to the insurance company. The insurance company's obligation to provide benefits is suspended until the statement of assignment has been submitted.

3. Claims of the policyholder, the party entitled to insurance or the insured person against a medical practitioners due to excessive fees pass to the insurance company to the statutory extent, if the insurance company has reimbursed the appropriate bills. If necessary, the policyholder, the party entitled to insurance or the insured person are obligated to assist during assertion of claims. Furthermore, the policyholder, the party entitled to insurance or the insured person are obligated, if necessary, to provide a declaration of assignment to the insurance company. The insurance company's obligation to provide benefits is suspended until the declaration of assignment has been submitted.

§ 10 OFFSET

Policyholder, the party entitled to insurance or the insured person is only entitled to a set-off against claims of the insurance company in the case of undisputed or finally asserted counterclaims.

§ 11 DECLARATIONS OF INTENTION AND NOTIFICATIONS

Declarations of intention and notifications to the insurance company require the written form (Letter, fax, e-mail, electronic data medium, etc.). The person insured has an intrinsic right to assert claims based on the contract against the insurance company.

§ 12 APPLICABLE LAW / LANGUAGE OF THE CONTRACT

German law shall apply unless international law takes precedence. The language of the agreement is German.

§ 13 SURPLUS SHARING

The insurance specified here is not entitled to surplus.

§ 14 SUPERVISORY AUTHORITY AND OMBUDSMAN

If you should not be satisfied with a benefit or a decision of the insurance company, please contact the respective insurance company directly.

The responsible supervisory authority for complaints is the Bundesaufsichtsamt für Finanzdienstleistungen, Graurheindorfer Straße 108, 53117 Bonn.

The Würzburger Versicherungs-AG is member of the Versicherungsombudsmann e.V. (registered association of the insurance ombudsman). This entitles persons insured in tariffs covered by the Würzburger Versicherungs-AG to address the independent and neutral Ombudsman, if they do not agree with a decision made. The procedure is free of charge.

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PART B – SPECIAL PROVISIONS

§ 1 OBJECT OF THE INSURANCE

So far as has not been agreed to the contrary, the following shall apply:

1. The insurance company offers insurance cover against loss of income in consequence of illness or accidents either within Germany or abroad. In case of a claim arising based on inability to work, it will provide a daily sickness benefit allowance.
2. A claim shall exist in case of a proven inability to work in the course of medically necessitated treatment by a doctor. The claim shall be considered to begin with the treatment, and shall end when medical findings indicate that the patient is no longer incapable of working.

3. It shall be seen as a case of inability to work in the sense of these conditions if the person insured, on the strength of medical evidence, cannot in any way exercise his or her profession, does not practise it and has no other means of gainful employment. If the medical treatment must be extended to an illness or the consequences of an accident which is unconnected, in terms of origin, with the condition treated hitherto, to that extent it shall be considered to be a new claim.

4. Insurance cover extends to a case of inability to work in the country of residence defined by the insurance agreement.

§ 2 SCOPE OF INSURANCE BENEFITS

So far as has not been agreed to the contrary, the following shall apply:

1. The insurance company's obligation to pay benefit shall begin with the first day of inability to work, with the addition of any days without benefit that form part of the terms of the agreement (period of restriction). The obligation to pay benefit ends when the person insured is able to resume work or with the end of the insurance cover according to conditions of insurance part I, A, § 4, para. 5 conditions of insurance part I, B, II, § 4, but at latest with the end of the duration of benefit as defined in the given tariff.

2. The insurance company hereby undertakes to adjust the insurance cover with effect from the first of the following month after application has been made by the party entitled to insurance and the person insured, if and to the extent that,

   a) through a change in the regular net income derived from professional activity an increase in the sickness daily allowance agreed upon is necessary, so as to maintain the previous percentage ratio between sickness daily allowance and net income. This obligation is also incumbent on the insurance company in case of a reduction in the level of a sickness benefit claim on a statutory benefit provider.

   b) through a change in the duration of continued payment of salary, in case of inability to work, a switch to a different tariff level with a different waiting period should be called for.

   This adjustment must be applied for within two months from the occurrence of the reasons for the change. The reasons for the change must be presented in a convincing way, and should be supported by documentary evidence at the request of the insurance company. In the case of current claims, the increased level of cover shall be allowed from the time when the change becomes effective.

3. If it should come to the knowledge of the insurance company that the net income of insured person has sunk below the level of the income on which the insurance agreement is based, it shall be entitled, without distinction as to whether an insurance claim has already occurred or not, to reduce the sickness daily allowance and the premium correspondingly, with retrospective effect from the onset of the reduction, or call for the reimbursement of benefit paid in excess.

4. The payment of sickness daily allowance is based on the assumption that the person insured will be treated by a doctor or in hospital for the duration of the period that he/she is unable to work.

5. In case of medically necessitated hospital treatment, the person insured has free choice from among those public and private hospitals that are under constant medical supervision, possess sufficient diagnostic equipment and conduct case histories.

6. In case of medically necessitated hospital treatment in licensed hospitals which also carry out health resort or sanatorium or convalescent treatments but which in other respects conform to the conditions of insurance part I, B, § 2, para. 5, benefits in terms of the given tariff will only be paid if the insurance company has given written consent to this before the start of the treatment. In case of a TB condition, benefit will be paid to the extent defined by the contract for hospital treatment in TB treatment centres and sanatoria as well.

§ 3 SPECIAL EXCLUSIONS

So far as it has not been agreed to the contrary, no benefit will be paid:

1. in a case of inability to work resulting exclusively from pregnancy, also from termination of pregnancy, miscarriage or childbirth. As an exception to this, benefit will be paid to individuals in a position of employment who are insured for the payment of sickness daily allowance with a waiting period (period without benefit) of at least 42 days, outside the statutory prohibitions on working in accordance with conditions of insurance part I, B, § 3, para. 2.

2. in case of inability to work during a period of statutory prohibition on working for expecting mothers in a position of employment and women in childbirth (maternity protection).

§ 4 ADDITIONAL STIPULATIONS ON THE END OF INSURANCE COVER

1. The insurance cover comes to an end, in addition to the circumstances mentioned in conditions of insurance part I, A, § 4, para. 5 with the person insured's giving up gainful employment, with the onset of occupational disability or earning incapacity or a partial reduction of earning ability or when the person insured starts to draw an old age pension or pension for occupational disability or earning incapacity or for reduced earning capacity.

2. The insurance company will decide on the question whether, to what degree and starting from what time occupational disability or earning incapacity or reduced earning capacity has set in, on the basis of the documentary evidence submitted to or obtained by the company, and will communicate its decision on the matter in writing.

State: 23.10.2019

§ 5 SPECIAL OBLIGATIONS

1. The insurance company should be notified immediately of a medically attested inability to work, through presentation of the appropriate documents. The doctor's certificate may be sent in advance by fax. The originals must be sent by post without delay. Certification by spouses or life partners, parents or children are not sufficient as a proof of inability to work. If notification is received late, the sickness daily allowance will be paid only from the day of receipt, not however before expiry of the period of restriction. Documentary proof of continuing inability to work should be regularly supplied to the insurance company, in so far as the insurance company does not request it on a different basis, at two-weekly intervals at most.

2. If a sickness daily allowance policy is concluded for a person insured with another insurance company, or if a person insured has recourse to the insurance entitlement included in statutory health insurance, the party entitled to insurance and the person insured shall be obliged to inform the insurance company forthwith of the other insurance policy.

3. The insurance company is to be notified without delay of any change of career by the person insured.

4. The party entitled to insurance and the insured person must immediately notify the insurance company of the termination of the employment contract between the party entitled to insurance and the insured person.

5. A new insurance policy with a third party insurer that includes a claim to sickness daily allowance may be taken out, or an existing one increased, only with the consent of the insurance company.

6. Persons insured are obliged to notify the insurance company immediately of a reduction in their net income derived from professional activity, if this is not just a temporary condition, or of a change in the duration of continued salary payment by their employer.

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RIGHT OF REVOCATION

1. Right of Revocation

You may revoke your contract declaration in text format within a term of 14 days without being obliged to indicate the reasons therefore (e.g. by letter, fax message, e-mail). Said term shall commence upon your receipt in text format of the confirmation of cover, the contractual provisions inclusive of the General and Special Insurance Terms and Conditions, the other information according to Section 7 paragraphs 1 and 2 of the German Insurance Contract Act (VVG) in conjunction with Sections 1 through 4 of the VVG-Decree on Information Duties and this information on your right of revocation.

For observing the revocation period, the revocation must have been dispatched in due time. The revocation shall be addressed to:

BDAE Expat GmbH, Kühnehöfe 3, 22761 Hamburg, Fax: +49-40-30 68 74-90, E-mail: info@bdae.com

2. Consequences of a Revocation

In the event of an effective revocation, insurance coverage shall cease to exist and all amounts paid by you within the framework of the contractual relationship shall be reimbursed to their full extent. The reimbursement of refundable amounts shall take place immediately and in no case later than 30 days after receipt of the revocation. If insurance coverage does not commence prior to the expiry of the revocation period, an effective revocation shall result in the obligation to refund any payments and surrender any benefits (e.g. interest) received.

3. Attention

The right of revocation shall lapse upon your explicit request if the contract has been completely fulfilled both by you and by us prior to your exercise of the right of revocatio.

End of Instructions on the Right of Revocation

State: 30.09.2019

INSURANCE AGREEMENT
EXPAT CASH

BETWEEN PARTY ENTITLED TO INSURANCE:		
Company:		
Address:		
Contact person:		Function:
Phone:	Fax:	e-mail:
AND POLICY HOLDER:		
BDAE EXPAT GMBH		
1.	The policy holder offers employees of the party entitled to insurance the opportunity of being included in the insurance cover of the product EXPAT CASH on the basis of registration with the insurance company. This will be based on the terms and conditions for limited sickness daily allowance cover of the EXPAT-series for long-term journeys part I and part II respectively (EXPAT CASH). The party entitled to insurance hereby confirms that he is in receipt of the above-mentioned basic conditions of an insurance agreement and undertakes that he will likewise bring these to the awareness of the persons insured.	
2.	The registration of the persons insured will be effected by the party entitled to insurance in list form, according to the given tariff. The registration list will be created for the first time at the start of the insurance agreement, after that annually up to 14 days before the start of the new insurance year. Changes in the duration of the year (new registrations and deregistrations) should be communicated to the policy holder on a monthly basis. The party entitled to insurance commits itself to inform the insured person about deregistration and if requested provide proof of that to the policyholder. The party entitled to insurance has to inform the policyholder about any changes of employment of an insured person without any delay if those changes might affect the insurability of the insured person or the scope of benefits. The party entitled to insurance is liable for all unjustified payments of benefits made by the policyholder caused by a breach of the duty to disclose.	
3.	The payment of premiums will be effected in connection with the first registration of persons insured, in advance and by the end of the current insurance year defined in keeping with the given tariff, thereafter annually in advance, payment to be made to an account to be designated by the policy holder within 14 days from the time when the policy holder makes out the invoice. Premium claims and/or liabilities resulting from amendments taking place during the year shall be settled within 14 days following issuance of an appropriate interim billing in the form of reimbursements to the party of entitled to insurance or subsequent refunds to the policy holder. Instead of annual payments the policyholder might accept shorter instalment payment periods with the following surcharges: monthly +5%, quarterly +3%, semiyearly +2%. The premium debtor is the party of entitled to insurance as concerns the policyholder, and the policyholder as concerns the insurer. The policyholder shall pay insurance premiums to the insurer.	
4.	The party entitled to insurance is aware that in case of non-payment of the premium due at any time, along with associated costs, or of payment not being made to the full extent, for reasons for which the party entitled to insurance can be held responsible, the policy holder will not register the persons insured who have been named with the insurance company, or in case of subsequent payments not being made will deregister them again. The party entitled to insurance is also aware that in this case the insurance cover is jeopardised.	
5.	This insurance agreement becomes effective on the:	
6.	Other agreements:	
SIGNATURES AND COMPANY STAMP:		
Place, date:	Party entitled to insurance:	(Signature, company stamp)
Hamburg, date:	Policy holder: BDAE EXPAT GmbH	(Signature, company stamp)

State: 23.10.2019

• BDAE EXPAT GMBH •
Kühnehöfe 3 • 22761 Hamburg
Phone: +49-40-306874-0 • Fax: +49-40-306874-90
info@bdae.com • www.bdae.com
Registered office of the company: Hamburg • HRB 122052 • Local court of Hamburg • Managing Direcor: Philipp Belau

REGISTRATION EXPAT CASH

PARTY / PARTIES ENTITLED TO INSURANCE:

EMPLOYEES TO BE INSURED:

GENERAL DETAILS													INSURED PARTY SCOPE OF BENEFITS*						
Serial no.	Surname, first name(s)	Nationality	Sex* m	Sex* f	Date of birth	Intended country of residence	Start of insurance month/year	Does a further sickness daily allowance cover exist? no	yes	Insurer	Insurance-No.	EXPAT CASH	Days without benefit 14	42	91	183	Daily allowance (EUR) max. 150 EUR/day	Empl.** is sent abroad

(*please tick)

(**In the context of human-resource relocation the expatriate changes the country/cultural area on instruction by his employer.)

Place, date: _____ Signature / stamp: _____

State: 23.10.2019

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ENDORSEMENTS EXPAT CASH

PARTY / PARTIES ENTITLED TO INSURANCE:

ADDITIONAL EMPLOYEES TO BE INSURED:

GENERAL DETAILS													INSURED PARTY SCOPE OF BENEFITS*						
Serial no.	Surname, first name(s)	Nationality	Sex* m	Sex* f	Date of birth	Intended country of residence	Start of insurance month/year	Does a further sickness daily allowance cover exist? no	yes	Insurer	Insurance-No.	EXPAT CASH	Days without benefit 14	42	91	183	Daily allowance (EUR) max. 150 EUR/day	Empl.** is sent abroad

CANCELLATION OF INSURED PERSONS:

Serial no.	Surname, first name(s)	Insurance-No.	Last month of insurance month/year

CANCELLATION OF INSURED PERSONS:

Serial no.	Surname, first name(s)	Insurance-No.	Last month of insurance month/year

Place, date:

Signature / stamp:

State: 23.10.2019

(*please tick) (**In the context of human-resource relocation the expatriate changes the country/cultural area on instruction by his employer.)

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LEGAL INSTRUCTIONS

by Würzburger Versicherungs-AG (Insurer) as per Section 19 Paragraph 5 Sentence 1 of the German Contract Insurance Act (VVG)

Information as per Section 19 paragraph 5 of the German Contract Insurance Act (VVG) about the Consequences of an Infringement of Statutory Reporting Duties

In order to enable the Insurer to properly review your application, you are required to give true and complete answers to the questions asked in the application documents. Circumstances considered by the applicant as being of little importance must also be reported. Any information you do not want to render to the insurance broker is to be directly reported in writing to the Insurer without any delay. Please note that you put your insurance cover at risk whenever you render incorrect or incomplete information. For more details on the consequences of an infringement of reporting duties, reference is made to the following information.

Are there Pre-Contractual Reporting Duties?

Until the time of submitting your contract declaration, you shall be obliged to give the Insurer correct and complete notice of any and all risk-relevant circumstances known to you and requested by the Insurer in text format. Risk-relevant circumstances are circumstances having significance for the Insurer's decision to conclude the contract with the contents agreed upon. Risk-related circumstances requested by the Insurer after your contract declaration, but prior to contract acceptance by the Insurer must also be reported.

What are the Possible Consequences of an Infringement of the Pre-Contractual Reporting Duty?

1. **Rescission of Contract and Loss of Insurance Cover**

   In the event that you and/or the person to be insured fails to comply with the pre-contractual reporting duty, the Insurer shall be entitled to rescind the contract, unless you are able to provide evidence that you did not infringe the reporting duty with intention or with gross negligence. In the event of a grossly negligent infringement of the reporting duty, the Insurer shall not be permitted to rescind the contract if the contract would also have been concluded by the latter, even if under different terms and conditions, had the Insurer been aware of the undisclosed circumstances. In the event of a rescission, insurance coverage shall cease to exist. If the Insurer rescinds the contract after occurrence of an insured event, the Insurer shall continue to be obliged to pay compensation if you are able to provide evidence that the circumstance that failed to be reported or to be correctly reported by you has neither been the cause for the occurrence or determination of the insured event nor for the determination or volume of the duty to indemnify. The Insurer's duty to indemnify shall, however, cease to exist if the reporting duty has been violated by you with fraudulent intent. In the event of a rescission due to an infringement of the reporting duty, the Insurer shall be entitled to receive insurance premiums until the rescission becomes effective.

2. **Cancellation**

   In the event that the Insurer is not permitted to rescind the contract due to the absence of intention or gross negligence on your part when you failed to comply with your reporting duty, the Insurer shall be entitled to terminate the contract by observing a notice period of one month. The Insurer's right to terminate shall be excluded if the contract would also have been concluded by the latter, even under different terms and conditions, had it been aware of the undisclosed circumstances.

3. **Amendment of Contract**

   If the Insurer is not permitted to rescind or terminate the contract because it would have had concluded the contract also in knowledge of the undisclosed risks, even if under different terms and conditions, the other terms and conditions shall upon the Insurer's request retroactively become a part of the contract if you negligently violated the reporting duty. If the premium is, due to the contract amendment, increased by more than 10% or the Insurer excludes the coverage of the risk related to the undisclosed circumstance you shall be entitled to terminate the contract with immediate effect within one month after having received the respective notice of the Insurer about the contract amendment. The Insurer shall draw your attention on this right in its notification.

4. **Execution of the Rights of the Insurer (Section 21 of the German Insurance Contract Act (VVG))**

   The Insurer shall be entitled to assert its rights of rescission, cancellation or contract amendment in writing within a term of one month. Said term shall commence on the date on which the Insurer becomes aware of the infringement of the reporting duty underlying the right asserted by it. When executing its rights, the Insurer shall indicate the circumstances relied on in this context. As long as the time period according to sentence 1 has not yet expired, the Insurer may in support of its decision also indicate additional circumstances at a later time. The Insurer shall not be permitted to rely on the rights of rescission, cancellation or contract amendment if it was aware of the undisclosed risk or the incorrectness of the reported information. Its rights of rescission, cancellation or contract amendment shall terminate upon expiry of three years after contract conclusion. This shall not apply to insured events occurred prior to the expiry of said time period. In the event that you infringed the reporting duty intentionally or fraudulently, the period shall be extended to ten years.

5. **Fraudulent Misrepresentation (Section 22 of the German Insurance Contract Act (VVG))**

   The Insurer's right to contest the contract on the grounds of fraudulent misrepresentation shall remain unaffected.

6. **Representation by another Person (Section 20 of the German Insurance Contract Act (VVG))**

   In the event that you have yourself represented by another person when concluding the contract, both the knowledge and fraudulent intent on the part of your representative and your own knowledge and fraudulent intent shall be taken into account with respect to the reporting duty, the rescission, cancellation, contract amendment and the deadline for the execution of the Insurer's rights. A reliance on an absence of intention or gross negligence when failing to comply with the reporting duty may only be relied on when neither your representative nor you can be made liable for intention or gross negligence.

Place, date

Signatures/Stamp (Person Entitled to be Insured)

State: 10.10.2019

CONSENT

to the Collection and Use of Health Data and Declaration of Release from Secrecy towards Würzburger Versicherungs-AG (Versicherer)

Part I - Statement upon Application

The declarations of consent and release from secrecy according to Part I. were prepared on the basis of the coordination process between the Gesamtverband der deutschen Versicherungswirtschaft e.V. (GDV) and the data protection supervisory authorities.

The German Insurance Contract Act, the Federal Data Protection Act as well as other data protection regulations do not provide for an adequate legal basis for the collection, processing and use of health data by insurance companies. In order to be able to obtain and use your health data in connection with this application and the contract, we therefore need your consent(s) according to data protection regulations. In addition, Würzburger Versicherungs-AG is in need of your statements of release from secrecy in order to be able to obtain your health data from parties subject to secrecy such as, for instance, physicians.

As health insurance company, Würzburger Versicherungs-AG needs your statement of release from secrecy also in order to be able to disclose your health data or any other data protected according to Section 203 StGB [German Criminal Code] such as, for instance, the fact that a contract has been concluded with you, to other entities or parties such as e.g. assistance, reinsurers.

The following statements of consent and release from secrecy are indispensable for checking your application and for concluding, implementing or terminating your insurance contract for Würzburger Versicherungs-AG. If you fail to make such statements, the conclusion of a contract will, as a rule, not be possible.

The statements relate to the handling of your health data and other data protected according to Section 203 StGB

- on the part of the Würzburger Versicherungs-AG itself (see clause 1.);
- in connection with enquiries addressed to third parties (see clause 2.);
- when disclosing data towards entities or parties outside Würzburger Versicherungs-AG (see clause 3.), and
- if the contract fails to come into being (see clause 4.).

These statements will apply with respect to co-insured persons legally represented by you, such as your children, to the extent that they are not able to recognise the significance of this consent and are therefore not able to make statements on their own.

1. Collection, storage and use of health data provided by you on the part of Würzburger Versicherungs-AG

I agree that Würzburger Versicherungs-AG collects, stores and uses the health data provided by me in connection with this application as well as in future to the extent that this is necessary for the examination of my application and for concluding, implementing and terminating this insurance contract.

2. Request for information on health issues from third parties

2.1 Request for health data from third parties for risk assessment and verification of the duty to indemnify

For assessing the risks to be insured, it may become necessary to obtain information from entities or parties retaining health data concerning your person. In addition, it may become necessary for Würzburger Versicherungs-AG to check the information on your health condition, as rendered by you for substantiating your claims or as it can be derived from submitted documents (e.g. invoices, prescriptions, expert reports) or information rendered by, for instance, a physician or other members of the medical profession, in order to verify its duty to indemnify. Such examination shall be carried out to the necessary extent only. Würzburger Versicherung-AG needs your consent thereto, inclusive of a release from secrecy for itself as well as for these parties for the case that health data or other information protected according to Section 203 StGB must be forwarded within the framework of such requests.

You may make these statements already here (I) or at a later time with respect to an individual case (II). You may change your decision at any time. Please select one of the following two options:

Option I:

☐ I agree that - to the extent necessary for risk assessment or verification of the duty to indemnify - Würzburger Versicherungs-AG collects my health data from physicians, caregivers as well as employees in hospitals, other health institutions, care homes, personal insurers, statutory health insurance funds, trade associations and public authorities and uses them for these purposes.

I release the indicated persons and employees of the aforementioned institutions from their secrecy duties to the extent that health data permissibly stored with respect to my person and arising from examinations, consultations, treatments as well as insurance applications and contracts made during a period of up to ten years prior to the date of my application are disclosed towards Würzburger Versicherungs-AG.

In addition, I agree that in this context my health data are - to the extent necessary - disclosed by Würzburger Versicherungs-AG towards these parties or entities and, to this extent, also release the persons becoming active for Würzburger Versicherungs-AG from their secrecy duties.

Prior to every data collection according to the preceding paragraphs, I will be informed about the persons by whom and the purpose for which data are planned to be collected, and furthermore about the fact that I may raise objections and submit the required documents on my own.

Option II:

☐ I want Würzburger Versicherung-AG to inform me in each individual case from which persons or entities and for what purpose information is required. Afterwards, I will decide whether I

- agree to the collection and use of my health data by Würzburger Versicherungs-AG, release the indicated persons or entities and their employees from their secrecy duties and agree to the disclosure of my health data to Würzburger Versicherungs-AG
- or whether I want to submit the required documents myself.

I am aware that this may result in a delay of application processing or the verification of the duty to indemnify. To the extent that the aforementioned declarations relate to my statements at the time of application, they shall be valid for a period of five years after contract conclusion.

If, after contract conclusion, Würzburger Versicherungs-AG becomes aware of specific circumstances indicating that, at the time of application, incorrect or incomplete information was deliberately furnished and, as a result, influence was exerted on risk assessment, the statements shall be valid for a term of up to ten years after contract conclusion.

2.2 Statements for the event of your death

In order to verify our duty to indemnify, it might become necessary to check health data even after your death. An examination may also become necessary if, up to a period of ten years after contract conclusion, Würzburger Versicherungs-AG becomes aware of circumstances indicating that incorrect or incomplete information might have been rendered at the time of application and that, hence, influence was exerted on risk assessment. For this purpose, too, we need a consent and a statement of release from secrecy. Please select one of the following two options:

State: 01.09.2019

Option I:

☐ For the case of my death, I give my consent to a collection of my health data from third parties for the purpose of verifying a duty to indemnify or for examining the application again, if necessary, as described in the first checkbox (see above 2.1. - Option I).

Option II:

☐ If, after my death, health data must be collected in order to verify a duty to indemnify or to examine the application again, my heirs or - if different - the beneficiaries of the contract shall be authorised to decide upon consents and statements of release from secrecy.

3. Disclosure of health data and other data protected according to Section 203 StGB to entities or parties outside Würzburger Versicherungs-AG

Würzburger Versicherungs-AG contractually obliges the following entities or parties to comply with the provisions on data protection and data security.

3.1 Disclosure of data for medical assessment

In order to assess the risks to be insured and to verify the duty to indemnify, it may become necessary to involve medical experts. Würzburger Versicherungs-AG is in need of your consent and statement of release from secrecy if, in this context, your health data and other data protected according to Section 203 StGB are disclosed. You will be given notice of the respective data disclosure.

I agree that Würzburger Versicherungs-AG transfers my health data to medical experts if this is necessary within the framework of risk assessments or verifications of the duty to indemnify and that my health data are used there according to the purpose of the transfer and that the results are sent back to Würzburger Versicherungs-AG. With respect to my health data and other data protected according to Section 203 StGB, I release the persons active for Würzburger Versicherungs-AG and the experts from their secrecy duties.

3.2 Delegation of tasks to other entities or parties (business enterprises or persons)

Some tasks such as, for instance, risk assessments, processing of submitted claims or customer service by phone, which may involve the collection, processing and use of your health data, are not carried out by Würzburger Versicherungs-AG itself, but instead delegated to another entity or party. If, in this context, your data protected according to Section 203 StGB are disclosed, Würzburger Versicherungs-AG needs your statement of release from secrecy for itself and, where appropriate, for the other entities or parties.

BDAE Expat GmbH as policyholder maintains a constantly updated list where the entities/parties and categories of entities/parties contractually engaged in collecting, processing or using health data for BDAE Expat GmbH and Würzburger Versicherungs-AG as well as the delegated tasks are indicated. The currently valid list is available on the Internet under www.bdae.com/images/forms/docs/en/List_of_service_providers.pdf or can be obtained from the data protection officer of the BDAE Group, HUBIT e.K., Postfach 610120, 28261 Bremen, e-mail: datenschutz@bdae.com. In order to be able to disclose your health data towards the entities/parties mentioned in this list and to have them processed your data, we and Würzburger Versicherungs-AG are/is in need of your consent.

I agree that Würzburger Versicherungs-AG discloses my health data towards the entities/parties indicated in the aforementioned list and that the health data are collected, processed and used there for the indicated purposes to the same extent as Würzburger Versicherungs-AG would be allowed to do. To the necessary extent, I release the employees of Würzburger Versicherungs-AG and other parties or entities from their secrecy duties with respect to the disclosure of health data and other data protected according to Section 203 of the StGB.

3.3 Data disclosure to reinsurers

For the purpose of safeguarding your claims, Würzburger Versicherungs-AG may involve reinsurers who assume the risk either totally or in part. In some instances, the reinsurers make use of other reinsurance companies for such purposes so that your data will also be disclosed towards such other reinsurance companies. In order to enable the reinsurers to get their own impressions of the risk or insured event, Würzburger Versicherungs-AG might submit your application form or claims for payment of benefits to the reinsurance companies. This will particularly be the case when the insurance sum is especially high or the risk is difficult to assess. Moreover, it is possible that the reinsurance company renders assistance to Würzburger Versicherungs-AG on the basis of its special expertise during the risk assessment process or verification of the duty to indemnify as well as during the assessment of process sequences. If reinsurers have hedged the risk, they can monitor whether Würzburger Versicherungs-AG has assessed the risk or an insured event correctly. In addition, data on your existing contracts and applications are disclosed towards reinsurers to the required degree so that they are able to check whether and to what amount they can participate in the risk. Data on your existing contracts may be forwarded to reinsurers for the purpose of billing premium payments and settling insured events. For the aforementioned purposes, anonymised or pseudonymised data, if possible, but also personal health data will be used. A use of your personal data by reinsurance companies will be limited to the aforementioned purposes. Würzburger Versicherungs-AG will give you notice about a disclosure of your health data to reinsurers.

I agree that my health data are - to the necessary extent - forwarded to reinsurers and used by them for the indicated purposes. I release persons active for Würzburger Versicherungs-AG to the necessary extent from their secrecy duties with respect to health data and other data protected according to Section 203 StGB.

3.4 Disclosure of data to self-employed intermediaries

As a rule, Würzburger Versicherungs-AG does not disclose data on your health state to self-employed intermediaries. In the following events, however, data permitting conclusions on your health or information on your contract, as protected according to Section 203 StGB, might be disclosed towards insurance intermediaries for information purposes. To the extent required for contract-related consultation purposes, the intermediary supporting you might receive information on the fact whether and, when appropriate, under what conditions (e.g. acceptance of a risk markup, exclusion of certain risks) your contract can be accepted. The intermediary having submitted your contract will get knowledge of a contract conclusion and its content. In this context, the intermediary will also be informed whether risk markups or exclusions of certain risks have been agreed upon. If you change the intermediary supporting you, the contract data containing the information on risk markups and exclusions of certain risks may be disclosed towards the new intermediary. When you change the intermediary who supports you we will give you notice of the disclosure of health data towards the new agent and of your possibility to raise objections.

I agree that, in the aforementioned events, Würzburger Versicherungs-AG discloses my health data and other data protected according to Section 203 StGB to the required extent towards the self-employed insurance intermediary who is in charge of my affairs and that such data are collected, stored and used there for consultation purposes.

4. Storage and use of your health data if the contract fails to come into being

If a contract with you fails to come into being, Würzburger Versicherungs-AG will retain your health data collected within the framework of the risk assessment for the case that you apply for insurance coverage again. Würzburger Versicherungs-AG will also store your data in order to give a reply to enquiries, if any, by other insurance companies. Your data will be stored by Würzburger Versicherungs-AG until expiry of the third calendar year after the year of application.

I agree that Würzburger Versicherungs-AG may, for the aforementioned purposes, store and use my health data in case that the contract fails to come into being for a period of three years after the expiry of the calendar year during which the application was filed.

Place, Date

Signatures (Employee entitled to be insured; if appropriate as legal representative of persons to be co-insured)

State: 01.09.2019