**TERMS AND CONDITIONS FOR LIMITED HEALTH INSURANCE OF THE EXPAT-SERIES FOR LONG-TERM JOURNEYS PART II**

**EXPAT PRIVATE**

1. **INSURANCE COMPANY:** Swiss Life Prévoyance et Santé, 7 rue Belgrand, F-92300 Levallois-Perret, France

2. **POLICY HOLDER:** BDAE EXPAT GmbH

3. **PARTIES ENTITLED TO INSURANCE:**
   - Natural persons. Only one person per family may be nominated as party entitled to insurance.

4. **INDIVIDUALS INSURABLE:**
   - Persons entitled to insurance and their family members, if they are also insured according to the terms and conditions of insurance, part I, A, § 1. The maximum insurable age is 66 years. Insurance cover automatically ceases at the end of the month prior to the month in which the insured person turns 67 years. Family members are spouses and children living in the same household.

5. **CONTRACTUAL BASIS:**
   - Terms and conditions for limited health insurance of the EXPAT-series for long-term journeys part I and part II (EXPAT PRIVATE).

6. **AREA OF APPLICATION:**
   - 1. For temporary stays outside the countries where the insured person is usually domiciled, worldwide insurance cover is provided under consideration of the terms and conditions of insurance part I, A, § 1, para. 4 and 5 and part II, number 15.
   - 2. Countries of usual domicile of the insured person are fully included in this insurance cover as long as the respective coverage area including these countries has been opted for (Please note the terms and conditions of insurance, part II, number 15).
   - 3. It is in the insured persons responsibility to ensure that this insurance cover meets the legal and local requirements of a specific country.
   - 4. This insurance cover does not correspond to a compulsory health insurance which is mandatory for a permanent domicile in the Federal Republic of Germany.

7. **START OF INSURANCE COVER:**
   - At the time specified in the insurance confirmation document subject to the terms and 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:**
   - 5 years. A one-off extension for further 5 years is possible with the consent of the insurance company.

10. **TERMINATION OF INSURANCE RELATIONSHIP:**
    - 1. The policyholder is obliged to inform the party entitled to insurance and the insured persons about a termination of the framework insurance agreement at least two months before the termination becomes effective.
    - 2. The insurance cover for single insured persons may be terminated by the party entitled to insurance or the respective insured person at any time. In this case the insurance cover ceases at the end of the month following the month in which the notice of termination has been submitted in writing to the policy holder.
    - 3. If the party entitled to insurance and the insured person are not identical, a termination becomes effective only if the insured person affected by the termination has been informed accordingly and if the policyholder can prove to the insurance company at deregistration from the framework insurance agreement knowledge of the insured person about the termination of insurance cover. The insured person affected by the termination is entitled to continue the insurance contract under designation of a new party entitled to insurance. An appropriate declaration must be submitted within two months after receipt of the notice of termination.

11. **PREMIUM PAYMENTS:**
    - The premium is an annual premium, which is broken down into equal monthly installments. It is payable in advance up to the end of each insurance year.

12. **DATA ON INSURED PERSON’S STATE OF HEALTH:**
    - None. Please observe the exclusion of benefits in the terms and conditions of insurance.

13. **BENEFITS:**

   **EXPAT PRIVATE**

   **EXPAT PRIVATE**

13.1 **OUTPATIENT TREATMENT:**
    - 100% of the amount invoiced for medically necessary outpatient treatment as a private patient, including radiology, light therapy and other physical treatments, if prescribed by a doctor, at reasonable and customary rates.

13.2 **INPATIENT TREATMENT:**
    - 100% for medically necessary inpatient treatment and treatment related accommodation in a hospital for medically necessary surgery, X-rays, radiological treatment and diagnostics. As a private patient in a 2-bed room, if available. Notwithstanding the terms and conditions of insurance part I, A, § 6 para. 2b medically necessary rehabilitation following inpatient treatment is covered.

13.3 **PHARMACEUTICALS, BANDAGES AND MEDICINES:**
    - 100%, if prescribed by a doctor and medically necessary.
13.4 **DENTAL TREATMENT:**
100% of the invoiced amount for medically necessary outpatient dental treatment. Inlays and onlays are not covered. For each year of insurance cover a one-time checkup and prophylactic treatment for preventive purposes (including tooth polish and tooth cleaning) is covered.

13.5 **TOOTH REPLACEMENT / ORTHODONTIC TREATMENT:**
Notwithstanding the terms and conditions of insurance part I, A, § 6, para. 2q insurance cover continues for newly occurring claims after the expiry of the waiting period of 8 months for:
- 80% of the amount invoiced for medically necessary tooth replacement and
- orthodontic treatment up to the age of 18,
- to a maximum amount, however, of EUR 2,000 in toto in the first two years of the policy,
- up to EUR 3,000 in toto in the first three years of the policy,
- from the fourth year of the policy, at most up to EUR 4,000 per year of the policy.
The waiting period does not apply to tooth replacement necessary due to an accident occurring during the insurance period subject to the limits listed above. The limits apply on a pro-rata basis for registration / deregistration during the insurance year.

13.6 **PREVENTIVE CHECKUPS:**
Preventive outpatient medical examinations for children, as well as for early detection of cancer in accordance with statutory programmes which have been introduced in Germany.

13.7 **BENEFITS FOR PREGNANCY AND DELIVERY:**
Insurance cover exists for:
a) medically necessary treatment including pregnancy examinations, pregnancy treatment, in as far the pregnancy had not yet commenced at the beginning of the insurance relationship of the insured persons as well as treatment for miscarriage;
b) medically necessary pregnancy treatment due to acute complaints caused by and treatment due to miscarriage as well as medically necessary abortions and deliveries up to the end of the 36th week of pregnancy (premature birth), even if the pregnancy had already commenced at the start of the insurance relationship of the insured person, if the necessity for treatment was not yet obvious at this time;
c) deliveries after expiry of the waiting period according to the agreed tariff.

13.8 **MEDICAL AIDS:**
Notwithstanding the terms and conditions of insurance Part I, A, § 6, para. 2g insurance cover is granted for medical aids in simple form and their repair costs up to 80% of the amount invoiced, up to a maximum of EUR 1,000 per insurance year, provided the medical aid is medically necessary and prescribed by a doctor. Visual aids are covered within the limits, up to EUR 50 per insured person and insurance year. The limits apply on a pro-rata basis for registration / deregistration during the insurance year.

13.9 **PSYCHOLOGICAL THERAPY:**
In case of a trauma (being defined as a distressing external event, caused by being confronted with bodily injuries or threat to the physical well-being of the insured or a closely related party or by being confronted with imminent or actual death): 80% of the amount invoiced for outpatient treatment up to a maximum of EUR 2,000 per insurance year. The limits apply on a pro-rata basis for registration / deregistration during the insurance year. Inpatient treatment up to 30 days per contract duration. The exclusion of benefits referred to the terms and conditions of insurance part I, A, § 6, para. 2l and n remain unaffected.

13.10 **OTHER BENEFITS:**
a) 100% of the transportation costs to the nearest suitable hospital for inpatient treatment and for first aid after an accident to the nearest suitable doctor and back.
b) For medically necessary evacuation to the country where the insured person is usually domiciled, the insurance company will reimburse:
- up to EUR 5,000 within a continent,
- up to EUR 10,000 between continents.
If an authorised air ambulance is medically required, these limits do not apply. The most economical method of evacuation has to be selected, as long as this is possible from the medical point of view. An evacuation is considered medically necessary, if at the actual location of the insured sufficient medical care is not available. A qualified certificate stating the medical necessity of an evacuation provided by the treating doctor has to be submitted.

13.11 **CONTINUED LIABILITY:**
In the event that an evacuation of an insured person is not possible prior to the end of the long-term journey due to a necessary and not predictable treatment the insurer covers the costs of medical treatment up to the date of transportability for a period of maximum 30 days after the regular insurance period has ceased.

14. **MONTHLY PREMIUM:**
8 months for tooth replacement, orthodontic treatment and delivery.

15. **MONTHLY PREMIUM:**

15a. **DEDUCTIBLE:**
- **WORLDWIDE EXCLUDING USA / CANADA:**
  - EUR 0
- **WORLDWIDE INCLUDING USA / CANADA:**
  - EUR 500 per person and insurance year in the whole premium area. The deductible for insurance cover which is required for less than one year is calculated proportionally.

16. **OTHER MATTERS:**
No pension reserve fund will be established. You are recommended to take out a dormant insurance policy scheme.

*Effective: 01.11.2014*
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 respective 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 part 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 objective 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 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 how-ever upon expiration of the maximum duration of insurance of the selected 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 events, resulting from intentional activities of the policyholder, as well as for such events, resulting from intentional activities of the policyholder.
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 as 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, occlusal overlay aids and gnathological 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 unnesessitated 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 willfully 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 with-in 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 5 years, as matters then stand stop 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.

8. 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.
3. Claims of the policyholder, the party entitled to insurance or the insured person against a medical practitioner due to excessive fees pass to the insurance company to the statutory extent, if the insurance company has reimbursed the appropriate bill. If necessary, the policyholder, the party entitled to insurance or the insured person is obligated to assist during assertion of claims. Furthermore, the policyholder, the party entitled to insurance or the insured person is 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 granted benefit or a decision of the insurance company, please contact the respective insurance company directly.

The “Bundesanstalt für Finanzdienstleistungsaufsicht (BAFin)”, Graurheindorfer Straße 108, 53117 Bonn, and the “Autorité de Contrôle Prudentiel et de Résolution” (ACPR - French regulating authority), 61 rue Taitbout 75009 Paris France, are the responsible authorities for any litigation regarding this insurance contract.

In the case of any disputes regarding the practice of this contract, the policyholder and the insured persons need to explain the reason for the complaint or rejection in writing to the service department (Direction Services Clients), Assurances Collectives SwissLife Prévoyance et Santé – 7, rue Belgrand 92682 Levallois-Perret Cedex France.

If the answer is not satisfying, the policyholder and the insured persons may request the opinion of an independent mediator. The terms and conditions for implementation of the Ombudsman are available on request at the head office of Swiss Life Prévoyance et Santé – 7, rue Belgrand 92300 Levallois-Perret France.

PART B – SPECIAL PROVISIONS FOR INDIVIDUAL INSURANCES

THE RELEVANT SECTION APPLIES IN DEPENDENCE ON THE INSURANCE COVER AND TARIFF SELECTED

§ 1 OBJECT OF INSURANCE
So far as has not been agreed to the contrary, the following shall apply:

1. Grounds of a claim shall be the medically necessitated treatment of a person insured on account of illness or in consequence of an accident. The claim shall be considered to begin with the treatment, and shall end when medical findings indicate that there is no further need of treatment. If the medical treatment must be extended to an illness or consequence of an accident, with no causal connection to the previously treated condition, then this is considered a new claim.

2. In so far as the tariff defines the relevant benefits, further grounds for a claim shall also be:
   a) Medically necessitated treatment including pregnancy examinations, pregnancy treatments, in as far the pregnancy had not yet commenced at the beginning of the insurance relationship of the insured persons as well as treatment for miscarriage;
   b) Medically necessitated pregnancy treatment due to acute complaints caused by and treatment due to miscarriage as well as medically necessitated abortions and deliveries up to the end of the 36th week of pregnancy (premature birth), even if the pregnancy had already commenced at the start of the insurance relationship of the insured person, if the necessity for treatment was not yet obvious at this time;
   c) Deliveries after expiry of the waiting period according to the agreed tariff;
   d) Outpatient examinations for early diagnosis of illnesses according to programmes and introduced to the Federal Republic of Germany and prescribed by statute (purposeful preventive medical checkups);
   e) Death.

3. The nature and amount of the insurance benefits shall be derived from these conditions of insurance of the respectively selected tariff.

4. In the area of cover the insured person may choose from those medical doctors, dentists, licensed general practitioners specialised on alternative medicine and midwives who are practising on a legally approved basis in the insured’s country of residence and who invoice on a locally customary basis or - if applicable - according to the official scale of charges for their profession.

5. Pharmaceuticals, bandages, medicines and medical aids must be prescribed by the qualified practitioners mentioned in conditions of insurance section I, B, I, §1, para. 4. Pharmaceuticals may also be obtained from a pharmacy. Nutrients, tonics, mineral water, disinfectants and cosmetics, mineral water, dietary, and baby food and the like are not considered pharmaceuticals even if they have been prescribed.

6. 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 and therapeutic equipment and conduct case histories and do not provide health resort respectively sanatorium treatments or accept convalescent patients. Insurance protection is granted for the general class (multiple bedrooms) without coverage options (private treatment by doctor).

7. In case of medically necessitated hospital treatment in licensed hospitals, which also carry out health resort or sanatorium or convalescent treatments by which in other respects conform to the conditions of section I, B, I, §1, para. 6, benefits at the agreed rate 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 sanatorium as well.

8. The insurance company will pay benefit to the extent defined by the contract for examination and treatment methods and pharmaceuticals that are generally recognised by school medicine. It will in addition pay benefit for methods and pharmaceuticals, which have proved themselves in practice to be equally effective and able to achieve success. The insurance company may however reduce the level of benefit to the amount that would have been paid if existing school medicine methods or pharmaceuticals had been used.

9. The insurance company will pay to the extent defined in the tariff the conveyance and funeral costs, if the death of an insured person is the consequence of an insured event.

10. The insurance company carries additional costs to the extent defined in the tariff for a medically necessitated return transport prescribed by a doctor to the nearest suitable hospital in the native country or to the permanent place of residence of the insured person. Medical necessity for a return journey is given, if it is proven that in the agreed tariff area sufficient medical treatment is not ensured and the return journey is recommended by the doctor of the insurance company. The costs of an also insured accompanying person are assumed, as far the accompaniment is medically necessitated, officially ordered or required by the accomplishing transport company.

§ 2 SPECIAL EXCLUSIONS
So far as has not been agreed to the contrary, there is no obligation to provide benefits for treatments by doctors, dentists, licensed general practitioner specialised on alternative medicine, hospitals or midwives whose invoices the insurance company has excluded from reimbursement on good grounds. Precondition for this is that the insurance company has notified the party entitled to insurance and the insured person before occurrence of the insured event and of the practitioner who will not be reimbursed. In so far as at the time of notification a claim should be pending, no obligation to pay benefit for the practitioner concerned shall exist for expenses incurred after the expiry of three months from the time of notification being given.

2. If the medical treatment or other measure for which benefit has been agreed upon should exceed the medically necessitated limits, or if the remuneration claimed is out of proportion, the insurance company may reduce benefit to an acceptable level.

§ 3 SPECIAL OBLIGATIONS AFTER OCCURRENCE OF THE INSURED EVENT
1. The insurance company is to be notified of any hospital treatment within ten days from its starting.
2. The person insured must submit the relevant documentary evidence to the insurance company within three months from the time of each individual course of treatment.

3. If a person insured has concluded a contract for the insurance of medical expenses with another insurance company, if such exists or a person insured avails himself/herself of the entitlement to insurance in connection with statutory health insurance cover, the party entitled to insurance or the person insured shall be obliged to notify the insurance company without delay of the other insurance cover arranged.

4. The insurance company is to be informed of a case of pregnancy within four weeks after the existence of a pregnancy has been established, unless defined otherwise in terms of the relevant tariff.

5. The insurance company is to be informed of medically necessitated return transports before being carried out.

6. The legal consequences of a breach of one of these obligations are set out in conditions of insurance part I, A § 7, para. 4.

d 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.
PATIENT LEGAL EXPENSES INSURANCE FOR BDAE CLIENTS

NEW: PATIENT LEGAL EXPENSES INSURANCE WORLDWIDE FOR THE FIRST TIME

In addition to your health insurance, BDAE has now arranged a patient legal expenses insurance for your stays abroad. This increase of benefits is provided on a complimentary-basis to your existing cover. Originally developed by the renowned legal insurer ARAG Group at the beginning of 2010, this product, following the cooperation between BDAE and ARAG, is now available on a worldwide basis.

WHAT IS INSURED?

The policy responds to situations where the professional negligence of doctors or other medical personnel cause you serious harm. Although the relationship between patient and doctor is based on a high level of trust, even medical professionals are capable of making mistakes. In such situations, it is difficult for patients to assert and protect their rights while trying to resolve a complicated conflict about errors in treatment. Even more so when they are not able to communicate directly with the doctor, but have to address his professional indemnity insurers.

The policy covers legal cases up to One Million Euro, world-wide. ARAG accepts all costs for legal and court expenses up to this limit. If required, ARAG will also recommend a lawyer specialised in healthcare law. Additionally you have access to ARAG’s online platform where you have access to more than 1,000 sample letters and contracts from different areas, e.g. labour law, family law and transportation law. The team of ARAG-JuraTel® will assist you with a free initial legal consultation for indemnity claims and violations of criminal law. Once per year you are also entitled to consult a lawyer accredited in Germany to create or edit a Patient Decree and Power of Attorney - up to the costs of 250 Euro.

WHAT ARE TREATMENT ERRORS AND AN INCORRECT CONSULTATION?

Treatment errors are not merely instances of a pair of scissors being forgotten in the abdomen during a surgery they can also include incorrect advice given about the dosage of a medicine. A treatment error can also be in the form of inappropriate or delayed treatment of a patient by a physician or surgeon. The failure of a physician or a surgeon to advise a patient about the necessity or risks of a treatment is also considered to be an act of professional negligence and hence would be covered under the policy. This not only applies to physicians but also to hospital staff, psychotherapists, pharmacists and nursing service providers. They are equate to physicians in the patient legal expenses insurance.

ABOUT ARAG

The ARAG Group is an internationally renowned independent provider of legal services and is the largest family-owned company in the insurance market. Apart from Germany, ARAG also operates in 12 European countries and in the USA, where it has taken a leading position in the legal insurance market. ARAG is also market leader with its legal insurance products in Spain and Italy. BDAE has been associated with ARAG since 2008 and the two companies have now developed the first legal expenses insurance for overseas stay and travel on a worldwide basis.
MEDICAL ASSISTANCE FOR PERSONS INSURED
BY BDAE AND MEMBERS OF BDAE

For fast and smooth processing of medical services anywhere in the world, the BDAE GROUP has integrated an Assistance Programme into its insurance concept. The BDAE makes its Assistance services – i.e. the aid, emergency and service offer – available to its persons insured and members in collaboration with the specialist AGA Service Deutschland GmbH (ALLIANZ GLOBAL ASSISTANCE). The following services to insured and members are included:

24 H BDAE EMERGENCY VIA
+49 - 40 - 30 68 74 - 74

- Multilingual, qualified 24-hour Emergency Hotline
- A worldwide network of medical service providers
- Information about (dental) medicine service providers (e.g. names, addresses and telephone numbers as well as consulting hours for doctors, dentists, hospitals and clinics within the region of the current place of residence)
- Patient advice in routine cases and emergencies
- Assistance in arranging treatment appointments at hospitals and with doctors for outpatient treatment
- Organisation of hospital admission in the event of illness
- Help and support to family members by means of provision of country specific health care data and information
- Transfer of information between general practitioner and hospital as well as message transfer service, where necessary
- Support in the obtention and shipment of prescription medicines (insofar as statutorily permitted)
- Organisation of interpreting and translation services
- Access to worldwide medical information in German and in English
- Advice and support in the event of loss of important documents and means of payment

In addition to the services listed above, BDAE assumes the costs for the services it covers, for which ALLIANZ GLOBAL ASSISTANCE seeks authorisation directly from BDAE and its risk carriers (insurer). These services include:

- Organisation of emergency evacuations as well as transfers to appropriate hospitals in cases of medical necessity
- Organisation and implementation of repatriations to a value of up to 250,000 Euro per insurance event
- Implementation of and cost assumption for body repatriation in the event of death, for up to 10,000 Euro

These services are available to persons insured by BDAE and members of BDAE 365 days a year, 24 hours a day. To ensure smooth processing in your dealings with the Assistance company, please always have your BDAE policy or membership number ready when you contact ALLIANZ GLOBAL ASSISTANCE.
LEGAL INSTRUCTION AS PER § 19 ABS. 5 SATZ 1 VVG

LEGAL INSTRUCTION BY
SWISS LIFE PRÉVOYANCE ET SANTÉ (INSURER)

NOTIFICATION AS PER § 19 ABS. 5 VVG REGARDING THE CONSEQUENCES OF BREACHING THE DUTY OF DISCLOSURE

In order for the Insurer to comprehensively evaluate an insurance application all questions asked in the application forms must be answered truthfully and completely. Any information that the Applicant may consider to bear no significance must also be provided. Any information the Applicant does not wish to provide to an insurance broker is to be reported to the Insurer directly without delay and in writing. Kindly be advised that insurance cover may be withdrawn or cancelled in case false, incomplete or misleading information is provided to the Insurer. Please find below further details regarding the consequences of breaching the duty of disclosure.

WHAT ARE THE DETAILS OF THE PRE-CONTRACTUAL DUTY OF DISCLOSURE?

At the time of submitting the insurance application the Applicant shall disclose all information relevant to the risk requested by the Insurer in writing. All questions must be answered truthfully and completely. All circumstances which may affect the evaluation of the application and the decision of the Insurer are considered being of relevance to the risk. Upon submission of the application the Applicant is also obliged to provide any additional information requested by the Insurer prior to the policy approval.

WHAT ARE THE CONSEQUENCES OF BREACHING THE PRE-CONTRACTUAL DUTY OF DISCLOSURE?

1. RESCINDMENT OF CONTRACT AND WITHDRAWAL OF COVER

The Insurer is entitled to rescind the contract should the Applicant or an insured member suppress, misrepresent or misstate any material fact, unless proof of absence of willful intent or gross negligence is provided. In case of gross negligence, the Insurer is not entitled to rescind the contract if the policy would have been issued despite the knowledge of the full circumstances, even if contract alterations by the Insurer would have been applicable. Insurance cover is withdrawn in the event of contract rescindment. Should the Insurer rescind the contract after a claim has been submitted the Insurer is still obliged to reimbursement, if the Insured Person proves that the reasons for the claim have no connection with the reasons for contract rescindment. The reimbursement obligation ceases, however, in case of willful intent. The Insurer is entitled to retain the insurance premium in case of contract rescindment up to the effective date of the rescindment.

2. CANCELLATION

Should any breach of the pre-contractual duty of disclosure not have occurred due to willful intent or gross negligence the Insurer is entitled to cancel the policy with a notice period of one month. The right of policy cancellation by the Insurer shall not be applicable if the policy would have been issued despite the knowledge of the full circumstances, even if contract alterations by the Insurer would have been applicable.

3. CHANGE OF CONTRACT

Should the Insurer not be entitled to cancel or rescind the existing contract, because cover would have been offered despite the full knowledge of the circumstances, albeit under different conditions, the circumstances shall become part of the contract retroactively upon request by the Insurer, provided the Insured Person has suppressed, misrepresented or misstated any material fact out of negligence. In case the premium after the change of contract is more than 10% higher than before or cover for the respective benefit ceases then the Insured Person shall be entitled to cancel the contract with immediate effect within one month after receiving the notification by the Insurer. The Insurer will inform the Applicant about this right in the change of contract notification.

4. EXECUTION OF THE RIGHTS OF THE INSURER (§ 21 VVG)

The Insurer is entitled to assert his rights of resindment, cancellation or change of contract in writing within a period of one month. The term begins on the date on which the Insurer obtains knowledge of the breach of duty of disclosure on which they claim and constitute their entitlement to recede, cancel or change the contract. Assertion of these rights shall be accompanied by a notification declaring the reasons for the Insurer as to why the contract is rescinded, canceled or changed. Further reasons may be added within the notification period. The right to rescind, cancel or change the contract ceases if the Insurer had been aware of the circumstances or the breach of duty of disclosure. The right to rescind, cancel or change the contract ceases three years after conclusion of the contract. This shall not apply to claims dated to within the period of three years after conclusion of the contract. The period shall be extended to ten years if the breach of duty of disclosure has occurred out of willful or malicious intent.

5. WILLFUL DECEIT (§ 22 VVG)

The right of the Insurer to contest the validity of the contract remains unaffected.

6. REPRESENTATIVE PERSON (§ 20 VVG)

In case of a third party representing the Insured Person at the time of application and conclusion of the contract any possible willful or malicious intent of both, the Representative and the Insured Person, are to be considered regarding any actions involving breach of the duty of disclosure, rescindment, cancellation and the change of contract. The Insured Person shall only be entitled to claim absence of willful intent or gross negligence when neither is to be imposed on the Insured Person nor its Representative.

ADDITIONAL DECLARATION:

The insurance contract applied for is governed by German law, and is to be interpreted exclusively consistent with German law and usage of terminology. This includes, without limitation, the legal concepts and terms contained in the contract, the English translations of which may not be identical with the original German terms in their respective legal understanding. In case of discrepancy between the German version of this contract and the English version, the German version prevails.

Place, date: ____________________________

Signatures: ____________________________

(applicant or legal guardian of persons who are to be included in the insurance and all adults to be insured)

- BDAE EXPAT GMBH -
KÜHNEHÖFE 3 • D-22761 HAMBURG
FON +49-40-3 06874-0 • FAX +49-40-3 06874-90
info@bdae.com • www.bdae.com
REGISTERED OFFICE: HAMBURG • HRB 122052 • LOCAL COURT HAMBURG • CEO: SILVIA OPITZ, ANDREAS OPITZ
DECLARATION AND INFORMATION ON DATA
PROCESSING BY SWISS LIFE PRÉVOYANCE ET SANTÉ
(INSURER)

I. CONSENT TO THE COLLECTION AND USE OF HEALTH DATA AND DECLARATION OF RELEASE FROM SECRECY.

The declarations of consent and of release from secrecy printed under I. were prepared as coordinated between the Gesamtverband der deutschen Versicherungswirtschaft e.V. (GDV) and data protection authorities.

The Insurance Contract Act, the federal Data Protection Act and other data protection provisions do not include an adequate legal basis for the collection, processing and use of health data by the insurer. For this reason we need your consent as required by data protection laws. In the event of a claim, we may require your release from secrecy in order to obtain your health data from parties subject to secrecy (e.g. physicians).

Furthermore, we require your release from secrecy in order to disclose your health data or other data protected under Section 203 of the German Criminal Code, e.g. the fact that there is a contract with you, your customer number or other identification data, to other parties, e.g. assistance, logistics or IT service providers.

The following declarations of consent are indispensable for the implementation or termination of your insurance contract (processing of your claim). Should you not submit these, it will not usually be possible to enter into any contract.

The declarations relate to the way we handle your health data and other data subject to secrecy (under 1.), in connection with requesting these from third parties (under 2.) and when disclosing them to parties external to the insurer (under 3.).

The declarations also apply to persons legally represented by you who are included in the insurance, e.g. to your children, if they do not recognise the significance of this consent and thus cannot submit their own declarations.

1. CONSENT TO THE COLLECTION, SAVING AND USE OF YOUR HEALTH DATA

I consent to Swiss Life Prévoyance et Santé collecting, saving and using the health data notified by me in the future, provided that this is required to implement or terminate the insurance contract.

2. REQUEST OF HEALTH DATA FROM THIRD PARTIES TO VERIFY THE DUTY TO INDEMNIFY

To check our duty to indemnify it may be necessary for us to check information on your state of health which you provided to substantiate claims or which is shown in the documents submitted (e.g. bills, prescriptions, expert opinions) or notifications, e.g. by a physician or other member of the health profession.

This verification is carried out only to the extent necessary. To do so, we require your consent including a release from secrecy for us and for these parties if, in the course of these requests, health data or other information subject to secrecy are disclosed.

We will inform you in each individual case of the persons or establishments that are required to provide information and for what purpose. You can then decide in each case whether you consent to the collection and use of your health data by the insurer, release the persons or establishments named and their employees from secrecy and consent to the transfer of your health data to the insurer, or whether you will provide the required documents yourself.

3. DISCLOSURE OF YOUR HEALTH DATA AND OTHER DATA SUBJECT TO SECRECY TO PARTIES OUTSIDE SWISS LIFE PRÉVOYANCE ET SANTÉ

We contractually oblige the parties named below to observe provisions on data protection and data security.

3.1. DISCLOSURE OF DATA FOR MEDICAL ASSESSMENT

To check our duty to indemnify, it may be necessary to call in medical experts. We require your consent and release from secrecy for this purpose if your health data and other data subject to secrecy are transferred in this connection. You will be informed of each transfer of data.

3.2. TRANSFER OF TASKS TO OTHER PARTIES (BUSINESS ENTERPRISES OR PERSONS)

Health data might be collected, processed and used. We have therefore transferred these tasks to other companies. If your data subject to secrecy are disclosed in the course of this, we require your release from secrecy for us and, where necessary, for other parties. We carry out a constantly updated list of the parties and categories of parties that collect, process or use data subject to secrecy on our behalf as agreed. This list shows the tasks which have been transferred to the individual parties. The currently valid list is enclosed directly with the declarations. 1). An up-to-date list can also be viewed on the Internet under www.bdae.com/en/downloads/GesundheitsdatenSchweigepflichtentbindung.pdf. We need your consent for the disclosure of your health data and for use of such data by these parties.

I consent to Swiss Life Prévoyance et Santé transferring my health data to the parties named in the list mentioned above. In the event of a claim, we may require your release from secrecy in order to disclose your health data and other data protected under Section 203 of the German Criminal Code to the parties in the list to ensure that the insurance can be processed.

To ensure that your claims are satisfied, Swiss Life Prévoyance et Santé can conclude contracts with reinsurers that partially or completely assume the risk insured by us. In some cases the reinsurers use other reinsurers for this purpose to whom they also transfer your data. To allow the reinsurer to check whether Swiss Life Prévoyance et Santé has correctly assessed a claim, Swiss Life Prévoyance et Santé might be required to present your claim documents to the reinsurer.

4. DISCLOSURE OF DATA TO REINSURERS

To ensure that your claims are satisfied, Swiss Life Prévoyance et Santé can conclude contracts with reinsurers that partially or completely assume the risk insured by us. In some cases the reinsurers use other reinsurers for this purpose to whom they also transfer your data. To allow the reinsurer to check whether Swiss Life Prévoyance et Santé has correctly assessed a claim, Swiss Life Prévoyance et Santé might be required to present your claim documents to the reinsurer.
I hereby make the declarations on data processing submitted by the applicant or the person interested in insurance on my own behalf or on behalf of the person(s) to be insured.

I consent to Swiss Life Prévoyance et Santé transferring my health data to the parties named in the list mentioned above and to the collection, processing and use of my health data by those parties for the purposes stated to the same extent as Swiss Life Prévoyance et Santé would be allowed to do. Insofar as necessary, I release the employees of the parties entrusted with this task from secrecy for the disclosure of health data and other data protected under Section 203 of the German Criminal Code.

AGA Service Deutschland GmbH (assistance services)
Experts (medical and nursing assessment and preparation of expert reports),
Nursing services and providers of medical aids (arrangement of nursing services and medical aid providers),
Patient repatriation transports (medically necessary repatriation from abroad).
BDAE Expat GmbH
BDAE Dienstleistungsgesellschaft mbH
BDAE Holding GmbH
BDJ Versicherungsmakler GmbH & Co. KG

II. DISCLOSURE OF DATA TO OTHER INSURERS

Pursuant to the Insurance Contract Act the insured person must notify the insurer of all important circumstances for claim settlement in case of damage. This can also include previous illnesses and claims or notifications about other similar insurance. In certain cases, such as double insurance, legal subrogation and where there are cost sharing agreements, personal data must be exchanged between insurers. Also to prevent any misuse of insurance it may be necessary to request information from other insurers or to provide suitable information upon request. In the process, the data of the person affected are disclosed, such as his or her name and address, type of insurance cover and the risk or information on the claim (type of damage, amount of claim, date of damage).

Place, date: Signatures:

(applicant or legal guardian of persons who are to be included in the insurance and all adults to be insured)
# OVERSEAS HEALTH INSURANCE FOR OF UP TO 60 MONTHS

## EXPAT PRIVATE APPLICATION

### APPLICANT / PARTY ENTITLED TO INSURANCE:

<table>
<thead>
<tr>
<th>Surname</th>
<th>First name(s)</th>
<th>Current occupation</th>
<th>No. of membership, if existing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
<th>e-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PAYMENT DETAILS:

- **Payment type**: 
  - □ annually
  - □ every 6 months (+2%)
  - □ quarterly (+3%)
  - □ monthly (+5%)

- **Bank**: ____________  
- **IBAN**: ____________  
- **BIC / SWIFT-Code**: ____________

- **Credit Card (+6%)**:  
  - □ Master-/Eurocard
  - □ Visa
  - □ Diners
  - **Valid until**: ____________  
  - **Card-No.**: ____________

**Account / card holder, if not applicant (please sign below also):**

<table>
<thead>
<tr>
<th>Do you have additional health insurance?</th>
<th>□ Non</th>
<th>□ Yes, with:</th>
<th>Insurance no.:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INFORMATION ON ADDITIONAL HEALTH INSURANCE:

<table>
<thead>
<tr>
<th>The following persons are to be included in the insurance:</th>
<th>(Please consider applicant)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surname,</strong></td>
<td><strong>First name(s)</strong></td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(*please tick)</th>
<th>(**Only necessary if Germany is the choosen area of application)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In accordance with article 32 of the french data protection law No. 78-17 of 6. January 1978, I am aware that my personal data is being processed by SwissLife Prévoyance et Santé. I can assert my rights of accessing and correcting my personal data in terms of article 39 and 40 according to above-mentioned law, by contacting SwissLife Marketing department, 1 rue du Mal de Lattre de Tassigny – 59671 Roubaix Cedex 01 France, and for medical data: Swiss Life, 7 rue Belgrand 92300 Levallois-Perret France. The for my process collected personal data will be used by the Swiss Life Group, the receiver of the data – along with his deputies and reinsurers, under strict medical confidentiality. I have to answer every given question, otherwise SwissLife Prévoyance et Santé cannot check the process.
I / we hereby apply for insurance cover as outlined by the terms and conditions for limited health insurance and sickness daily allowance cover of the EXPAT-series for long-term journeys part I and part II (EXPAT PRIVATE) for the persons listed above by registering them with the insurer as insured persons.

The total premium must be paid in advance in accordance with the chosen payment method. The premium debtor is the party of entitled to insurance as concerns the policyholder, and the policyholder as concerns the insurer. I hereby give authorization to BDAE Holding GmbH to debit the premiums from my account or credit card (see above). As service provider of the BDAE Expat GmbH the BDAE Holding GmbH is authorized to administer its contracts to the full extend and to collect debts. The debit will be assignable by the Creditor Identifier DE23ZZZ00000131378. The individual mandate reference will be disclose on the Confirmation of Insurance Coverage. I hereby authorize my bank to redeem the debit notes presented by BDAE Holding GmbH for the benefit of the insurer. Note: the premium is due after confirmation of insurance cover has been received and no later than the beginning of the insurance. I / we am / are aware that the policy holder will not register the listed persons as insured persons with the insurer or will terminate their registration if the premium or other charges have not been paid in full due to the actions of parties entitled to insurance. I / we am / are also aware that we do not have insurance cover in this case.

Place, date: 

Signatures: 

(applicant or legal guardian of persons who are to be included in the insurance and all adults to be insured and possibly different account holder / card owner) 

Insurer: Swiss Life Prévoyance et Santé
Policy holder: BDAE EXPAT GmbH
TO ENSURE THAT YOUR APPLICATION IS PROCESSED QUICKLY AND PROMPTLY WE KINDLY ASK YOU TO CHECK THE FOLLOWING POINTS.

### 1. The application must be filled in completely and in block capitals.

### 2. Each application must include a signed copy of the Legal Instruction and the Declaration and Information on Data processing.

### 3. Payment method data:
- Bank transfer of the premium is only possible once a year or every six months (+2%).
- A direct debit is only possible from a German account on a monthly (+5%), quarterly (+3%), six monthly (+2%) or annual basis. As an alternative, you can also pay the premium by credit card (+6%) using the same payment method as for a direct debit.

### 4. The application must be signed by the applicant and all adult insured persons.

### 5. If the account holder is different from the applicant, the signature of the account holder is also required.

### 6. The following must be noted for the rates Expat Flexible, Expat Private Premium, Expat Retired and Expat Resident:
- **EXPAT FLEXIBLE:** A health certificate or evidence of a German previous insurance must be submitted if the insured person has been staying in Germany for longer than 31 days. The health certificate must not have been issued more than 14 days previously.
- **EXPAT PRIVATE PREMIUM:** Information on the health declaration must be submitted with the application. A health certificate which has not been issued more than 3 months previously must be submitted for persons aged 50 and over.
- **EXPAT RETIRED und EXPAT RESIDENT:** Information on the health declaration as well as the additional declaration must be submitted with the application. A health certificate which has not been issued more than 3 months previously must be submitted for persons aged 60 and over.

### 7. Health certificate Expat Flexible, Expat Private, Expat Retired and Expat Resident:
- The health certificates must be issued in German or English and be legible.
- Each question must be answered.
- Questions answered with yes or questions that indicate an abnormal result require an explanation.
- The explanation in the presence of the doctor must be signed by the applicant and the doctor.
- The last page of the certificate must also be signed by the doctor.
- If the Expat Resident, Expat Retired Top or Expat Flexible Plus is selected, a dental report is required.
- The first and last name must be specified on each page of the findings.
- Always specify your GP using their full name and the exact address.
- If any inpatient treatment has taken place, it would speed up the inspection if corresponding discharge reports and reports on findings were submitted to us along with the health certificate.
- If there are any further inquiries, please adhere to the deadlines specified in the letter of request as acceptance is otherwise not possible.

WITH THESE REGULATIONS, WE CAN ENSURE THAT YOUR APPLICATION IS PROCESSED SMOOTHLY AND PROMPTLY. THANK YOU FOR YOUR UNDERSTANDING!