VIVIUM

COLLECTIVE INSURANCE INCAPACITY FOR WORK

General terms and conditions – ref. 6138/6139 (07/2018)

This translation is provided as an aid for policyholders or insured parties who are English-speaking. In the event of any differences arising as to the meaning or interpretation of any part of these terms and conditions, only the original Dutch or French wording will be considered valid.

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COLLECTIVE INSURANCE INCAPACITY FOR WORK

Article 1 – Definitions

Accident:
Sudden and unforeseen event beyond the affiliate's control and/or that of any person with an interest in the insurance policy, where the affiliate sustains a medical injury with an external cause and an immediate effect.

An accident is either an occupational accident or a personal accident.

An occupational accident is an accident as defined in the Belgian legislation on occupational accidents, including accidents when travelling to and from work. The reference to the legislation on occupational accidents is only included to define the concept of occupational accident.

A personal accident is every accident that is not an occupational accident.

Affiliate:
An employee who belongs to the category of employees for which the organiser has set up a collective insurance incapacity for work and who meets the conditions for affiliation.

Annual adjustment date:
The date on which the rights for every affiliate are recalculated in line with the elements of calculation to be taken into account at that time.

Modifications made to the elements of calculation in the course of an insurance year take effect only from the next annual adjustment date.

Benefit statement:
Overview of the guarantee.

Change date:
The date when the rights of the affiliate are administratively adjusted in function of:

- a change in family situation (insofar as it results in a change);
- a change of the type of employment (part-time employment contract, part-time time-credit and part-time thematic leave);
- suspension of the employment contract:
  - following the taking of full-time time-credit or full-time thematic leave;
  - following incapacity for work with loss of salary;
- "end of career" time-credit;
- suspension of the employment contract with loss of salary.

The change date is the first day of the month coinciding with or following one of the above-mentioned events. However, the insurer grants immediate cover as from the moment of change.

Guaranteed salary:
If the affiliate, in the event of a covered incapacity for work, is entitled to the maintenance of his or her salary at the expense of the organiser, the insurer does not owe the insured benefits during the period in which the guaranteed salary is at the expense of the organiser.

Incapacity for work:
The partial or complete inability to engage in any professional activity corresponding to the affiliate's social situation, knowledge and skills as a result of the impairment of the affiliate's physical or psychological integrity. The incapacity for work is fully independent of any other economic criterion and is established by medical decision.

Insurance year:
The period from the annual adjustment date of any year up to and including the day immediately preceding the next annual adjustment date.

If the scheme is cancelled between two annual adjustment dates, the last insurance year will run from the last annual adjustment date to the day on which the scheme is cancelled.

Illness:
Any impairment to a person's health not caused by an accident and established by a physician who is authorised to practice medicine in Belgium.

Insurer:
Vivium, a brand of P&V Assurances/Verzekeringen sc/cv, an insurance company authorised under code 0058.

Organiser:
The company concluding the scheme with the insurer.

Scheme:
The general terms and conditions, the special terms and conditions and the benefit statement together form the scheme. Any schedules and annexes to the special terms and conditions form an integral part of this scheme. However, the provisions contained in the special terms and conditions and any riders and annexes take precedence over the general terms and conditions.

The insurer reserves the right to settle all issues not provided for by the special terms and conditions in accordance with the general terms and conditions.

Waiting period:
The period that begins on the day determined by a physician to be the beginning of the incapacity for work and the duration of which is determined in the special terms and conditions. During this period, the insured benefits are not payable by the insurer.

Article 2 – Cover

This insurance is intended to make up for the loss of employment income and is therefore a collective benefit as referred to in Article 52, 3°, b, fourth indent of the Income Tax Code 1992, which provides for a supplement to the statutory benefits in the event of incapacity for work due to an occupational accident or accident or illness.

If the affiliate becomes incapable of working as a result of a covered cause with, as a consequence, a loss of employment income, the affiliate shall be entitled to the annuity mentioned in the special terms and conditions during the period of incapacity for work. The special terms and conditions also mention which causes of incapacity for work are covered.

In order to obtain and continue to receive this annuity, the level of incapacity for work has to be at least 25%. The annuity is paid in proportion to the degree of incapacity for work. A level of incapacity for work of 67% or more shall be equated to a 100% level of incapacity for work.

Should the level of incapacity for work change, the amount of the annuity will be adjusted in line with the new level.

The insurer will pay the annuity as from the moment the waiting period specified in the special terms and conditions expires. The annuity shall be paid out up to at the latest the maturity date specified in the special terms and conditions.

Article 3 – Claim settlement

In the case of total incapacity for work, the affiliate shall be awarded 1/365th part of the insured annuity per day. In case of partial incapacity for work, the annuity shall be in proportion to the level of incapacity for work.

The annuity is payable per month, for the first time 30 calendar days after the expiry of the waiting period. The payment is settled with a proportional payment at the end of the incapacity for work.

The waiting period starts on the date established by a physician as the beginning of the incapacity for work.

Article 4 – Beginning and ending of affiliation

For administrative purposes, affiliation occurs on the first of the month coinciding with or following the date on which the employee meets the conditions for affiliation. However, the insurer grants immediate cover from the date on which the conditions for affiliation are met.

If an employee is partially unable to work and/or his or her employment contract is partially suspended on the day that he or she meets the conditions for affiliation, the rights are defined as from the affiliation date in accordance with the procedure described under "Affiliates with an employment contract for part-time work" (Article 6 "Determination of rights for affiliates who are not full-time employed").

If an employee is fully unable to work and/or his or her employment contract is suspended at such time as he or she meets the conditions for affiliation, his or her affiliation will be postponed until the first of the month coinciding with or following the date of partial or full resumption of work.

The affiliation is terminated on:
- the first of the month coinciding with or following
  - the day on which the definition of affiliate and/or the conditions for affiliation are no longer complied with;
  - the affiliate being no longer subject to Belgian social security;
  - the affiliate leaving left the organiser's employ before the maturity date;
  - (early) retirement;
  - redundancy in the context of the system of unemployment with company complement (RCC/SWT);
  - full exemption from working in the case of end-of-career arrangements;
- the date on which the affiliate dies if prior to the maturity date;
- the maturity date.

Article 5 – Indexation after claim

If the special terms and conditions provide for an indexation after claim, the amount of the annuity will be annually increased on the anniversary of the commencement date of the incapacity for work (if the minimum level of incapacity for work is reached). This occurs by multiplying the amount of the annuity with the indexation factor equal to (1 + indexation percentage) to the n^{th} power, where n represents the number of full years since the commencement date of the incapacity for work. The indexation percentage is specified in the special terms and conditions.

When the affiliate is no longer affected by the incapacity for work for which the cover was applied, the insured amount of the annuity is brought back to its level before the period of incapacity for work.

Article 6 – Determination of rights for affiliates who are not full-time employed

Affiliates with an employment contract for part-time work:

For salary-related rights, the calculation is made on the basis of the salary corresponding to part-time work.

Lump-sum rights are proportionally reduced in line with the type of employment.
The maximum annuity is not reduced in line with the type of employment.

Employees, who are partially exempted from work under end-of-career arrangements, are regarded as affiliates with an employment contract for part-time work.

Suspension of the affiliate's employment contract with loss of salary:

If the affiliate's employment contract is suspended for any reason other than availing of time-credit or thematic leave, the collective insurance incapacity for work is terminated for the employee in question. From the moment of resumption of work, the employee is once again affiliated.

If the employment contract is suspended for less than 30 days, the procedure above will not be applied and the rights are further determined as if the affiliate's type of employment had remained unchanged.

Article 7 – Transfers

If the affiliation is defined in the special terms and conditions as a function of the years of service, the years of service with former employers are also taken into account:

- in case of a collective transfer of employment of employees; and
- in case of a transfer of employment of an employee within the group of companies with legal-economic ties, to which the organiser belongs.

Article 8 – Geographical scope

The cover is valid worldwide.

Article 9 – Medical acceptance

Medical acceptance refers to defining the scope of the cover for each individual affiliate on the basis of his or her health. The medical condition is defined on the basis of a medical questionnaire and/or medical examination. The choice of how the medical condition is established depends on the insurer's acceptance criteria at the time a request for affiliation or for an increase in cover is made. For a medical examination, the affiliate must report to a physician in Belgium. The cost of the fee will be borne by the insurer. Any special expenditure incurred as a result of this (for example, travel costs) shall be borne by the affiliate.

In case of medical acceptance, the insurer may, if an increased risk is found, in application of its medical acceptance policy and insofar as permitted by current legislation, charge an additional premium or refuse the risk in whole or in part.

Article 10 – Pre-existent conditions

Injuries and disorders are deemed to be pre-existent, if they were medically established before the date of affiliation. Injuries and disorders, of which the symptoms were medically established before the date of affiliation, are also pre-existent.

Affiliates who have not undergone medical acceptance will be paid the insured annuity for full incapacity for work as a result of pre-existent injuries or disorders occurring within the first year after the date of affiliation, albeit limited to a reduced payment applied by the insurer under the terms of its medical acceptance policy. The annuity thus determined shall apply for

all future periods of incapacity for work, including after the first year has passed, as a result of such pre-existent injuries or disorders. In case of partial incapacity for work, the benefit will be calculated proportionally on the basis of said annuity.

If the incapacity for work due to a pre-existent injury or disorder occurs more than one year after the affiliation date and if no incapacity for work has occurred during the first year of affiliation as a result of these injuries or disorders, the insured annuity will be paid and no upper limit will apply.

Affiliates who underwent the medical acceptance procedure and for whom pre-existent injuries or disorders were found will, regardless of the moment when full incapacity for work occurs as a result of the found pre-existent injuries or disorders, be paid the annuity that was communicated to the affiliate in writing after the medical acceptance. In case of partial incapacity for work the benefit will be calculated proportionally on the basis of this annuity.

Article 11 – Financial acceptance

The insurer may request additional information to check whether the insured annuity is in accordance with its financial acceptance policy.

Article 12 – Excluded risks

The cover does not include incapacity for work caused, promoted or aggravated by:

- any suicide attempt by the affiliate;
- subjective disorders without objective symptoms or without medically demonstrated grounds;
- the effects of a change in a material's atomic structure, the artificial acceleration of the atomic particles and radiation from radioisotopes, unless as part of medical and/or paramedical professions;
- the use of weapons and explosives;
- the abuse of alcohol, narcotics or drugs, addiction or any other form of substance dependence;
- an accident involving an aircraft the affiliate boarded as a pilot or crew member;
- an accident involving an aircraft the affiliate boarded as a passenger:
    - if the aircraft is being prepared for or participating in a sporting event;
    - if the aircraft is of the "ultralight motorised" type (ULM).

Sports

The risks associated with the practice of sports are covered, except where the act that gave rise to the incapacity for work was a result thereof:

- a professional engagement in any sport or the engagement in any sport under an employment contract, even as a secondary activity, including training exercises;
- participation in record attempts, exploratory trips or sporting expeditions.

Article 13 – Incapacity for work as a result of psychological disorders, burn-out, CFS and fibromyalgia

Psychological disorders are disorders that belong to the domain of psychiatry and the diagnosis of which was indisputably established by a psychiatrist authorised in Belgium on the basis of objective symptoms, and that meet the criteria of the Diagnostic and Statistical Manual of Mental disorders, Fifth Edition (DSM-V) or later versions.

The following psychological disorders are covered: bipolar disorder, psychotic disorder, schizophrenia, dissociative disorder, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa.

In the event of incapacity for work resulting from depression or a psychological disorder other than those listed above, the insured benefit is awarded for a consecutive or non-consecutive period of no more than 730 calendar days, on condition that the actual existence of the disorder and the incapacity for work is clear and recognized.

This limitation in time and the condition for recognition also applies in the event of incapacity for work as a result of burn-out, chronic fatigue syndrome (CFS) and fibromyalgia. The extent of the condition and the accompanying incapacity for work must be substantiated by a medical report specifying the diagnosis, a description of the symptoms, the specialist examinations

and the results of any technical examinations conducted by a specialist physician and/or expert in the field authorised in Belgium.

The 730-calendar day period is extended by the periods of admission to a psychiatric hospital or a psychiatric section of a general hospital that took place before the end of the 730-calendar day period. The 730-calendar day period applies once per affiliate over the entire term of the insurance, regardless of whether this involves a new incapacity for work or a continuation of an existing incapacity for work, and commences after the end of the waiting period.

Depending on the condition, the insurer retains the right to appoint a specialist physician and/or an expert in the subject authorised in Belgium.

Article 14 – Maternity leave and adoption leave

Incapacity for work caused, promoted or aggravated by a pregnancy or childbirth is covered for the period of statutory maternity leave.

A pathological pregnancy is also covered outside the period of statutory benefit, provided the incapacity for work is not the result of unhealthy activities.

A pathological pregnancy is understood to be the pregnancy complications, both for the insured party and her foetus, as a result of a pathological or abnormal condition.

Unhealthy activities are activities involving exposure to a professional risk, whether or not this poses a potential danger for the mother and/or the foetus, such as:

- working with chemical substances;
- working with infectious agents;
- working with ionising radiation;
- working with cytostatics (such as e.g. anti cancer drugs);
- work involving lifting loads;
- working in high temperatures; and
- working nights.

An affiliate who avails himself or herself of the right to adoption leave is entitled, after the end of the waiting period, to the insured benefits.

Article 15 – Criminal intent and gross negligence

The cover does not include incapacity for work caused, promoted or aggravated by:

- a deliberate act committed by the person who has an interest in the benefit, or aided and abetted by him or her; a deliberate act committed with the intention of causing injury to the affiliate.
- the cases of gross negligence committed by the affiliate or the person has an interest in the benefit as listed below:
  - any participation in crimes, offences or fights, whether or not the result of a provocation or dispute, except cases of legal self-defence;
  - reckless acts of which it is known that they form a threat to the physical integrity of the affiliate, except in cases of saving persons or goods;
  - reckless acts, committed by a third party with the approval of the affiliate or any other person with an interest in the benefit, which cause injury/damage to the affiliate;
  - being under the influence of alcoholic beverages or narcotics or drugs, except if there is no causal relation between this condition and the claim.

Article 16 – Acts of war, riots and terrorism

Incapacity for work caused, promoted or aggravated by acts of war or civil war is excluded from cover.

Incapacity for work caused, promoted or aggravated by civil unrest or riots, or by politically, ideologically or socially inspired collective acts of violence is not covered. Where the affiliate demonstrates that he or she did not take an active part, or was in a position of legal self-defence, or acted with a view to saving persons or goods, he or she is covered.

Incapacity for work caused by an event recognised as terrorism is covered in accordance with the provisions of the Act of 1 April 2007 on insurance against damage caused by terrorism. The insurer is a member of the "Terrorism Reinsurance and Insurance Pool" (TRIP non-profit organization) that was established in application of the aforementioned act.

Article 17 – Relapse

A relapse means the affiliate is unable to work as a result of a previously covered accident or illness.

In case of a relapse within 30 days no new waiting period will apply.

The annuity at the start of the continued incapacity for work is the same as the annuity last paid during the previous period of incapacity for work, as if there had been no interruption of the incapacity for work. This annuity is not payable, however, during the period of guaranteed salary, when the latter is paid by the organiser.

Article 18 – Restriction of the annuity

If the level of incapacity for work can be reduced by means of a surgical intervention, a special treatment or wearing a prosthesis and the affiliate refuses to undergo such treatment or use such aids, the insurer shall be required to pay only such reduced benefit as would have been the case if the affiliate had undergone such treatment or used such aids and insofar as the thus reduced level of incapacity for work qualifies for any benefits.

Article 19 – Reporting incapacity for work and medical follow-up

Every case of incapacity for work that may give rise to a payment must be reported to the insurer within 45 days at the latest following the beginning of the incapacity for work. The insurer reserves the right to refuse or limit payment if the report is made outside of that period. The insurer will not invoke that right if the report is made as fast as reasonably possible, taking into account the circumstances.

The report must be made using the form intended for this purpose and must be accompanied by all original documents, certificates and reports, which can demonstrate the existence and seriousness of the claim.

The medical reports of the attending physician will be submitted by the affiliate to the insurer's advisory physician. The insurer may request additional information from the affiliate or invite him or her to undergo additional medical examinations. Where appropriate, the insurer will await the results before adopting a standpoint on whether or not the claim is covered

The provisions of this article continue to apply in the event of incapacity for work while abroad. Upon request by the insurer, the affiliate must see a physician in Belgium designated by the insurer. Any special expenditure incurred as a result of this (for example, travel costs) shall be borne by the affiliate.

The affiliate will report within 15 days after their detection any changes in his or her health condition which results or may result in an increase or reduction in his or her level of incapacity for work. The granted annuity will be adjusted to take account of changes in the level of incapacity for work. The insurer may claim back any sum that was wrongfully paid out.

The insurer may revise the degree of incapacity for work at any time. The insurer may to this end request additional information from the affiliate or invite him or her to undergo additional medical examinations.

Article 20 – Beginning and termination of the guarantee

The cover period starts and ends at the latest on the respective dates indicated in the special terms and conditions. The scheme shall not become effective before the insurer has received the first premium.

Article 21 – Duration and cancellation of the scheme

The scheme is concluded for a duration of 1 year. Barring notice, the scheme is automatically renewed for one year at the end of every insurance year.

The organiser may terminate the scheme by registered letter at least three months before the annual adjustment date or on the anniversary or the insurance policy's effective date.

The insurer may terminate the scheme by registered letter at least three months before the annual adjustment date.

Article 22 – Rate change

If the insurer changes the rates, the organiser shall be entitled to cancel the scheme. The rate change shall be notified at least 4 months before the scheme's' annual adjustment date and the organiser may cancel the scheme within one month after the notification by means of registered letter. If the rate change is notified within 4 months before the annual adjustment date, the organiser may give notice within a term of three months after the notification.

Article 23 – Obligations of the insurer when the scheme is terminated

When the scheme is terminated, for any reason whatsoever, the insurer will intervene for every covered incapacity for work that started before the date on which the scheme was terminated.

Except in the event of individual continuation, no payments will be made for an aggravation of the incapacity for work that began after the termination of the scheme. A physician shall establish the date on which the incapacity for work began or increased.

Article 24 – Premium payment

The insurer provides the organiser with a periodical premium statement detailing the premium to be paid. The frequency of premium payment is specified in the special terms and conditions.

If the premium is not paid on the due date, the insurer will send a registered notice to the organiser. If the premium is not paid within the set payment term, the insurer may suspend the coverage or cancel the scheme.

The suspension of the cover ends on the day following payment of the premium arrears, plus interest and costs, to the insurer.

Article 25 – Premiums and taxes due

Premiums fall due for each affiliate:

- as of the administrative affiliation for the respective rights;
- if affiliation commences during an insurance year, the premiums are payable on a pro rata basis for that year;
- as from full resumption of work after a period of suspension of the employment contract on account of incapacity for work;
- as from the resumption of work after a period of suspension of the employment contract with loss of salary.

Amending and cancelling the premium due date:

- when amending rights or elements used for the calculation, the due date for new premiums takes effect on the annual adjustment or change date;
- premiums are no longer payable from the first of the month coinciding with or following termination of employment;
- if the employment contract is suspended in full or in part on account of incapacity for work and after the end of the waiting period, the premiums will no longer be payable as from the first day of the month coinciding with or following the suspension;
- if the employment contract is suspended in full with loss of salary for longer than 30 days for a reason other than taking up time-credit or thematic leave, the premiums will no longer be payable as from the first day of the month coinciding with or following the suspension;
- when the maturity date is reached, no more premiums are due;
- if the affiliate dies, premiums are no longer due as of the due date preceding the death, unless premiums are paid at the beginning of the period, premiums will no longer be due on the due date following the death.

Taxes are due as of the moment that premiums are due.

The premiums and taxes are paid by the organiser to the insurer on the due date.

The organiser shall deduct any premiums and taxes due from the affiliate's salary at the same time as his or her salary is paid.

Article 26 – Consequences for an open claim file on the termination of affiliation

If the affiliation is terminated, the insurer is obliged to pay the benefits relating to each covered period of incapacity for work that began during employment by the organiser, insofar as the incapacity for work results in a loss of employment income. Upon (early) retirement, the compensation within the ongoing claim file is terminated.

Except in cases of individual continuation, no payments will be made for any aggravation of the incapacity for work that began after the termination of the affiliation. A physician shall establish the date on which the incapacity for work began or increased.

The affiliate shall inform the insurer of any change that may affect the benefits paid. The insurer may claim back any sum that was wrongfully paid out.

Article 27 – Right to individual continuation

An affiliate who loses the benefit of this occupational insurance is entitled to continue the insurance policy individually in full or in part without having to undergo an additional medical examination or having to fill in a new medical questionnaire.

The continuation is possible if the affiliate has been affiliated during an uninterrupted period of at least 2 years before the loss of the benefit of the collective insurance policy.

Within 30 days of the loss of the benefit, the organiser must inform the affiliate of:

- the exact date on which the benefit will be lost;
- possibility of individual continuation;
- the deadline by which the affiliate may exercise his or her right to individual continuation;
- the contact details of the insurance company.

The affiliate has 30 days after receiving the above-mentioned information to notify the insurer of his or her intention to continue the insurance policy.

The affiliate may extend that 30-day period if he or she notifies the insurer of this. The organiser must notify the affiliate of this possibility of continuation in a communication made within 30 days of the loss of the benefit of the contract. In any event, the period in which the affiliate may notify his or her intention to continue the insurance contract individually ends at the latest 105 days after the date of the loss of the benefit of the collective insurance policy.

The insurer has 15 days in which to make the affiliate an offer and to remind the affiliate that he or she has a period of 30 days to accept the offer, starting on the day of the receipt of the offer.

After the 30-day period has ended, the right to individual continuation lapses.

The various exchanges of information mentioned above may take both electronic and written form.

Article 28 – Pre-financing of the individual continuation

The affiliate has the option to pay individual additional premiums as a result of which the premium for the individual continuation will be calculated on the basis of the age at which the affiliate starts paying additional premiums.

The organiser must notify the affiliate immediately upon affiliation of the possibility of pre-financing.

Article 29 – General data Protection Regulation (GDPR)

The following stipulations concern the applicable legislation in respect of privacy and, in particular, Regulation (EU) No 2016/679 of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC.

P&V Assurances/Verzekeringen sc/cv, with registered office at Rue Royale/Koningsstraat 151, 1210 Brussels, in its capacity as controller, collects and processes personal data in connection with the acceptance and management of the group insurance using the following forms (completed on paper or in digital form):

- Affiliation to group insurance;
- Notification of illness/accident/pregnancy/childbirth;
- Proposal or study of a group insurance;
- Medical questionnaire or report;
- Salary specification for the annual adjustment.

To keep this data up to date, we ask, among other, the organiser, the affiliates, the beneficiaries and various government agencies or databases to supply these details.

By personal data, we mean data relating to the organiser as well as data the organiser or affiliates would share about other persons, who are represented by them (for example the affiliates represented by the organiser and the family members or beneficiaries represented by the affiliates). When the organiser shares the personal data of persons, the organiser must inform them in advance of these provisions and the privacy policy and obtain their prior consent to share their personal data.

As part of this relationship with P&V Assurances/Verzekeringen sc/cv, P&V Assurances/Verzekeringen may collect and process the following personal data: personal identification information, identification information provided by the authorities, identification information or electronic localisation information, financial identification information, national registration number, personal and physical information, lifestyle habits, health information, legal information, political information (politically exposed persons - PEPs), education, occupation and employment as well as audio and visual recordings.

Personal data may be processed for the following purposes:

- evaluating risks; concluding, managing and executing contracts/insurance policies; managing claim files, including legal assistance and defence and possible reimbursement;
- payments;
- managing reserves;
- accounting and taxation associated with these various services;
- complaints management;
- disputes management;
- reinsurance;
- preventing breaches such as fraud, money laundering and terrorism;
- compliance with the legal and regulatory obligations on P&V Assurances/Verzekeringen sc/cv;
- promoting other products or services on the basis of anonymised personal data of the affiliates in the group insurance;
- processing for statistical purposes;
- improving the quality and security of the services of P&V Assurances/Verzekeringen sc/cv;
- carrying out satisfaction surveys.

Only for these purposes may personal data be shared, if necessary, with other recipients, more specifically, the organiser, other insurers, re-insurers, (re-)insurance brokers and other intermediaries, lawyers, consultants and supporting service providers, experts/technical advisers, repair companies, medical advisers, auditors, IT service providers and ombudsmen established in Belgium or abroad and with conventional authorities in connection with a legal obligation.

P&V Assurances/Verzekeringen sc/cv ensures that the persons it employs who are authorised to process personal data have received appropriate training and are committed to respecting the confidentiality of said personal data.

The legal basis for the processing of personal data is the insurance contract, a legal provision, the consent or legitimate interest of P&V Assurances/Verzekeringen sc/cv. The management of the group insurance, including the processing of personal data, is always subject to the supervision by the competent authorities and controlling agencies.

P&V Assurances/Verzekeringen sc/cv shall take the necessary preventative measures to ensure maximum security.

P&V Assurances/Verzekeringen sc/cv may hire subcontractors at any time and shall take the necessary preventative measures in doing so by concluding model contracts to require them to take the appropriate technical and organisational security measures to process personal data in full compliance with the GDPR.

In its capacity as controller, P&V Assurances/Verzekeringen sc/cv carries out internal checks and collaborates in any checks to be carried out by the competent authorities and controlling agencies.

Personal data is stored by P&V Verzekeringen sc/cv for the duration necessary to achieve the objective. Said data are stored on digital media that can be found in the European Union at all times.

More specifically, health information will be processed with the greatest discretion and only by a person who is authorised to do so.

P&V Assurances/Verzekeringen sc/cv may transfer personal data to third countries. In this case, P&V Assurances/Verzekeringen sc/cv shall ensure that the personal data shall only be passed on, or made available or accessible to the representation of the organiser in the European Union or to countries on the list of sufficiently protected countries, unless in connection with foreign legislation it is required to exchange personal data with a country that does not offer an appropriate level of protection.

In the event of a data leak of personal data, P&V Assurances/Verzekeringen sc/cv shall, without a waiting period and if feasible within 72 hours after the leak has been established, inform the supervisory body of the data leak in accordance with Article 55 of the GDPR, unless it is highly improbable that the data leak presents a risk to the rights and freedoms of the natural persons concerned. When informing the supervisory body is not possible within 72 hours, the reason for the waiting period shall be provided.

The affiliates may view their personal data and have it corrected by way of a dated and signed request, accompanied by a front and back copy of the identity card, addressed to P&V Assurances/Verzekeringen sc/cv at Rue Royale/Koningsstraat 151, 1210 Brussels, Belgium, for the attention of the Data Protection Officer, Compliance Department (dpo@pvgroup.be).

Furthermore, using the same procedure affiliates may also, within the prescribed limits of the GDPR and insofar as these questions are not in conflict with the management of group insurances and the applicable legislation, object to the processing of their personal data or request the limitation thereof, request that their personal data be deleted or exercise the right to data portability.

Where appropriate, affiliates may also request an explanation of any automated decisions that may be made. More information can be found at the same address.

Any complaints may be submitted to the Commission for the Protection of Privacy (www.dataprotectionauthority.be).

Article 30 – Applicable legislation and jurisdiction

The contract falls under Belgian legislation, more particularly the Act of 4 April 2014 on insurance. Disputes shall be heard solely by the Belgian courts.

Article 31 – Violations of the duty of disclosure

If the organiser, when conluding the contract, deliberately concealed or incorrectly reported information about the risk, thus misleading the insurer in the assessment of the risk, the scheme will be null and void.

If an affiliate commits such a violation of the duty of disclosure, the scheme will be null and void vis-à-vis that affiliate.

The premiums due up to the moment the insurer became aware of the deliberate concealment or deliberate incorrect information will be payable.

Article 32 – Medical disputes

Disputes about medical matters can be settled in an out-of-court medical expertise, provided the insurer and the person to be examined or his representative agree. Both parties each appoint their own physician. The third party physician appointed by both physicians will only intervene when no agreement can be reached between both physicians.

Every party will pay the fees and expenses of the physician appointed by it. The fees and expenses of the third party physician and the specialised tests will be paid by both parties, for 50% each.

However, on pain of nullity of their decision, the physicians may not deviate from the provisions of the scheme.

Articlel 33 – Handling of complaints

For a complaint relating to the present contract, the policyholder may contact:

- In the first instance: Vivium's Complaints Management service, Rue Royale/Koningsstraat 151, 1210 Brussels, tel.: 02 250 90 60, e-mail: klacht@vivium.be;
- For appeals: Insurance Ombudsman, Square de Meeûs/de Meeûsplantsoen 35, 1000 Brussels, www.ombudsman-insurance.be.

Such a complaint does not preclude the possibility of bringing legal proceedings.

Article 34 – Correspondance

Letters will be sent in a legally valid way if sent to the address stated by the addressee. If one of the parties changes address, the new address shall be notified to the other party without delay. If a party fails to communicate the new address, letters will be validly sent to the previous address.