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

EXPAT CASH

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

effective: 01.09.2014

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

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

PART A - GENERAL PROVISIONS

§ 1 INSURABLE PERSONS AND INSURABILITY

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

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

2. Natural persons may be insured.

3. Not insurable and despite premium payment not insured are

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

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

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

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

§ 2 CONCLUSION AND DURATION OF THE INSURANCE CONTRACT

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

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

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

§ 3 PREMIUM, BENEFIT ADJUSTMENT, INSURANCE YEAR

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

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

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

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

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

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

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

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

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

   c) not before payment of the premium;

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

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

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

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

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

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

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

   c) death of the person insured;

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

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

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

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

§ 5 OBJECT OF INSURANCE COVER AND SCOPE OF INSURANCE BENEFITS

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

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

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

§ 6 GENERAL LIMITATIONS OF THE OBLIGATION TO PAY BENEFIT

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

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

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the party entitled to insurance or the insured person.

2. There is no obligation to pay benefit:

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

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

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

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

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

   f) For immunisation measures;

   g) For medical aids;

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

   i) For preventive medical examinations;

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

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

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

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

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

   o) For attempted suicides and their consequences;

   p) For organ donations and their consequences;

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

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

§ 7 OBLIGATIONS AND CONSEQUENCES OF FAILURE TO OBSERVE TO OBLIGATIONS

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

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

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

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

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

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

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

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

§ 8 PAYMENT OF INSURANCE BENEFITS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

concerning distribution of costs.

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

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

§ 10 OFFSET

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

§ 11 DECLARATIONS OF INTENTION AND NOTIFICATIONS

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

§ 12 APPLICABLE LAW / LANGUAGE OF THE CONTRACT

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

§ 13 SURPLUS SHARING

The insurance specified here is not entitled to surplus.

§ 14 SUPERVISORY AUTHORITY AND OMBUDSMAN

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

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

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

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PART B – SPECIAL PROVISIONS

§ 1 OBJECT OF THE INSURANCE

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

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

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

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

§ 2 SCOPE OF INSURANCE BENEFITS

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

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

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

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

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

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

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

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

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

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

§ 3 SPECIAL EXCLUSIONS

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

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

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

§ 4 ADDITIONAL STIPULATIONS ON THE END OF INSURANCE COVER

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

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

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§ 5 SPECIAL OBLIGATIONS

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

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

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

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

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

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