General conditions | **Group insurance policy**
Outpatient Healthcare
AMBU COMFORT

AXA Belgium SA/NV insurance company admitted under No 0039 to conduct Life and Non-Life insurance business (Royal Decree 04-07-1979, BS 14-07-1979)
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GLOSSARY

The key terms used in these general conditions and the associated special conditions are defined in the glossary.

IMPORTANT INFORMATION

Clause 1 - PARTIES TO THE INSURANCE CONTRACT

The policyholder is the company indicated in the special conditions which takes out the group insurance with the company.

The company/insurer is AXA Belgium.

AXA Belgium grants INTER PARTNER ASSISTANCE authority to accept the risks and manage the policies and claims.

The insured and the beneficiary is the person indicated in the special conditions who bears the risk of the occurrence of the insured event and who as such enjoys the benefits.

Clause 2 - CONTRACTUAL DOCUMENTS

The insurance proposal and any annexes set out the characteristics of the transaction which the policyholder requests the company to enter into and of the risk concerned.

The special conditions are the personalised presentation of the conditions of insurance, adapted to the specific situation. In particular, they set out the covers actually granted to the policyholder.

The general conditions can be found on the following pages. These provisions apply unless the special conditions deviate from them.

Clause 3 - INCLUSION IN THE POLICY

The insured can only be included in the policy if:

- The insured is on the policyholder's payroll, subject to Belgian social security and entitled to statutory reimbursement for his or her medical expenses; and
- The insured fulfils the conditions for inclusion set out in the special conditions.

Family members can only be included in the policy if:

- This is provided for in the special conditions; and
- The family members are subject to Belgian social security and entitled to statutory reimbursement for their medical expenses; and
- The family members fulfil the conditions for inclusion set out in the special conditions.

The policyholder must inform the company immediately of any changes relating to the insureds and their families (new addition, departure, changes in the insured's family situation).
These changes will lead to an adjustment of the premiums.

Clause 4 - TERRITORIAL SCOPE

The covers of this insurance apply worldwide.

If the insured's usual place of residence is not or will not be in Belgium or if he or she lives or will live abroad for more than three months per year, the company shall be notified of this in advance by the policyholder and/or the insured.
In that case, the covers will only be granted on condition that the insured has obtained the company's agreement in advance.

The above provisions only apply to frontier workers if their usual place of residence is in a country other than Belgium or their country of residence or if they live for more than three months a year in a country other than Belgium of their country of residence. For them, the policy conditions also apply in their country of residence.

COVERS AND BENEFITS OF THE POLICY

Clause 5 – COMMON PROVISIONS

The covers are granted where this is stipulated in the special conditions of this group policy.

They are included in the policy according to the conditions applying at the time of the policyholder's request.

The insured has a free choice of healthcare provider for his or her care and treatment provided that they are approved practitioners.

The costs associated with hospitalisation are not covered by this policy.

Clause 6 – "OPTICAL CARE" COVER

The company will contribute towards the costs of optical treatment and care, exclusively curative, provided that these are carried out by an ophthalmologist, excluding vision correction (for example by laser).

The company will also contribute towards the costs listed below of optical prostheses provided that these prostheses are medically necessary and prescribed by an ophthalmologist:

- lenses and frame costs, provided that there is a change in dioptre or after the end of a period of 5 years

or

- contact lenses

Clause 7 – "DENTAL CARE" COVER

The company will contribute towards all costs of dental treatment and dental care both preventive and curative provided that these are carried out by a dental practitioner. Notwithstanding the above, the company will only pay for orthodontic expenses of insured under the age of 25 years.

The company will also contribute towards the cost of the dental prostheses listed below provided that these prostheses are medically necessary and fitted by a dental practitioner:

- removable or fixed dental prostheses
- implants
- posts
- crowns
- bridges

The cost of prostheses is limited to one treatment every five years for any one tooth.

Clause 8 – "OUTPATIENT CARE" COVER

The company will contribute towards the costs listed below where they are prescribed by a healthcare provider and carried out in the context of curative treatment of a health problem:

- medical and paramedical services and fees
- medical tests and medical imaging
- medical prostheses
- orthopaedic appliances
- drugs (including homeopathic remedies)
- parapharmaceutical products;

Clause 9 – THE COMPANY'S CONTRIBUTION

The following provisions apply to all covers described in clauses 6 to 8 inclusive.

Calculation of the company's contribution

The company will contribute towards the medical and paramedical treatments and drugs mentioned in the above clauses only provided that they are approved by the NIHDI, regardless of whether reimbursement takes place by the NIHDI.

In all cases, the company will contribute towards the costs described in the above clauses, minus:

- the statutory reimbursement, meaning any payment made under Belgian legislation or an international agreement;
- any payments made under other policies or additional insurance covers with the same purpose, taken out with another insurance company or a health insurance fund.

The company's contribution towards the amount determined in this manner is specified in the special conditions. In particular, the insured will bear any excess on the amount determined in this manner, as defined in the special conditions.

The company's contribution will always be based on the amounts actually billed for the services provided. Downpayments are disregarded.

Expense bills made out in a foreign currency will be reimbursed based on the exchange rate of the currency on the date of reimbursement by the company.

Contribution towards the cost of frames

The company's contribution towards the cost of frames is a maximum of €200.00 per insured, once every five years.

Self-employed

The premiums for the category of active persons with the employment status of self-employed or director correspond to those for salaried staff and, in the event of contribution by the company, will allow for NIHDI reimbursements that are the same as or assumed to be equivalent to those for salaried staff.

Payment of the company's contribution

The company will reimburse the insured for the insured expenses.

TERMS OF THE COVERS

Clause 10 - START AND END OF THE COVERS AND BENEFITS

The covers start:

- on the date on which the insured fulfils the conditions for inclusion;
- and at the earliest on the start date of this policy stipulated in the special conditions.

The company will contribute towards the benefits and expenses arising as from the start of the covers.

The covers end:

- on the date on which insured no longer fulfils the conditions for inclusion;
- upon the death of the insured;
- on the date on which this insurance is cancelled.

The company will contribute towards the benefits and expenses arising up to the termination of the covers.

Clause 11 - TERRORISM

This policy covers losses caused by terrorism in accordance with the Act of 1 April 2007 on insurance against damage caused by terrorism.

AXA Belgium participates in the Terrorism Reinsurance and Insurance Pool (TRIP), which was set up in accordance with the above-mentioned Act. Consequently, when a loss is caused by an event recognised as terrorism and only for AXA Belgium's share of the co-insurance, the company will fulfil its contractual obligations according to the provisions of this Act, in particular with regard to the amount and payment terms of the benefits.

Clause 12 - RISKS NOT COVERED

The insured benefits according to clauses 6 to 8 inclusive will not be granted when the insured risk arises from the circumstances specified below. The company will produce proof of the fact that releases it from its cover.

- suicide attempt;
- intentional act on the part of the insured leading to injury, whether or not this is intended by the insured, with the exception of acts of legitimate self-defence or rescue;
  Intentional act means behaviour, an act or voluntary and deliberate omission leading to harm which is reasonably foreseeable;
- war between states or similar events, civil war.
  However, the risk is covered during a stay abroad:
  - on the one hand when the conflict has broken out during the stay,
  - and, on the other hand, when the company has explicitly granted the cover, at the

policyholder's prior request,
- and provided that the insured does not play an active part in the hostilities;

- active participation in rioting or collective acts of violence;
- gross negligence, insofar as a causal connection exists between the gross negligence and the event leading to the payment of benefits.
  Cases of gross negligence are:
  - wager, dare,
  - being under the influence of a narcotic, hallucinogenic or other drug,
  - finding oneself in a state of drunkenness or alcohol intoxication according to the Belgian highway code;
- allergy displaying no objective symptoms enabling an accurate diagnosis;
- subjective or mental disorder displaying no objective symptoms enabling an accurate diagnosis;
- drug addiction, including alcoholism and abusive use of medications;
- aesthetic treatments, fertility treatment (except medically assisted reproduction) and sterilisation treatments. However, aesthetic treatments are covered in the case of pure reconstructive surgery following an accident or an illness;
- preventive treatment forming part of outpatient medicine (vaccinations, check-ups, ….);
- medical and paramedical treatments and drugs not recognised by the NIHDI.

Clause 13 - INDIVIDUAL CONTINUATION

When the insured no longer enjoys the covers specified in this policy due, for instance, to the circumstances listed below, he or she can continue all existing covers on an individual basis with no medical formalities or waiting period.

This continuation is brought about by the insured taking out an individual "product" offering similar covers and belonging to the company's product range.

In order to be able to retain the covers, the insured in the policyholder's service must have been covered continuously by one or more successive "outpatient healthcare" insurance policies taken out with an insurance company for at least two years before the date of termination of the covers.

Circumstances leading to the termination of the covers of this policy include:

- the termination of the insured's service with the policyholder, either on reaching retirement age, or in mid-career:
  possibility of taking out a policy for the aforementioned insured and family members already insured by this policy;
- once each insured child no longer fulfils the conditions for inclusion set out in the special conditions,
  or, in the absence of a stipulation to this effect in these conditions, once each child of the insured has reached the age of 25 years or is no longer financially dependent on the insured's household (or the household of the former spouse or partner), with the exception of a disabled child receiving a disability allowance:
  possibility of taking out a policy exclusively for the child;
- death, legal separation or divorce of the insured in the policyholder's service:
  possibility of taking out a policy on the one hand for the widower / widow and family members who were already insured by this policy and on the other hand for the former spouse or cohabiting partner;

- the termination of this policy, for whatever reason.

Information for the insured in the policyholder's service

From his or her inclusion in this policy, the policyholder is legally obliged to inform the principal insured immediately of the possibility of paying an individual additional premium for him/her and, if applicable members, of his or her family for the purpose of prefinancing the individual continuation of this insurance. However, the law does not require either the company or the policyholder to propose such a product to the insureds. The company does not have such a product at present.

In addition, within thirty days after the loss of the benefit of this policy, the policyholder will notify the insured in its service, in writing or electronically:

- of the date of the termination of the covers,
- of the possibility of continuing the covers on an individual basis,
- of the period during which the insured in the policyholder's service and, if applicable, the member or members of his or her family, can exercise their right to individual continuation,
- of the contact details of the insurance company.

Provisions concerning the individual policy

The insurance policy accepted by the insured starts once he or she loses the benefit of the group insurance.

Its duration is lifelong.

The applicable rating conditions are those for "individual continuation" policies, applying at the time of the loss of the benefit of the covers of the group policy.

PRACTICAL GUIDE: LIFE OF THE POLICY

Clause 14 - START

The group policy takes effect on the date indicated in the special conditions, but at the earliest on the date on which the first premium is paid.

Clause 15 - PERIOD

The policy is taken out for a period of one year from the start date.
At the end of each annual period, it will be renewed by tacit agreement for an equal period, unless notice of cancellation is given by either party, by registered letter sent three months before the end of the current annual period.

Clause 16 – AMENDMENTS TO THE POLICY

The policyholder may request the company to amend the special conditions of the policy. If the amendment leads to an increase in the insured risk, its acceptance is subject to the conditions applying at the time of this amendment.

The amendment must be set out in an endorsement or any other similar document.

Clause 17 – AMOUNT AND PAYMENT OF THE PREMIUM

Amount

The premium represents the price charged by the company for covering the benefits insured under this policy. Its level takes into account the collective nature of the policy and the absence of a long-term rate guarantee for this type of policy.

The amount of the insurance premiums is specified in the special conditions.

Payment of the premiums

The policyholder pays the premiums to the company.
The payment terms for the insurance premiums are defined in the special conditions.

In the event of inclusion or withdrawal on a date other than a premium due date, the premium will be calculated pro rata. Where applicable, this will lead to the refund of the unearned part of the premium already charged.

In the event of non-payment of a premium on its due date, the policy will be cancelled thirty days after the sending of a registered letter to the policyholder.
This letter will specify the due date for the premium and its amount. The letter will also set out the consequences of failure to pay within the specified period and the start of this period.

Clause 18 - ADJUSTMENT OF THE PREMIUM AND AMENDMENT OF THE CONDITIONS OF INSURANCE

If the company changes its rate, it is entitled to apply this rate change to this policy from the next annual premium due date.

If the policyholder is informed of the change at least four months before the annual due date, it is entitled to cancel the policy at least three months before the due date. This means that the policy will terminate on that due date.

If the policyholder is informed of the change less than four months before the annual due date, it is entitled to cancel the policy within a period of three months from the sending of notification of this change. This means that the policy will terminate one month after the day after notification, after the date of receipt or in the case of registered mail of posting of this registered letter, but no earlier than the annual due date.

In the event of a fundamental change to the social security legislation in the case of the introduction or amendment of regulations affecting this policy, the company may amend the conditions of insurance in proportion to the change to the relevant legislation and its financial consequences for the company, after informing the policyholder of this in advance. The policyholder has a period of three months in which to cancel this policy if desired.

Clause 19 - AUTOMATIC ADJUSTMENT OF THE COVERS AND PREMIUMS

If “Optical care, Dental care and Outpatient care” Cover

On each annual premium due date, all premiums, excesses and contribution limits expressed in absolute numbers may be adjusted based on the change in the index for the cost of the services covered by the policy, namely the “Ambulatory care cover” index for the “Global” age category, where this change exceeds the change in the consumer prices index.

The change in the “Ambulatory care cover” index for the “Global” age category is determined based on the ratio of the last index figure published before the annual premium due date to the index figure published the previous year.

Where the change in this index does not exceed the change in the consumer prices index or in the absence of the calculation and/or publication of this index, the company will refer to the general consumer prices index. In this case, the adjustment is based on the ratio between the index figures for the month of November.

In the event of an amendment to the legislation regarding indexation of health policies, the company may apply a new indexation method and/or new annual reference due dates to this policy in accordance with the new statutory guidelines.

If "Dental care” cover only

On each annual premium due date, all premiums, excesses and contribution limits expressed in absolute numbers may be adjusted based on the change in the index for the cost of the services covered by the policy, namely the “Dental care cover” index for the “Global” age category, where this change exceeds the change in the consumer prices index.

The change in the “Dental care cover” index for the “Global” age category is determined based on the ratio of the last index figure published before the annual premium due date to the index figure published the previous year.

Where the change in this index does not exceed the change in the consumer prices index or in the absence of the calculation and/or publication of this index, the company will refer to the general consumer prices index. In this case, the adjustment is based on the ratio between the index figures for the month of November.

In the event of an amendment to the legislation regarding indexation of health policies, the company may apply a new indexation method and/or new annual reference due dates to this policy in accordance with the new statutory guidelines.

Clause 20 - SUBROGATION

By virtue of the mere existence of the group policy, the company shall be subrogated to the rights and claims of the insured and his or her beneficiaries against any third party who may be held liable for the loss or is legally or contractually obliged, on whatever grounds, to indemnify him or her, up to the amounts paid or still to be paid by the company.

Clause 21 – MISCELLANEOUS CHARGES

The annual tax on insurance transactions and all current or future tax, social insurance or other charges shall be borne by the policyholder or the insureds.

Exemption from charges

If the policyholder or the beneficiary enjoys full or partial exemption from the tax, social insurance or other charges under the applicable legislation, the policyholder or the beneficiary must inform the company of this exemption and its amount in advance and supply proof of this in the form of documentary evidence such as an official certificate from the relevant authority or a circular from the authority.

If the company is not informed in advance or has received no documentary evidence, the company may deduct all tax, social insurance or other charges.

Under no circumstances shall the company bear the financial consequences of deductions over and above the amounts which can be claimed back from the relevant authorities.

Article 22 - MISCELLANEOUS

Any problem relating to the policy can be referred to the company, via their usual intermediaries, by the policyholder or the insured.
Enquiries regarding this can also be addressed to the company's Quality department
(at the company's registered office, e-mail: quality.brussels@ip-assistance.com, Tel.: 02/550 04 00, Fax: 02/552 51 66).

If the policyholder or the insured have not obtained a satisfactory solution, they can turn to the Insurance Ombudsman Service (Square de Meeus/de Meeûssquare 35, 1000 Brussels, e-mail: info@ombudsman.as, Fax: 02/547 59 75) as the qualified entity.

Requesting the intervention of either of these services does not affect the possibility for the person concerned to take legal action.

Clause 23 - APPLICABLE LAW

The policy is subject to Belgian law and is currently governed by the Belgian Insurance Act of 4 April 2014.

Clause 24 – PROTECTION OF PERSONAL DATA

The relevant data subjects are the insureds whose personal data the company has recorded in relation to the performance of this contract.

The employer will supply the insured, from entering into this insurance policy, with all information required by the regulations regarding the processing of personal data (GDPR).

The insured will inform the insured family member(s) that their personal data form the subject of processing (GDPR).

Data controller

AXA Belgium nv, registered office, Place du Trône/Troonplein 1, 1000 Brussels, registered with the Crossroads Bank for Enterprises under number 0404.483.367 (referred to below as 'the company').

Data protection officer of the data controller

The company's data protection officer can be contacted at the following addresses:

by mail:	AXA Belgium - Data Protection Officer (TR1/884) Place du Trône/Troonplein 1 1000 Brussels
by e-mail:	privacy@axa.be

Processor

The company has entrusted the management of this policy to Inter Partner Assistance sa/nv, trading under the name AXA Partners Belgium, registered office, Avenue Louise/Louizalaan 166/1, 1000 Brussels, registered with the Crossroads Bank for Enterprises under number 0415.591.055 which acts as processor for the company.

Data protection officer of the processor

Inter Partner Assistance's data protection officer can be contacted at the following address:

by mail:	AXA Partners Belgium– Data Protection Officer Boulevard du Régent/Regentlaan 7 1000 Brussels
by e-mail:	DPO.bnl@axa-assistance.com

Purposes of data processing and recipients of data

Personal data disclosed by data subjects themselves or received by the company legitimately from companies in the AXA group, from companies related to such companies, from the data subject's employer or from third parties, may be processed by the company for the following purposes:

- relationship management:
    - This processing is carried out to compile and update databases – especially identification details – concerning all natural and legal persons related to the company.
    - These databases are updated and added to based on information supplied to the company by the data subject, or information from reliable external data sources.
    - This processing is necessary for the performance of the insurance contract and for compliance with legal requirements.
- insurance contract management:
    - This concerns processing carried out with regard to – automated or non-automated – acceptance or rejection of risks before entering into the insurance contract or in the case of subsequent revisions; the drafting, updating and termination of the insurance contract; the – automated or non-automated – collection of unpaid premiums; the management of claims and the payment of the insured benefits.

- This processing is necessary for the performance of the insurance contract and for compliance with legal requirements.

- customer services:
  - This concerns processing carried out in relation to digital services which are provided to customers — alongside the insurance contract — (for example offering tools and services to simplify the management of the insurance policy, to view the documents relating to the policy, or to simplify the formalities for the data subject in case of a claim).
  - This processing is necessary for the performance of the insurance contract and/or of these additional digital services.
- management of the relationship between the company and the insurance intermediary:
  - This concerns processing carried out in the context of the partnership between the company and the insurance intermediary.
  - This processing is necessary for the protection of the company's legitimate interests involving the performance of contracts between the company and the insurance intermediary.
- detection, prevention and combating of fraud:
  - This concerns processing carried out to – by automated or non-automated means – detect, prevent and combat insurance fraud.
  - This processing is necessary for the protection of the company's legitimate interests involving the safeguarding of the technical and financial equilibrium of the product, the line of business or the insurance company itself.
- combating of money laundering and financing of terrorism:
  - This concerns processing carried out to – by automated or non-automated means – detect, prevent and combat money laundering and financing of terrorism.
  - This processing is necessary for the fulfilment of a legal requirement with which the company must comply.
- performance of tests
  - This involves processing to develop new and updated applications and ensure their correct operation.
  - This processing is necessary for the legitimate interests whereby the company endeavours to develop applications in order to carry out its activities or to provide services for its customers.
- monitoring of the portfolio:

- This concerns processing carried out to – by automated or non-automated means – monitor the technical and financial equilibrium of the insurance portfolios and adjust this where necessary.

- This processing is necessary for the protection of the company's legitimate interests involving the safeguarding or restoration of the technical and financial equilibrium of the product, the line of business or the insurance company itself.

- statistical studies:

  - This concerns processing carried out by the company or a third party for the purpose of statistical studies for various purposes, such as road safety, prevention of accidents in the home, fire prevention, improvement of the company's management processes, acceptance of risks and rating.

  - This processing is necessary for the protection of the company's legitimate interests involving social engagement, striving for efficiency and enhancing knowledge of its specialist areas.

- risk management and monitoring:

  - This involves processing by the company or a third party to ensure the risk management and monitoring for the company's organisation, including inspections, complaints management and internal and external audit.

  - This processing is necessary for the fulfilment of a legal requirement to which the company is subject, or in the legitimate interests of the company to ensure adequate security measures for the management of its activities.

To the extent that it is necessary to disclose personal date for the purposes listed above, the personal data may be disclosed to other companies belonging to the AXA Group and to related companies and/or persons (lawyers, adjusters, medical advisors, reinsurers, co-insurers, insurance intermediaries, service providers, other insurance companies, external auditors, representatives, rating follow-up agencies, claims settlement agencies, not-for-profit organisation TRIP, Datassur and other industry organisations) to be processed in accordance with these purposes.

This data may also be disclosed to inspection bodies, to the relevant government departments and to any other public or private body with which the company can exchange personal data in accordance with the applicable legislation.

If the data subject is also a customer of another entity in the AXA Group, this personal data may be processed by the company in combined files for the purpose of relationship management, in particular the management and updating of identification details.

The data subject may receive special clauses from the company while the policy is in force, for example a clause applying to the processing of a claim. These special clauses will not affect the validity of this clause and its applicability for the purposes mentioned above.

Transfer of data outside the European Union

Other companies in the AXA Group, related companies and/or persons to whom the personal data is disclosed, may be located both within and outside the European Union. In the event of the transfer of personal data to third parties located outside the European Union, the company complies with the legal and regulatory requirements applying to such transfers. In particular, the company ensures an adequate level of protection for the personal data transferred in this way, based on the

alternative mechanisms specified by the European Commission, such as standard contractual clauses or binding corporate rules for the AXA Group in the event of transfers within the group (Belgian Official Gazette 6/10/2014, p. 78547).

The data subject can obtain a copy of the measures taken by the company in order to be able to transfer personal data outside the European Union by sending a request to the company at the address stated below (under 'Contact opnemen met AXA Belgium').

Retention of data

The company retains the personal data collected in relation to the insurance contract for the duration of the contractual relationship or of the management of claims, updating this data whenever circumstances require, extended by the statutory retention period or limitation period in order to deal with any claim or recourse brought after the end of the contractual relationship or the closure of the claim.

The company keeps the personal data relating to rejected quotations or quotations which it has not followed-up for up to five years after the issue of the quotation or the refusal to enter into a contract.

Need to disclose personal data

The company requests personal data regarding the data subject in order to issue and implement the insurance policy. Non-disclosure of this information may make it impossible to enter into or perform the insurance contract.

Confidentiality

The company has taken all measures required to guarantee the confidentiality of the personal data and to guard against unauthorised access, misuse, alteration or erasure of this data.

To this end, the company follows the standards for security and continuity of service and regularly reviews the security level of its processes, systems and applications, and those of its partners.

Rights of the data subject

The data subject has the right:

- to obtain confirmation from the company as to whether or not the personal data relating to him or her is processed, and to consult this data - if it is processed;
- to have his or her personal data that is inaccurate or incomplete rectified and completed where applicable;
- to have his or her personal data erased under certain circumstances;
- to restrict the processing of his or her personal data under certain circumstances;
- to object, on grounds relating to his or her particular situation, to processing of the personal data based on the company's legitimate interests. The controller shall no longer process the personal data unless the controller demonstrates compelling legitimate grounds for the processing which override the interests, rights and freedoms of the data subject;
- to object to processing of his or her personal data for direct marketing purposes, which includes profiling to the extent that it is carried out with a view to direct marketing;

- to object to a decision based solely on automated processing, including profiling, that produce legal effects significantly affecting the data subject; if, however, this automated processing is necessary for the entering or performance of a contract, the person the right to obtain human intervention on the part of the company, to express his or her point of view and to contest the company's decision;

- to receive his or her personal data which he or she has provided to the company in a structured, commonly used and machine-readable format; to transmit this data to another controller, where (i) the processing of his or her personal data is based on his or her consent or is necessary for the performance of a contract and (ii) processing is based on automated processes; and to have his or her personal data transmitted directly from one controller to another, where technically feasible;

- to withdraw his or her consent at any time, without affecting processing which took place lawfully before its withdrawal, where the processing of his or her personal data is based on his or her consent;

Amendments to this privacy clause

The processing of personal data can evolve due to various factors, e.g. changes in the regulations, technical developments and changes regarding the purposes of the processing. The company will publish revised versions of the privacy clause on a regular basis on the 'Privacy' page on the website AXA.be. In the event of significant changes, the company will make reasonable efforts to ensure that data subjects are informed of these changes.

Contacting AXA Belgium

Where the data subject is a customer of the company, he or she can visit his or her Customer Area on AXA.be and manage his or her personal data and preferences regarding Direct Marketing there, and also consult his or her personal data.

The data subject can contact the company in order to exercise his or her rights, by filling in the form available on the "Ons contacteren" page via the "Bescherming van uw gegevens" button, accessible via a hyperlink at the bottom of the homepage on the AXA.be site.

A data subject wishing to exercise his or her rights can also contact the company by posting a dated and signed letter, enclosing a copy of his or her identity card, to the following address: AXA Belgium Data Protection Officer (TR1/884), Place du Trône/Troonplein 1, 1000 Brussels.

The company will process requests within the periods stipulated by law. Except for clearly unfounded or excessive requests, no payment whatsoever will be demanded for the processing of his or her requests.

Filing a complaint about the processing of personal data

Where the data subject considers that the company has not complied with the relevant regulations, he or she is requested to contact the company. The data subject can file a complaint with the company via the e-mail address privacy@axa.be or by filling in the form available on the 'Contact us' page via the "Niet tevreden over een product of service? Laat het ons hier weten' (If you are not satisfied with a product or service, get in touch with us here) button. You can access this page via a hyperlink at the bottom of the homepage on the AXA.be site.

The data subject can also file a complaint regarding the processing of his or her personal data with the Data Protection Authority at the following address:

Rue de la Presse/Drukpersstraat 35
1000 Brussels
Tel. + 32 2 274 48 00
Fax + 32 2 274 48 35
contact@apd-gba.be

The data subject can also file a complaint with the court of first instance of his or her place of residence.

FORMALITIES TO BE FULFILLED IN ORDER TO OBTAIN PAYMENT UNDER THE INSURED COVERS

We emphasise the importance of the warranties below.

The company may have to reduce its benefits depending on the loss it would suffer due to failure to comply with the warranties below within the specified periods, unless this breach is due to force majeure.

The company may also be led to refuse its covers if the insured, with fraudulent intent, is in breach of the warranties below.

Clause 25 – NOTIFICATION OF CLAIM

All services for which a request is not received by the company within a period of three years from these services will cease to be covered by this policy.

The insured shall provide the company, as soon as possible, with information and original documents, or failing this replacement documents, proving the existence and amount of the expenses insured under this policy.

Evidence of other contributions

The insured shall also supply the company, as soon as possible, with evidence of contributions by other insurance companies and/or the health insurance fund if the insured is covered by one or more insurances for the same purpose and has already received a contribution.

Clause 26 - OTHER WARRANTIES OF THE INSURED

The insured shall subject him or herself to any medical checks and other formalities required by the company within 30 days. It may request that the medical checks take place in Belgium.

Clause 27 - DOCUMENTATION AND EVIDENCE

The insured can choose whether to send all documents and information requested by the company electronically or on paper. If the insured opts to supply his or her documents and information electronically, he or she undertakes to make the originals available to the company.

Clause 28 - DISPUTES AND EXPERT ASSESSMENT

Should the policyholder and/or the insured disagree concerning a medical matter, this must be communicated to the company within 15 days following notification of its decision.

The dispute shall be referred by mutual agreement of the parties to a medical committee consisting of two expert physicians, one appointed by the policyholder and/or the insured and one by the company. If they do not agree, they will appoint a third expert physician, whose role will be to come to a final conclusion.

Should either party fail to appoint an expert or should the two experts disagree on the choice of the

third, the appointment shall be made by the Court of First Instance for the insured's place of residence at the request of either party.

Each party shall bear the fees of its expert; the fees of the third expert shall be borne by both parties equally.

The same applies to the fees of other physicians involved.

GLOSSARY

Outpatient care

Care provided outside of hospitalisation.

Treatment

In the medical field and for the NIHDI, a treatment is defined as all related services, which may or may not be divided into several sessions.

Abroad

For residents of Belgium: any country other than Belgium.
For frontier workers: any country other than Belgium or the country of residence of the frontier worker.

Drug

Product prescribed by a physician and recognised as such by the minister responsible for Public Health.

Frontier worker

Resident of the Netherlands, Germany, Luxembourg or France who works in Belgium for a Belgian policyholder.

Hospitalisation

Medically necessary stay, in an institution legally regarded as a hospital, which leads to the billing of accommodation costs under the categories of “Hospitalisation” and “One-day clinic (surgical or otherwise)”.

Medical fees

Fees for the performance of medical services by a physician.

Accident

Sudden and accidental occurrence caused directly by the operation of an external force beyond the insured’s control and leading to bodily injury.

The following are equivalent to accidents:

- drowning;
- injuries sustained while rescuing or salvaging persons or goods in danger;
- poisoning and burns resulting from either deliberate ingestion of toxic or caustic substances, or accidental release of gases or vapours;
- complications of original injuries caused by an insured accident;
- rabies and tetanus.

Suicide is not considered as an accident.

Orthopaedic appliance

Device designed to prevent or correct deformities of a body part.

Parapharmaceutical product

A product supplied in a pharmacy, parapharmacy or by a prosthetist/orthotist, prescribed by a physician, necessary for the insured's medical treatment and not recognised as a drug by the Belgian Association of Pharmacists.

Paramedical fees

Fees for the provision of medical services by recognised healthcare practitioners, prescribed by treating physicians (fees of a homecare nurse, dietician, podiatrist, speech therapist, physical therapist, physiotherapist, osteopath, chiropractor, homeopath, acupuncturist, psychoanalyst and/or fees of a psychologist).

Prosthesis

Appliance that performs all or part of the function of an organ or limb.

State of drunkenness

State of a person who has no permanent control over his or her actions, without necessarily having lost awareness of this.

Terrorism

Clandestinely organised campaign or threat of a campaign with ideological, political, ethnic or religious aims, carried out individually or by a group, involving the perpetration of violence against persons or the total or partial destruction of the economic value of movable or immovable property, either to make an impression on the public, to create a climate of insecurity or to exert pressure on the authorities, or to impede the performance or normal operation of a service or a business.

Waiting period

Period during which no benefits are due; this period begins on the insured's inclusion date.

Statutory reimbursement

- for expenses incurred in Belgium: any refund stipulated by Belgian laws applying to employees;
- for expenses incurred abroad: any refund stipulated by an agreement reached with the country in question regarding social security for employees or, failing this, a theoretical amount based on the refund stipulated by Belgian laws applicable to employees.

Belgian laws applicable to employees in case of illness or accident means:

- legislation concerning compulsory insurance against illness or disability;
- legislation concerning accidents at work;
- legislation concerning occupational diseases.

Hospital

Establishment legally recognised as such and where scientifically proven diagnostic and therapeutic means are used, except for:

- closed psychiatric institutions;
- medical pedagogical institutions;
- independent rehabilitation centres;
- institutions that merely serve as accommodation (care homes, etc.);
- care and nursing homes.

Illness

Impairment of health not originating from an accident, displaying objective symptoms.