TERMS AND CONDITIONS OF CONTRACT

DEATH AND ACTIVE ASSISTANCE

NATURAL 3

activeseguros.com

active seguros

General Terms and Conditions of Contract with Familiar de Seguros Active, S.A.

DEATH AND ACTIVE ASSISTANCE – NATURAL 3

Familiar de Seguros Active S.A.
Av. de las Cortes Valencianas, n. 17 - Mezz. - Flat 8 46015 Valencia
Telephone 963 519 885 · Email: atencion@activeseguros.com
www.activeseguros.com

V0125

active seguros

PRELIMINARY SECTION

Thank you for taking out this multi-risk insurance with **FAMILIAR DE SEGUROS ACTIVE**. Just by contracting the principle risk of death with ACTIVE, you have access to a large number of insurance benefits and additional services that complement it, through other entities associated with **FAMILIAR DE SEGUROS ACTIVE**. For greater clarity and transparency, we inform you that this **insurance contract** is divided into 9 different Sections, depending on the risks and branches covered, the services provided and the entity that grants the coverage or provides the corresponding services.

Below is a summary table of the benefits which you as an ACTIVE policyholder are entitled to receive or, as the case may be, to contract, under very advantageous conditions for having contracted the principle risk of death and for being an ACTIVE customer. For greater transparency, it also indicates whether it is an insured risk or a service and identifies the company providing the cover and the entity providing the service:

SECTION AND PAGE	PROVIDER	INSURANCE COVERAGE	ANCILLARY SERVICES INCLUDED IN THE MAIN COVERAGE	ANCILLARY SERVICES NOT INCLUDED IN THE MAIN COVERAGE (OPTIONAL CONTRACT)
SECTION I. Page 6	**ACTIVE**	**MAIN DEATH COVERAGE:** Funeral services in the event of death	These ancillary services are different from the death insurance, which is the main product. They are included in the insurance and are offered together with it. They **CANNOT** be purchased separately (Art. 184 RDL 3/2020 of 4 February).	These ancillary services are different from the death insurance, which is the main product. They are **NOT** included in the insurance but are offered together with it. The contracting of these services is voluntary.
SECTION I. Page 13	**ACTIVE**	**Complementary guarantees included in the main coverage:** • Transfer within the country in the event of death in Spain.		
SECTION I. Page 13	**ACTIVE**	**Optional complementary guarantees:** • Repatriation of insured persons of foreign nationality. • Accompaniment of mortal remains. • Repatriation of Latin American insured persons residing in Spain to their country of origin and funeral services for their relatives residing in Latin America specified in the Supplement for the Provision of Funeral Services in Latin America. • Repatriation or transport of the deceased Insured residing abroad. • Travel of a family member in the event of the death of the Insured residing abroad.		
SECTION I. Page 16	**ACTIVE**		**ADMINISTRATION AND INHERITANCE PROCEDURES, through JURISLEG,** to obtain death certificates, procedures with the National Institute for Social Security, widow's and orphan's pensions, tax settlements, etc.	
SECTION I. Page 17	**ACTIVE**		**COMPUTER AND TECHNOLOGICAL ASSISTANCE, through CENTRIBAL:** solution of incidents and computer queries of the insured party.	
SECTION I. Page 19	**ACTIVE**		**HOME ASSISTANCE - HANDYMAN, through EUROP ASSISTANCE:** basic repairs in the insured person's home. Includes **DAMAGE CLAIM**: management of amicable or legal claim to an identifiable third party for damages caused to the Insured. Includes **HANDYMAN SERVICE**: dispatch of a professional by the Reinsurer to the home of the Insured Party of the Assignor's Death Insurance policy, to carry out non-urgent work.	

SECTION AND PAGE	PROVIDER	INSURANCE COVERAGE	ANCILLARY SERVICES INCLUDED IN THE MAIN COVERAGE	ANCILLARY SERVICES NOT INCLUDED IN THE MAIN COVERAGE (OPTIONAL CONTRACT)
SECTION I. Page 19	**ACTIVE**		Includes **TELEPHARMACY SERVICE**: pick-up at home of Social Security prescription, health card or prescription from a private doctor to purchase the corresponding medicine. Includes **TELEPHONE TAX ADVICE**: response to any tax queries raised by the Insured relating to their personal sphere and limited to Spanish legislation.	
SECTION I. Page 23	**ACTIVE**		**LEGAL SERVICE: "Active Employment", through YO TENGO ABOGADO:** consultation of legal doubts raised by the Insured related to employment.	
SECTION I. Page 24	**ACTIVE**		**DENTAL SERVICE, through GIRA DENTAL:** access to a wide range of dental services (teeth cleaning, oral examination, emergency visits, etc.).	
SECTION I. Page 25	**ACTIVE**		**MEDICAL SERVICE: "Tu Salud", through HEALTHMOTIV:** health queries by phone, video call, email or web.	
SECTION I. Page 28	**ACTIVE**		**"ACTIVE MAS" CLUB, through Inspiring Benefits:** access to offers and promotions in partner shops.	
SECTION II. Page 28	**ARAG**	**ADDITIONAL COVERAGE OF TRAVEL ASSISTANCE included in the main coverage.** • Repatriation and transport of the deceased insured. • Travel of a companion. • International transfer in the event of the death of the Insured abroad. • Right to a companion for the deceased Insured during the transfer. • Repatriation or medical transport of the injured or sick abroad. • Repatriation or medical transport of the injured or sick in Spain. • Medical expenses abroad. • Repatriation or transport of other Insured parties. • Repatriation or transport of minors or disabled persons. • Displacement of a family member in the event of hospitalisation abroad. • Convalescence in a hotel abroad. • Early return due to the death of a family member. • Early return from abroad due to hospitalisation of a relative. • Search, location and dispatch of lost luggage. • Early return due to serious loss at the Insured's home or business premises. • Dispatch of forgotten or stolen objects during the trip. • Transmission of urgent messages. • Dispatch of medicines abroad.		

SECTION II. Page 28	**ARAG**	• Handling fees for lost or stolen documents. • Information service. • Theft and material damage to luggage. • Trip cancellation expenses.		
THE COVERAGE OF SECTIONS III, IV, V AND VI ARE OPTIONAL FOR THE POLICYHOLDER				
SECTION AND PAGE	PROVIDER	INSURANCE COVERAGE	SERVICIOS AUXILIARES INCLUIDOS EN LA COBERTURA PRINCIPAL	ANCILLARY SERVICES INCLUDED IN THE MAIN COVERAGE
SECTION III. Page 35	**SURNE**	**ADDITIONAL LIFE COVERAGE:** payment of compensation in the event of the death of the Insured		
SECTION IV. Page 42	**SURNE**	**ADDITIONAL COVERAGE FOR ACCIDENTS:** payment of compensation in the event of an accident to the Insured.		
SECTION V. Page 49	**SURNE**	**ADDITIONAL COVERAGE FOR ORPHAN'S INCOME:** payment of an annuity for education until the child reaches the age of 23.		
SECTION VI. Page 53	**SURNE**	**ADDITIONAL COVERAGE FOR HOSPITALISATION**: payment of of compensation in the event of hospitalisation of the insured person.		
SECTION VII. Page 54	**EUROP ASSISTANCE**	**ADDITIONAL COVERAGE OF PAYMENT PROTECTION:** reimbursement of the renewal premium of the death insurance due to hospitalisation, unemployment or temporary incapacity of the insured person.		
SECTION VII. Page 65	**EUROP ASSISTANCE**			**END-OF-LIFE DIGITAL MANAGEMENT:** removal of the deceased insured's digital references on social media and devices.
SECTION VII. Page 65	**EUROP ASSISTANCE**			**BASIC AND EXTENDED PERSONAL ASSISTANCE** employment of live-in assistants for home care; personal assistants to carry out specific tasks and other services.
SECTION VII. Page 69	**EUROP ASSISTANCE**			**LEGAL ASSISTANCE OF THE COMPLEMENTARY PRODUCT "ASISTENCIA MÉDICA BAREMADA" (SCALED MEDICAL ASSISTANCE)** (limit 3,000 euros): legal defence (in criminal jurisdiction) of the Insured in his/her private and family life for faults and offences due to imprudence, incompetence or negligence.
SECTION VIII. Page 69	**CH MASCOTAS**			**PET ASSISTANCE:** by means of previously contracted digital cards, you will be able to use a wide range of services related to your pet.
SECTION IX. Page 71	**CH SALUD / GUÍA DE LA SANIDAD / CANAL SALUD**			**MEDICAL / LEGAL ASSISTANCE:** service, by means of a personalised card, of private medical assistance. Voluntary

SECTION I. DEATH INSURANCE PROVIDED BY FAMILIAR DE SEGUROS ACTIVE, S.A.

I.1. DEATH COVERAGE

I.1.1. Preliminary information provided to the policyholder prior to contracting
In accordance with article 96 of the LOSSEAR and 122, 123 and 125 of the ROSSEAR, the policyholder acknowledges having received the information referred to in this section from the insurance company prior to taking out the insurance:

I.1.1.1. Applicable Legislation Member State, Supervisory Authority (Art. 96 LOSSEAR)
The General and Specific Conditions of this insurance contract are governed by the provisions of Law 50/1980, of 8 October, on Insurance Contracts, by Law 20/2015, of 14 July on the regulation, supervision and solvency of insurance and reinsurance entities and by Royal Decree 1060/2015, of 20 November, which develops it with regard to death insurance as a branch of service provision. **The clauses limiting the rights of the Insured that have not been expressly accepted in writing by the policyholder and that are highlighted in a special way in bold font are not valid.**

The Member State where the risk is located is Spain and the authority responsible for controlling the insurance company is the DIRECTORATE-GENERAL FOR INSURANCE AND PENSION FUNDS (DGSFP).

I.1.1.2. Internal and external instances of complaint and conflict resolution
In compliance with the provisions of Article 96 of Law 20/2015 of 14 July 2015 on the Regulation, Supervision and Solvency of Insurance and Reinsurance Entities and Article 123 of its implementing regulations (Royal Decree 1060/2015 of 20 November on the Regulation, Supervision and Solvency of Insurance and Reinsurance Companies), the Insurer reports on the following issues:

Internal complaint instances: In the event that you wish to submit a complaint or claim related to your legally recognized interests and rights, you may address it, in writing, to:
Customer Service
Telephone: 96 351 98 85
Email: atencion@activeseguros.com
Website: www.activeseguros.com

In all cases, please provide your policy number and/or claim number.
Once we receive your complaint, we will send you a written acknowledgment of receipt, providing the statutory deadlines for the resolution of your complaint.

The regulations applicable to this procedure are Order ECO/734/2004, of March 11 on customer service departments and services and the customer ombudsman of financial institutions.
The Customer Service Operating Regulations are available to customers at ACTIVE's home address.

External complaint instances:
1) In the event of a dispute, the Insured may file a claim with the Court of First Instance corresponding to his/her domicile in accordance with Article 24 of the Insurance Contract Law.

2) Likewise, the parties may voluntarily submit their differences to arbitration under the terms of articles 57 and 58 of the revised text of the General Law for Consumer and User Protection and other complementary laws, approved by Royal Legislative Decree 1/2007, of 16 November.
In any case, and except in those cases in which consumer and user protection legislation prevents it, they may also submit litigation issues to arbitration, under the terms of Law 60/2003, of 23 December, on Arbitration.

3) Furthermore they may submit their differences to a mediator under the terms provided for in Law 5/2012, of 6 July, on mediation in civil and commercial matters.

4) Likewise, and notwithstanding the actions to be taken before the Courts, the Policyholders, Insured and Beneficiaries, in the event of not obtaining a response from the Insurer's Customer Service within two months of the filing of the complaint or claim, or in the event of disagreement with the decision made, or if they consider that the insurer has violated their rights under the insurance contract, they may claim, pursuant to Article 119 of Law 20/2015, of 14 July, on the regulation, supervision and solvency of insurance and reinsurance companies, and in accordance with Order ECC/2502/2012, of 16 November and other applicable regulations, before the Directorate-General of Insurance and Pension Funds. The contact details are as follows:

Dirección General de Seguros y Fondos de Pensiones (Servicio de Reclamaciones)
Paseo de la Castellana 44, 28046 Madrid - España
Tel: 952 24 99 82
https://www.sededgsfp.gob.es/SedeElectronica/Reclamaciones/Reclamacion.asp
https://www.sededgsfp.gob.es/es/Paginas/Procedimiento.aspx?p=18

To file such a complaint, you must have previously submitted a complaint to the Insurer's Customer Service and not received a response within two months of the complaint being filed, or you may file such a complaint if the decision was contrary to your requests and you are still dissatisfied.

If you have purchased your insurance online, you can also file a claim via the EU Online Dispute Resolution (ODR) platform. The ODR platform's website is www.ec.europa.eu/odr.

I.1.1.3. Criteria to be applied for the renewal of the policy:
This insurance is monthly and tacitly extendable as set forth in Section 1.13 below.

I.1.1.4. Modality that is being offered, definition, characteristics and method for calculating the initial premium and successive premiums:
This death insurance is taken out under the modality of semi-natural premium, the amount of which is determined by the probability of death during the current year according to the life expectancy of the insured person, adapting, at each maturity, to the new actuarial age and to the insured capital.

I.1.1.5. Estimated evolution table of premiums and age: see table at the end of this section.

I.1.1.6. Updates of insured capital, benefits and premiums: see section 1.5 below.

I.1.1.7. Optional ancillary guarantees: see table of benefits in the previous Preliminary Section.

I.1.1.8. Conditions for termination of the contract.
You may terminate the contract at monthly maturities of your own free will in accordance with Section 1.13 below.

I.1.1.9. Right to reinstate the policy: not applicable.

I.1.1.10. Limits and conditions relating to the freedom of choice of the provider: see table of benefits in the Preliminary Section above.

I.1.11. Protection of personal data

Who is responsible for the processing of your personal data?
The data controller is FAMILIAR DE SEGUROS ACTIVE S.A. ("ACTIVE"), with registered office at Avenida de las Cortes Valencianas, 17-Entlo. 8, CP 46015, of the city of Valencia, C.I.F. A- 46001186 (hereinafter "the ENTITY" or "ACTIVE").

ACTIVE has formally appointed a Data Protection Officer and has also enabled the following communication channel:
NUNSYS, S.A.
CIF A97929566
C/ Gustave Eiffel, 3. Parque Tecnológico 46290 Paterna (Valencia)
963 122 868
dpo@nunsys.com

How did we obtain your personal data?
ACTIVE has obtained your personal data from one of the following sources:
• Provided by you in the application made, for the formation of the contractual relationship or those that are generated as a result of the development of the same.
• Companies of the ACTIVE Group or insurance intermediaries.
• From publicly accessible sources, common files, or public records. In the event that you provide third-party data, you guarantee that you have the express consent of the third parties for ACTIVE to process your data. You also guarantee that the third parties whose data you provide have been duly informed of the processing that ACTIVE will carry out with said data.

What kind of personal data do we process?
For as long as the contractual relationship is maintained, ACTIVE may process the following personal data:
• Identification data.
• Personal and family data.
• Data on social circumstances.
• Economic, financial and insurance data.
• Health data.

For what purposes and on what grounds do we process your personal data?
At ACTIVE, we process your personal data for the purposes set out below. Furthermore, each purpose of the processing has a legitimation on which the processing of your personal data is based.
At ACTIVE we process your personal data in order to comply with legal obligations or because the processing is covered by a legal provision for the following purposes:
• To protect your identity and duly detect fraudulent use of data both in the contractual and pre-contractual phase, undertaking the necessary

activities for the prevention, detection and control of fraud, as well as the prevention and/or detection of money laundering and/or terrorist financing.
• To comply with the sectorial regulations that affect ACTIVE as an obliged subject due to its activity and services provided, especially insurance regulations.
• Risk assessment, selection and pricing.
• Management and settlement of claims.

At ACTIVE we process your personal data for the purpose of developing and executing the contractual relationship with you for the following purposes:
• To comply with the benefits and coverage indicated in the insurance policy or any other service or obligation that we have subscribed with you.
• To process and manage the requests made by you in relation to products and services offered by ACTIVE, as well as to maintain, develop and control the existing business relationships between the parties, including for this purpose the evaluation, evaluation and monitoring.
• To establish, as appropriate, establish, exercise or defend claims that may arise in connection with your relationship with ACTIVE.

At ACTIVE we process your personal data based on the legitimate interest of the entity for the following purposes:
• To send you advertising or promotional information about ACTIVE products and/or services that are similar or related to those you have already contracted, through any means of communication used by the ENTITY, such as:
  - Postal mail
  - Email and social media (Whatsapp, Facebook, etc.)
  - SMS/MMS ACTIVE Web/Online Services
  - Phone Calls
• To know your financial and credit solvency.
• To consult your accident history in common files.
• To carry out statistical and historical studies.

Only in cases where you have given your consent will ACTIVE process your personal data for the following purposes:
• Access to information from external sources (e.g. social networks such as Facebook, collaboration platforms, blogs, forums, location data, cookies) to profile and offer the products that best suit my needs.
• Sending commercial information from third parties belonging to the following sectors of activity: insurance, finance, telecommunications, security, technology, energy, audiovisual, education, leisure, automotive and mass consumption, which have collaboration agreements with ACTIVE.
• Sending promotional and advertising information from the companies of the ACTIVE Group.
• Communication of your personal data to companies of the ACTIVE Group (www.activeseguros.com/avisoLegal.php), in order to maintain a common repository of your contracted products that allows you to achieve a more beneficial customer experience.

To which recipients will your personal data be disclosed?
The personal data processed by ACTIVE to achieve the purposes detailed above may be communicated to the following recipients depending on the legitimate basis of the communication.
By virtue of the above, the following data communications seek to guarantee the correct development of the contractual relationship, as well as to comply with legal obligations that require the aforementioned communications to be made:
To financial institutions, for the management of collections and payments.
To entities and bodies, public or private, involved in the management of the insurance contract (reinsurance or co-insurance entities or parties involved in the management of the policy) provided that communication is strictly necessary.
To common solvency files relating to the fulfilment and non-fulfilment of monetary obligations. In the event that payment is not made under the terms provided for in the contracts you enter into with ACTIVE and the requirements established for this purpose in the data protection regulations are met, the data relating to the nonpayment may be communicated to common solvency files relating to the fulfilment or non-fulfilment of monetary obligations.
To common files to which ACTIVE has adhered for the prevention and detection of fraud. To any other files to which your data must be communicated by law.

How long will we keep your data?
Personal data will be kept, unless otherwise provided by law, for the duration of the policy, including the management of pending claims. After that moment, unless you have given us your consent, the data will be blocked and will be at the exclusive disposal of the judges and courts, the Public Prosecutor's Office or the competent Public Administrations, or the insurance company itself, for the enforcement of possible liabilities arising from the processing and for the limitation period thereof.

What are your rights in relation to our processing of your data?
ACTIVE informs you that you have the right to access your personal data and to obtain confirmation on how such data is being processed. You also have the right to request the rectification of inaccurate data or, where appropriate, request its deletion when, among other reasons, the data are no longer necessary for the purposes for which they have been collected by the COMPANY. In certain circumstances, you may request the restriction of the processing of your data, in which case ACTIVE will only keep them for the exercise or defence of possible claims.

Likewise, also in certain circumstances, you may oppose the processing of your personal data for the purpose informed by the COMPANY.

In this case, ACTIVE will cease the processing of personal data unless there are legitimate reasons, or to ensure the exercise or defence of possible claims.
Finally, you may request the right to portability and obtain for yourself or for another service provider certain information derived from the contractual relationship formalized with ACTIVE.
To exercise any of these rights, you may contact FAMILIAR DE SEGUROS ACTIVE S.A., at Avenida de las Cortes Valencianas, 17-Entlo. 8, CP 46015, in the city of Valencia or through the following email: dpo@activeseguros.com, attaching a copy of your ID card or official document proving your identity. You can also file a complaint with the Spanish Data Protection Agency (www.aepd.es).
By signing this document, you declare that you have received all the information regarding the protection of your personal data and, likewise, you consent to the processing shown below and which you have ticked with the box "I accept": Adjust according to whether or not you intend to process customer data for the purposes indicated below:
I agree that Active may use information from external sources (e.g. social networks such as Facebook, collaboration platforms, blogs, forums, location data, cookies) to profile and offer products that best meet my needs.

☐ I accept ☐ I do not accept

I consent to the sending of promotional and advertising information from third parties belonging to the following sectors of activity: insurance, financial, telecommunications, security, technology, energy, audiovisual, education, leisure, automotive and mass consumption, which have collaboration agreements with Active.

☐ I accept ☐ I do not accept

I consent to the transfer of my personal data to the companies of the Active Group (www.activeseguros.com/avisoLegal.php) for the sending of promotional and advertising information.

☐ I accept ☐ I do not accept

I accept that my data will be communicated to companies of the Active Group (www.activeseguros.com/avisoLegal.php), in order to maintain a common repository of my contracted products, which allows me to achieve a more beneficial customer experience.

☐ I accept ☐ I do not accept

I.1.2. Definitions
In this contract, the following definitions apply:

INSURER: The legal entity that assumes the contractually agreed risks.

POLICYHOLDER: The natural or legal person who, together with the Insurer, signs this contract in representation of the Insured, and who is responsible for the obligations arising therefrom, except those that by their nature must be fulfilled by the Insured.

INSURED: Each of the persons listed in the Particular Conditions of the policy or in its Supplements.

BENEFICIARY: The person or persons who must receive the benefits derived from the guaranteed risks or services offered or, failing that, the legal heirs of the deceased.

POLICY: The contractual document that contains the regulatory conditions of the insurance. The following are an integral part of the policy: the General Conditions, the Special Conditions, the Particular Conditions that individualise the risk, the Supplements or Appendices that are issued to complement or modify it and, in the case of funeral insurance, in addition, the description of the Funeral Service.

LOSS: The fortuitous event beyond the control of the parties whose harmful economic consequences are guaranteed in the policy.

INSURED AMOUNT: The amount fixed in the Particular Conditions and in the successive updates and revaluations and which is the maximum limit to be compensated for the value of the service provided by FAMILIAR DE SEGUROS ACTIVE S.A. in the event of a claim.

PREMIUM: The price of the insurance, according to the rates. The receipt shall also contain the legally applicable surcharges, fees and taxes. It will be monthly, unless otherwise agreed in the Particular Conditions

ADDRESS OF THE POLICYHOLDER AND THE INSURED: The address that appears in the Particular Conditions of the policy, which must coincide with that of their habitual residence.

FUNERAL SERVICE: The set of elements and services necessary to carry out the burial of the deceased Insured, which are indicated in the Particular Conditions of this policy.

I.1.3. Purpose of the Insurance policy
By taking out this insurance, the Insurer guarantees, in accordance with these General Conditions and the Specific Conditions of the policy, the benefits of the death insurance policy.

I.1.4. Death Insurance Guarantees
The Insurer guarantees the provision of Funeral Services in the event of the death of each of the Insured Persons, in accordance with the General and Specific Conditions contained in this policy. In the event that the Insurer has not been able to provide the service due to reasons beyond its control, force majeure, or because the service has been performed through other means than those offered by the Insurer, the Insurer will be obliged to pay the sum insured. In accordance with article 106 bis of the Insurance Contract Law (LCS), the compensation of these costs will be paid by the Insurer to the heirs of the deceased Policy Holder and is not responsible for the quality of the services provided.

The insurance guarantee extends to the Insured, regardless of the cause of death, except for the risks excluded in the policy. Under the Insurance Contract Act for minors under fourteen years of age, cash compensation is not eligible.

The insurance will also include the provision of a special funeral service, in the event of the death of the children of Insured in this policy, if it occurs during the gestation period or before reaching thirty days of age, after which they must be insured in order to be entitled to the corresponding funeral service.

Cremation is also guaranteed, and if this is not possible, the burial of any limb that was amputated from any of the Insured included in the policy. In both cases, transfer to another location is expressly excluded.

The maximum limit of the benefit payable by FAMILIAR DE SEGUROS ACTIVE S.A. will be the value of the funeral service that appears at the time of death in the Particular Conditions with its revaluations.

I.1.5. Automatic revaluation clause
Regardless of the automatic application of the premium rate that corresponds at any time to the age of the Insured, in order to guarantee the necessary revalued service agreed in the policy and, therefore, to cover the increase in the costs of the different elements that make up the funeral service, after the first year, an adjustment of premiums will be applied annually referring to the increase, in the previous period, of the cost of the agreed funeral service, if any, or referring to the increase in the consumer price index of the same previous period. In this case, the insurer, without issuing a supplement, will inform through the receipt of the new insured values and the new premium.

The same criterion will be followed in the event of a proposal for the inclusion of new guarantees. In the event that the proposed revaluation is not accepted by the Policyholder, the maximum limit of the benefit to be paid by the insurer will be the value of the service listed in the current policy.

I.1.6. Age limit on death insurance
The age limit is 75 years. Persons who suffer from a serious illness at the time of taking out the insurance policy are not insurable, unless it is expressly stated in the policy and the corresponding additional premium is paid.

I.1.7. Insurance Policy Basis

I.1.7.1. In the event of an inaccurate indication by the Policyholder of the age, date of birth or health status of any of the Insured covered by the policy, the contract shall not take effect, and FAMILIAR DE SEGUROS ACTIVE S.A. will be obliged to refund the premiums collected after deducting the expenses generated and taxes. The contract will therefore be considered null and void.

I.1.7.2. Before the conclusion of the contract, the Policyholder has the duty to declare to the Insurer, in accordance with the questionnaire submitted by the latter, all the circumstances known to him/her that may influence the assessment of the risk.

I.1.7.3. The Insurer may cancel the contract, by notifying the Policyholder, within one month of becoming aware of any reservation or inaccuracy on the part of the Policyholder. Unless there is fraud or gross negligence on the part of the Insured, the Insured shall be liable for the premiums relating to the period in progress at the time when such a decision to terminate the contract has been made.

I.1.7.4. If the content of the policy differs from the insurance proposal or the agreed clauses, the Policyholder may request that the Insurer correct the existing divergence within the period of one month from the delivery of the policy claim the Insurer. If this period elapses without making a claim, the provisions of the policy will apply.

I.1.8. Excluded Risks
For all the previously described guarantees, all risks of war, revolution, riots, epidemics, and those declared by the government to be catastrophic are excluded.

Likewise, death by suicide or injuries or illnesses resulting from the attempt or intentionally produced by the Insured to himself, and those derived from criminal enterprises of the Insured, are excluded. And the exclusion of suicide only applies if it occurs in the first year of the death policy.

I.1.9. Communications
The communication and payment of premiums made by the Policyholder to an Agent of the Insurer shall have the same effects as if they had been made directly to the latter. Communications made by an Insurance Broker to the Insurer on behalf of the Policyholder shall have the same effect as if they were made by the Policyholder himself, unless otherwise indicated by the Policyholder.

I.1.10. Modifications to the Contract
The new registrations of Insured Persons that occur in this policy will be subject to the stipulations of Articles 5, 6 and 7 of these General Conditions, from the day on which they are recorded in the appropriate supplement, provided that this has been signed by the parties and the Policyholder has paid the corresponding premium increase. unless otherwise agreed. **The Policyholder must notify the Insurer of any change of address within the locality in which he/she resides or to a different town.** In the latter case, he/she will adapt his/her contract to the funeral services existing in that place, within fifteen days of his/her change of residence, at the Insurer's offices in the locality of the new domicile, and the premium will be adjusted.

If the policyholder does not accept the adaptation of the value of the service, FAMILIAR DE SEGUROS ACTIVE S.A. is only obliged to pay the amount that appears in the Particular Conditions of the policy.

I.1.11. Effects of Insurance
The insurance coverage will take effect on the date established in the Particular Conditions of the policy.

I.1.12. Waiting period
The insurance guarantees shall not apply until twenty days have elapsed since the entry into force, except if the death of the Insured is due to an accident, in which case they shall take effect from the entry into force of the insurance.
However, by agreement of the contracting parties, the aforementioned waiting period may be waived and thus included in the Specific Conditions.

I.1.13. Duration of Insurance
This insurance will be taken out for a period of one month. At the expiry of this period, it will be tacitly extended for one more month, and so on, unless the policyholder or Insured wishes to cancel it, in which case he/she must notify this decision to the Insurer in writing at least one month before the expiration date of the monthly insurance period.

The policyholder or the Insured has the sole right to terminate the contract at the regular monthly maturities, and of their own free will. Therefore, the Insurer is obliged to tacitly extend the contract, provided that the policyholder is up to date with the payment of the premium that corresponds to the age of the insured. The Insurer may oppose the extension of the contract by means of written notice to the policyholder made at least two months before the end of the current insurance period.

I.1.14. Tariffs and premium payments

I.1.14.1. Premium Rate
The rate applicable to this insurance is semi-natural.

The premium rate is established on a monthly renewable basis and its calculations do not contemplate any levelling of premiums until the insured persons included in the policy reach the age of 75. Therefore, the initially insured sum and any possible increases in the cost of the service throughout the duration of the contract will have the premium rate corresponding to the age of the Insured at any given time. In other words, each month the Insured will pay the premium rate corresponding to his/her age, and no type of levelling out will be established for this insurance policy. From the age of 75 onwards, the rate becomes levelled, with no further increases in premiums due to the age of the insured person.

The inclusion of new elements or extensions in the coverage of the service, together with those of the value of the service, will be the sum insured at that time. The premium to be paid for the insurance coverage is the result of applying the corresponding rate of the age reached by the Insured to the sum insured at that time.

I.1.14.2. Method of payment of premiums
The Policyholder is obliged to pay are renewable monthly premiums, and payment may be agreed on a quarterly, half-yearly or annual basis, in which case the due date will coincide with the same calendar period.

Payment of the bill for the premium should be paid using accounts open in Banks or Savings Banks. In this case, the following rules will apply:

• The policyholder will provide the Insurer with a duly completed SEPA form, giving a direct debit order to the corresponding bank or credit institution.
• The first premium shall be paid when the policy is taken out. Subsequent premiums must be paid when due.

Cash payment of the premium bills may be agreed in the Specific Conditions.

If, due to the Policyholder's fault, the first premium has not been paid, the insurer has the right to terminate the contract. Unless otherwise

agreed in the Special Conditions, if the premium has not been paid before the loss occurs, the Insurer will be released from its obligation.

In the event of non-payment of one of the following premiums, the Insurer's coverage is suspended one month after the due date.
If the Insurer does not claim payment within six months of the premium due date, the contract shall be deemed to be terminated. In any case, the Insurer, when the contract is suspended, may only demand payment of the premium for the current period.

If the contract has not been terminated or terminated in accordance with the preceding paragraphs, the coverage shall take effect again twenty-four hours after the day on which the Policyholder paid his premium.

In no case shall there be a right of redemption.

I.1.15. Claims covered by the Death Insurance Policy
The sum insured, which in this insurance is the amount of the service contracted, represents the maximum limit to be paid by the Insurer in each claim.

In order to enforce the rights derived from this insurance in the event of the death of an Insured Party, **the completed Official Medical Death Certificate** must be delivered to the Offices of the Delegation, Branch or Agency of the Insurer or the Agent, in the place where the death occurred.

When an Insured dies within Spanish territory, in a location other than the one stated as the Insured's home address in the policy, the funeral service will be carried out in accordance with the existing arrangements in that place and at a cost equivalent to the one contracted in the policy, for the place of residence.

In the event that the death of the Insured occurs in a place where FAMILIAR DE SEGUROS ACTIVE S.A. is not represented, either in Spain or abroad, the beneficiaries must contact the Assistance Service of FAMILIAR DE SEGUROS ACTIVE S.A. by telephone, who will contact the corresponding funeral home in the place, so that the service is carried out at the expense of FAMILIAR DE SEGUROS ACTIVE S.A.

In the event that the family members of the deceased Policy Holder decide to carry out the service on their own, they should contact the office or agency where the policy was taken out. Having accredited their status as the legal heirs, and once the necessary investigations and expert reports have been carried out, the full settlement on the sum insured will be paid out to them.

If the Insurer is in default in the performance of the service, the compensation for damages shall be governed by the provisions of Article 20 of the Insurance Contract Act, notwithstanding the validity of the contractual clauses that are more beneficial to the Insured Party.

If the deceased Insured's successors wish to bury the body in a cemetery other than the one corresponding to their residence, the extraordinary expenses incurred in this regard will be borne by them, unless this service has been expressly contracted with the Insurer and this is stated in the Specific Conditions of the policy.

If, upon the death of the Insured, it turns out that he or she is with the same Insurer in more than one death insurance policy, the Insurer will only recognize the rights corresponding to one of them, which the beneficiaries may choose. The premiums paid by the Insured in the other policies will be reimbursed, with the deduction of taxes and expenses incurred.

In the event of an accident, the company must be notified immediately by calling **963 51 98 85**.

I.1.16. Taxes & Surcharges
All taxes, fees and surcharges, and those that may be established in the future on the policies and premiums are the responsibility of the Policyholder, when they are legally chargeable.

I.1.17. Prescription
The actions arising from this insurance contract shall be subject to a limitation period of five years.

I.1.18. Jurisdiction
The competent court for hearing actions arising from the insurance contract shall be the court of the Insured's place of residence.

I.1.19. Indisputability clause
After one year has passed, the Insurer waives the right to dispute the detrimental effects for the Insured Party due to any inaccuracies that the Policyholder may have incurred when declaring the risk.

NATURAL 3 POLICY
MONTHLY FEES FOR EVERY 1,000€
(taxes NOT included, subject to change in legislation)

Age	Total Premium	Age	Total Premium	Age	Total Premium
0	0,983	13	0,050	26	0,141
1	0,071	14	0,064	27	0,139
2	0,059	15	0,083	28	0,137
3	0,048	16	0,103	29	0,133
4	0,040	17	0,122	30	0,130
5	0,034	18	0,122	31	0,128
6	0,030	19	0,124	32	0,128
7	0,028	20	0,127	33	0,131
8	0,027	21	0,129	34	0,138
9	0,027	22	0,133	35	0,150
10	0,028	23	0,136	36	0,165
11	0,033	24	0,138	37	0,181
12	0,039	25	0,141	38	0,198

Age	Total Premium	Age	Total Premium	Age	Total Premium
39	0,216	52	0,862	65	2,150
40	0,235	53	0,943	66	2,379
41	0,259	54	1,032	67	2,651
42	0,289	55	1,130	68	2,972
43	0,326	56	1,235	69	3,352
44	0,368	57	1,347	70	3,801
45	0,413	58	1,456	71	4,333
46	0,462	59	1,559	72	4,968
47	0,516	60	1,658	73	5,725
48	0,574	61	1,752	74	6,634
49	0,638	62	1,843	LEVELLED FOLLOWING	
50	0,708	63	1,938	18,803	
51	0,784	64	2,039		

I.2. COMPLEMENTARY GUARANTEES FOR ACTIVE ASSISTANCE

The following complementary guarantees cover all persons insured in the Death insurance policy and are effective from the date of issue of this policy.

I.2.1. National transfer in the event of death in Spain
In the event of the death of the Insured within the national territory, the Insurance Company FAMILIAR DE SEGUROS ACTIVE S.A. shall take the necessary steps and shall also pay all expenses necessary for the transfer of the deceased Insured to the town within Spain that constitutes the habitual residence, which must coincide with the one that appears in the policy or, if the relatives of the Insured so wish, to any other point in Spanish territory that they so choose. Alternatively, the Insurer may also take charge of the cremation of the Insured at the place of death, excluding the expenses of the ceremony, and the transport of the ashes. The transfer of the deceased insured person within the national territory is subject to prior authorization by the competent authorities and provided that there are no causes of force majeure.

I.3. OPTIONAL COMPLEMENTARY GUARANTEES

You may also contract the following optional complementary services if you have chosen to do so and it has been stated in the Specific Conditions:

I.3.1. Repatriation of insured persons of foreign nationality

I.3.1.1. Purpose of Coverage
The Insurer hereby assumes the costs of the transfer of the deceased Insured in Spain to his or her country of origin.

I.3.1.2. Insured Individuals
Insured Individuals of foreign nationality legally residing in Spain, whose identities are previously stated in the Death Insurance contracted with FAMILIAR DE SEGUROS ACTIVE S.A.

I.3.1.3. Age limit
Age limit on taking out: 70 years

I.3.1.4. Duration
Its duration is linked to that of the Funeral Insurance to which it is complementary.

I.3.1.5. Scope of Coverage
The guarantees described are valid exclusively **for events that occur in Spain, and in order to be valid it is essential that the insured person be a resident of Spain and habitually residing there.**

However, the transport or repatriation of the Insured will also be covered if the death occurs while the Insured is travelling through a country of the European Union.

I.3.1.6. Guarantees

I.3.1.6.1. Repatriation or transport of the deceased Insured in Spanish territory
In the event of the death of the Insured, **with the exception of children under one month of age**, the Insurer assumes the organization of the transfer of the remains of the Insured to the international airport closest to the domicile of the country of origin and shall assume the costs thereof. Said expenses shall be understood to include those for post-mortem conditioning in accordance with legal requirements.

Alternatively, the body may also be cremated at the place of death (excluding ceremony expenses) and the ashes may be transported to the international airport closest to the place of residence in the country of origin. However, if the place of burial or burial is in a country of the European Union, the Insurer will assume the costs and organization of the transfer of the Insured's remains to the place of burial.

If, on the other hand, the place of burial is located outside a country of the European Union, the Insurer will assume the organisation of the transfer of the remains of the Insured to the international airport closest to the domicile of their country of origin. From that moment onwards, the Insurer will compensate up **to a maximum of 1,000 euros** for the cost of transferring the Insured provided that the corresponding invoices justifying the expense incurred are submitted.

Burial and ceremonial expenses and funeral expenses are not included.
This transfer will be carried out provided that the competent authorities grant the appropriate authorisations and there are no grounds of "force majeure."

I.3.1.6.2. Accompaniment of mortal remains
The Insurer shall provide a family member of the Insured or the person designated by the Policyholder with a return ticket by plane (economy class) or train (1st class), so that he/she may accompany the corpse on its repatriation journey to the place of burial or international airport indicated in the preceding article.

If the companion is in Spain, the costs of a transport ticket to the country of destination and return to Spain will be guaranteed. If, on the other hand, the companion leaves the country of destination, these transport costs to Spain to collect the body and the subsequent return to his/her country are guaranteed.

I.3.1.7. Exclusions
The covered guarantees **do not include:**

- **Events voluntarily caused by the Insured or those in which there is intent or gross negligence on the part of the Insured.**
- **Pre-existing chronic ailments or diseases, as well as their consequences, suffered by the Insured prior to taking out the policy.**
- **Death by suicide during the first year of taking out the policy.**
- **Death as a direct cause of the ingestion of alcohol, psychotropic drugs, hallucinogens or any drug or substance with similar characteristics.**
- **Cases that arise, directly or indirectly, from events caused by nuclear energy, radioactive radiation, natural disasters, war, riots or terrorist acts.**

The repatriation or transport of the corpse to those countries that at the time of the incident are in a state of war or siege, insurrection or military conflict of any kind or nature is excluded, even if they have not been officially declared.

I.3.1.8. Request for Assistance
In the event of a claim that may give rise to the benefits covered, the Insured must notify the Insurer through the emergency telephone service at the following telephone numbers: (+34) 961 59 35 10, indicating the name of the Insured, Policy number, place and telephone number where they are and type of assistance required. This notification may be made collect.

I.3.1.9. Additional Provisions
The Insurer shall not assume any obligation in connection with services that have not been requested or that have not been carried out with its prior agreement, except in duly justified cases of force majeure.

When the Insurer does not have a direct role in the provision of services, the Insurer will be obliged to reimburse the Insured for the duly accredited expenses arising from such services, within a maximum period of 40 days from the date of their presentation.

These complementary guarantees form an integral part of the corresponding policy and **are not valid separately from it.** The General Conditions of this policy are applicable as long as they do not conflict with the provisions hereof.

I.3.1.10. Subrogation
Up to the amount of the sums disbursed in compliance with the obligations arising from this policy, the Insurer will be automatically subrogated to the rights and actions that may correspond to the Insured or their heirs, as well as to other beneficiaries, against third parties, natural or legal, as a result of the loss causing the assistance provided.

In particular, this right may be exercised by the Insurer against land, river, sea or air transport companies, with regard to the total or partial reimbursement of the cost of tickets not used by the Insured.

I.3.2. Repatriation of Latin American insured persons residing in Spain
Repatriation of Latin American insured persons residing in Spain to their country of origin and funeral services for their relatives residing in Latin America specified in the Supplement for the Provision of Funeral Services in Latin America.

I.3.3. Repatriation of deceased insured persons residing abroad

I.3.3.1. Preliminary provisions

I.3.3.1.1. Insured persons
Individuals of Spanish nationality **residing abroad**, beneficiaries of the Death Insurance taken out with **FAMILIAR DE SEGUROS ACTIVE S.A.**

I.3.3.1.2. Duration
Its duration is linked to that of the Death Insurance to which it is complementary.

I.3.3.1.3. Age limit
Age limit on taking out: 70 years

I.3.3.1.4. Temporary validity
In order to benefit from the guarantees covered, **the Insured must have his/her habitual residence in a foreign country, habitually reside there, and his/her time spent away from said habitual residence must not exceed 60 days per travel or displacement.**

I.3.3.1.5. Territorial scope
The guarantees described above are valid for events that occur anywhere in the world **except in Spain**, in accordance with what is specified in the wording of each of the guarantees.

Excluded from the coverage of this policy are those countries that during the trip or displacement of the Insured are in a state of war or siege, insurrection or military conflict of any kind or nature, even if they have not been officially declared and those that specifically appear on the receipt or in the Particular Conditions.

I.3.3.2. Guarantees

I.3.3.2.1. Repatriation or transport of the deceased Insured
In the event of the death of an Insured in any place in the world except Spain, the Insurer will arrange the transfer of the body to the place where the Insured person has been habitually resident and which must coincide with the place listed in the policy, or to any other point in Spanish territory chosen by the relatives of the deceased Insured and will bear the expenses of the same. Said expenses shall be understood to include those for post-mortem conditioning in accordance with legal requirements. **Burial and ceremony expenses shall not be included.**

I.3.3.2.2. Displacement of a family member in the event of death
In the event of the death of the Insured, the Insurer shall provide a family member of the Insured or the person designated by the Policyholder, a return ticket by plane (economy class) or train (1st class) from Spain to the country where the death occurred, so that he or she can accompany the corpse on its repatriation journey to the nearest burial place or international airport in Spain.
If the companion is in the country where the death occurred, a transport ticket (plane or train) to Spain will be guaranteed to accompany the corpse and its subsequent return.

The Insurer shall also pay the expenses of the companion's stay **up to a limit of 42.07 euros/day and up to a maximum of 210.35 euros** upon presentation of the corresponding invoices.

I.3.3.3. Exclusions
The covered guarantees do not include:
Events voluntarily caused by the Insured or those in which there is intent or gross negligence on the part of the Insured, death by suicide during the first year of contracting the policy. Cases that arise, directly or indirectly, from events caused by nuclear energy, radioactive radiation, natural disasters, war, riots or terrorist acts.

I.3.3.4. Request for Assistance
In the event of a claim that may give rise to the benefits covered, the Insured must notify the Insurer by calling the emergency telephone service by dialing: (+34) 961 59 35 10, indicating the Insured's name, Policy number, place and telephone number where they are, and type of assistance required. This notification may be made collect.

I.3.3.5. Additional Provisions
The Insurer shall not assume any obligation in connection with services that have not been requested or that have not been carried out with its prior agreement, except in duly justified cases of force majeure.

When the Insurer does not have a direct role in the provision of services, the Insurer will be obliged to reimburse the Insured for the duly accredited expenses arising from such services, within a maximum period of 40 days from the presentation of the same.

These complementary guarantees are an integral part of the corresponding policy and are not valid separately. The General Conditions of this policy shall apply insofar as they do not conflict with the provisions hereof.

I.3.3.6. Subrogation
Up to the amount of the sums disbursed in compliance with the obligations arising from this policy, the Insurer will be automatically subrogated to the rights and actions that may correspond to the Insured or their heirs, as well as to other beneficiaries, against third parties, whether natural or legal persons, as a result of the loss causing the assistance provided.

In particular, this right may be exercised by the Insurer against land, river, sea or air transport companies, with regard to a total or partial reimbursement of the cost of tickets not used by the Insured parties.

I.4. ACTIVE ANCILLARY SERVICES

In accordance with the provisions of article 184 of RDL 3/2020 of 4 February, **it is hereby stated that the contracting of ACTIVE Death insurance includes, at no additional cost, the services referred to in this Section, which are ancillary and distinct from the death insurance as the main product, but which form part of the same agreement and cannot be purchased separately.** The interaction of these services **does not in any way modify the risk or coverage of the death insurance** and represents an undoubted advantage for the insured or beneficiary insofar as they avoid the burden of carrying out certain procedures, or provide certain services that are very useful in daily life.

I.4.1. ADMINISTRATION AND INHERITANCE PROCEDURES

The insurer, through the company JURISLEG ABOGADOS & ASESORES (JURISLEG), guarantees in the event of the death of the Insured and in favour of the beneficiaries, the claim for widow's, widower's and orphan's benefits against the National Social Security Institute.

Likewise, and in the event of the death of any of the insured parties, the Insurer, through JURISLEG, guarantees that the following documents will be obtained and that the following contingencies will be processed by the corresponding body:

Obtaining the necessary certificates from:
- Death
- Birth
- Marriage or cohabitation
- Registration of domestic partnerships
- Proof of Life Last Testamentary Will and Testament
- Social Security Contributions
- Procedures before the National Institute of Social Security
- Death Assistance
- Registration of the Death in the appropriate government records
- Application and processing of a widow's or widower's pension before the National Social Security Institute
- Application and processing of an orphan's pension before the National Social Security Institute
- Application and processing of disability pension before the National Social Security Institute
- Settlement of inheritance tax and other tax obligations
- Request for Authorized Copy of Will Declaration of heirs
- Deed of Partition and Adjudication of Inheritance
- Registration of immovable property in the land registers
- Filing and processing of capital gains tax

All procedures must be carried out amicably by the heirs, excluding contentious judicial proceedings and contemplating in all cases the work carried out by lawyers and solicitors appointed by Jurisleg Abogados & Asesores.

Under no circumstances are the following expenses included:
- Taxation
- Notary Fees
- Registration Fees
- Court fees

THE CONSULTANCY undertakes to carry out the following functions of advising the beneficiaries of THE COMPANY's insured persons, consisting of the advice, claims and processing included in judicial proceedings, where appropriate, of the following contingencies:

I.4.1.1. Divorces by mutual agreement
It includes the costs of lawyers and solicitors for all judicial and extrajudicial procedures aimed at obtaining a divorce by mutual agreement between the parties or measures relating to children in common, always by mutual agreement.
3 years waiting period.

I.4.1.2. Dismissal and Wage Claims
It includes lawyers' fees arising from the study and initial claim for possible severance pay and outstanding wages by an employee.

I.4.1.3. Claim for Amount
It includes the expenses arising from the claim of any monetary amount through the courts, provided that the amount claimed does not exceed 2,000 euros.

I.4.1.4. Claims for unfair interest contracts
It includes lawyers' fees arising from judicial and out-of-court claims relating to abusive interest rate cards and loans.

I.4.1.5. Dental Clinic Closure Claim
It includes lawyers' expenses arising from the judicial and out-of-court claim as a result of the closure of a dental clinic where the treatment has been financed by a credit institution.

I.4.1.6. Expert valuation report of passenger car
This includes the preparation of a valuation report on the market value price of a passenger car that is no more than 15 years old. The costs of judicial ratification are not included.

I.4.1.7. Right to honour
It includes the costs of lawyers arising from the judicial and out-of-court claims relating to the right to honour on the Internet.

I.4.1.8. Debtors files
It includes the costs of consultation and amicable cancellation of data in debtors' files and the feasibility study on compensation for a possible unlawful interference with the person's right to honour.

LA ASESORIA reserves the right not to go to court when it determines that it may be reckless because there is little chance of success.

Contact
Post-Mortem and Testamentary Management
Telephone: 956 70 07 49
Emergencies: 625 69 38 69
Email: central@jurisleg.com

The provider of this management service is JURISLEG, and will bear all expenses, within the stipulated limits.

I.4.2. COMPUTER AND TECHNOLOGY ASSISTANCE SERVICE

I.4.2.1. Content of the service
This service allows the insured to contact a computer expert in order to solve their computer incidents and queries (both hardware and software) on the spot. In order to provide the services, it is necessary that, in telephone communication with the assistance, the user identifies himself with his name and policy number and/or NIF.

I.4.2.2. Processing of the service
The insurance company has subcontracted the services to **Centribal**, an external specialized company.

The service will be carried out by telephone assistance, by calling (+34) 96 486 87 00, or by entering the website: https://asistenciatecnologica.activeseguros.com/ and if necessary, the technician can request access to the user's computer, to continue the assistance remotely. The user must give their permission to access their computer through a web tool. Once the remote assistance is finished, the technician is disconnected, and reconnection is not possible, with the consequent safety for the user.

Coverage will be provided 24 hours a day, all year round, and assistance will be unlimited.

I.4.2.3. Types of incidents supported by the general service
- Windows operating systems from version 7 and MAC OS from version X.
- Mobile operating systems: iOS from version 5 and Android from version 5.
- Office and MAC office software.
- Standard applications (compressors, antivirus, Internet browsers, etc.).
- E-mail clients (Hotmail, Gmail, Yahoo...).
- PDF viewers.

• Image and video players.
• Instant messaging (WhatsApp, Telegram, Line, Messenger...)
• Incidents related to the malfunction of the hardware of the PC/MAC/TABLET/MOBILE.
• Connection and configuration of peripherals (printers, scanner, modem/fiber/ADSL router).
• Email settings.
• Help for Internet services.
• Digital photography: basic retouching.
• Digital home entertainment (game consoles, smart flat screen TVs, DTT, ADSL, Smartphones (iPhone, Android, BlackBerry), Home cinema and MP3 players).
• Unlimited On-Site Assistance for incidents that could not be previously resolved by the remote service,
• Parental controls, annual license to install on 5 devices (PC/MAC/Smartphone/Tablet).
• Geolocation and Smartphone Erase, up to 5 devices.

I.4.2.4. GENERAL EXCLUSIONS
• LINUX/UNIX operating systems or derivatives.
• Enterprise-grade hardware (hardware) or software (Windows Server, MAC OS Server, Switch, Firewall, Systems) N.A.S., etc.).
• Custom or industry development software.
• Provision of IN SITU services at a different address from that of the policyholder.

I.4.2.5. On-site support
The service includes labour and travel to the insured's home in the event that the technical incident could not be resolved remotely. Replacement materials or other parts are not included. **Assistance per policy will be unlimited.**

I.4.2.6. Geolocation & Smartphone Lock
The service will be provided reactively at the request of the insured person. The insured person will contact the telephone helpline or web form to request a date and time for the configuration of the terminal and explanations of use if necessary. **Service is limited to 5 devices per policy.**

I.4.2.7. Parental controls
The service will be provided reactively at the request of the insured person, who must be the parent or legal guardian of the minor for whom the service will be requested.
The request for the license and support in its configuration/installation will be made by phone or through the form provided on the website. In it, the insured will electronically confirm their paternal relationship with the minor, and will be informed that it is forbidden to monitor devices whose user is of legal age.

The intervention will last a maximum of approximately one hour.
The service is limited to monitoring up to 5 devices (computers, mobiles or tablets).

This service is provided by installing parental control software in its free version, which has the following features:
• "Smart" filters.
• It protects your children from potentially harmful pages, which escape common controls. The software's "smart" technology is capable of filtering uncategorized pages using a sophisticated algorithm that works on all web browsers.
• Access control.
• Use the software's controls to tailor each child's internet usage. You can block pages, limit browsing time and access on certain days or times of the day, and turn on "safe search" to prevent harmful pages from appearing in your results.
• Application Control.
• If your child is using programs like Word, Excel, and StudyMinder to improve their school performance, or is spending more time playing video games and chatting with friends, the software shows them the apps they use and for how long.
• Online Management.
• Wherever you are, whether in the office or on the other side of the world, you can keep track of your children using the software's online dashboard. Simply access the portal via any computer, tablet or mobile device with internet access.
• Activity Reports. You'll be able to see exactly what your children are doing thanks to the software's activity reports. All the information you need is presented in easy-to-understand interactive charts available in selectable time periods.
• Important Notices.
• You can rest easy knowing that the software checks for suspicious online activity and can send you alerts if your child visits a potentially dangerous site. In addition, you will receive a daily email with your activity summary.

I.4.2.8. Digital Security (Antivirus)
Through this service, the Company provides the Insured person who so requests with a security service consisting of the installation of Antivirus Software for their devices. This service will reduce the risk of threats through protection, detection and response mechanisms against viruses and malware.

Scope of Service:
- Real-time protection against malware threats, active virus control for applications, vulnerability analysis and remediation.

- Anti-spam and two-way firewall.
- Performance optimizer and system analysis manager.
- Automatic mode for optimal security decision-making.
- Total Privacy: Personal Data Filter, Anti-Phishing, Chat Encryption, File Encryption, File Shredder.

Service limited to a maximum of 5 devices per policy.

LEGAL NOTICE
Active Seguros and Centribal, the service provider, are not responsible for the loss of information or damage to the Insured's computer systems as a result of actions on equipment that contains or is infected by viruses, malicious code: Trojans, worms, etc. spyware, peer to peer programmes, or any other programme, application, software or hardware that is installed with or without knowledge, on the insured's computer and behaving maliciously.

I.4.3. HOME ASSISTANCE - HANDYMAN

I.4.3.1. Service provider:
EUROP-ASSISTANCE SERVICIOS INTEGRALES DE GESTIÓN (hereinafter EASIG).

I.4.3.2. Preliminary Information:
In compliance with the provisions of article 96.1 of Law 20/2015, of July 14, on the regulation, supervision and solvency of insurance and reinsurance companies and in Royal Decree 1060/2015, of November 20 which approves its implementing regulations, it is expressly stated that the information contained in this clause has been communicated to the policyholder prior to the conclusion of the contract:

• That this insurance contract is concluded under the right of establishment with the Spanish branch of the French insurance company Europ Assistance, a French public limited company regulated by the French Insurance Code, with a share capital of EUR 46,926,941, registered under number 451 366 405 RCS Nanterre, and domiciled at Promenade de la Bonette, 1 - 92633 Gennevilliers Cedex, France.

• That Europ Assistance S.A., Branch in Spain is duly registered in the Administrative Register of Insurance Companies of the Directorate-General of Insurance and Pension Funds under code E-0243 and has its registered office at C/. Orense 4, Planta 14, 28020 Madrid.

• That, without prejudice to the powers of the Directorate-General for Insurance and Pension Funds (DGSFP), the Member State responsible for control of the Insurance Undertaking is France and, within that State, the Authority responsible for control is the Autorité de Contrôle Prudentiel et de Résolution (ACPR), with its registered office at 4, Place de Budapest, CS 92459, 75436 Paris Cedex 09, France.

• That this insurance contract is governed by the provisions of the General, Particular and Special Conditions, if any, in accordance with the provisions of Law 50/80 of 8 October, on Insurance Contracts; the Law on the Regulation, Supervision and Solvency of Insurance and Reinsurance Entities (Law 20/2015, of 14 July) and its implementing regulations.

• That the liquidation of Europ Assistance S.A. is not subject to Spanish law. The report on financial situation and solvency is available on the insurance company's website.

• That, in the event of a complaint or claim, Europ Assistance S.A., Branch in Spain provides the Insured with a Claims Service whose Regulations can be consulted on the website www.europ-assistance.es

Policyholders, beneficiaries, injured third parties or successors of any of the above may file complaints in the "Customer Defence" section of the website, or by writing to the Claims Service:
Claims Service
C/ Orense, 4 - Planta 14. 28020 Madrid.

This Service, which operates autonomously, will attend to and resolve written complaints directly addressed to it within a maximum period of two months, thus complying with Order ECO/734/2004 of 11 March and Law 44/2002 of 22 November.

Once the Complaints Service has been exhausted, the claimant may lodge a complaint with the Complaints Service of the Directorate-General of Insurance and Pension Funds, whose address is: **Paseo de la Castellana, 44. 28046 Madrid.**

• That the contract is subject to Spanish jurisdiction, with the competent judge being the one corresponding to the habitual domicile of the Insured:

I.4.3.3. Insured party:
An **individual with habitual domicile** in Spain who is the beneficiary of a funeral policy from **FAMILIAR DE SEGUROS ACTIVE, S.A. (ACTIVE)** and who is entitled to it.

I.4.3.4. Policyholder
The person who has taken out funeral insurance with **FAMILIAR DE SEGUROS ACTIVE, S.A.** and who, with the Insurer, signs this contract, and

to whom the obligations arising therefrom correspond, except those that by their nature must be fulfilled by the Insured.

I.4.3.5. Purpose of the Insurance
This insurance applies exclusively to the *Legal Aid and Handyman Service* guarantee integrated into the Funeral Policies of **FAMILIAR DE SEGUROS ACTIVE, S.A.**, and will be applicable only in relation to the Insured's private home.

I.4.3.6. International Sanctions
The Insurer will not cover, assume any claims, or provide any benefit or service described in the policy that could expose him/her to any sanction, prohibition or restriction under resolutions issued by the United Nations or trade or economic sanctions, laws or regulations of the of the European Union or the United States of America. For more details, please visit:
• https://www.un.org/securitycouncil/sanctions/information
• https://sanctionsmap.eu/#/main
• https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx

I.4.3.7. Geographical and temporal scope
The guarantees included in this contract shall apply to events occurring within Spanish territory and subject to Spanish Law and Courts. Events that occur during the period of validity of the policy are covered. Actions arising from this insurance contract expire within two years from the time they could be brought.

I.4.3.8. Responsibility
In the event of an accident, **EUROP ASSISTANCE** shall not be held liable for any decisions and actions taken by the Insured contrary to its instructions.

I.4.3.9. Procedures in the event of a claim
Any fact that may motivate the benefits of this contract must be declared by the Policyholder or the Insured, within a maximum period of seven days of becoming aware of it, unless otherwise expressly agreed in the Particular Conditions.

In the case of a speedy trial, or any other immediate judicial or administrative action, the Policyholder, Insured or Beneficiary must notify the Insurer immediately upon receipt of such communication by the Policyholder, Insured or Beneficiary.

In the event of non-compliance with these deadlines, and provided that **EUROP ASSISTANCE** has not been made aware of the loss by any other means, EUROP ASSISTANCE may claim damages caused by the failure to declare the claim.

The provision of the guarantees covered by this contract will be requested by the Insured directly by telephone to the Insurer, who will initiate the management and processing of the appropriate file. **EUROP ASSISTANCE** will make the telephone number **91.514.14.62** available exclusively and at the disposal of the Insured.

The Insured undertakes to deliver by post, fax, e-mail or directly to the offices of **EUROP ASSISTANCE** the notifications received as soon as possible and at the latest at least five working days before the expiry of the legal deadline for submission of the corresponding document, indicating the date and manner of receipt of the notification.

He/she is also obliged to cooperate with **EUROP ASSISTANCE** in any clarifications or steps necessary for the proper functioning of the service, as well as to communicate in writing the update of the data appearing in this contract in the event that they change.

EUROP ASSISTANCE is not responsible for the veracity of the data referred to and, consequently, will not assume any responsibility in the event of inaccuracy and/or lack of updating of the same. In the event that the information is not accurate and that this results in damage to **EUROP ASSISTANCE**, the latter may demand that the Insured Person repair the same.

The reimbursements made by **EUROP ASSISTANCE** are made in compliance with the provisions of Spanish law, specifically with the provisions for cash payments and capital outflows from the national territory. Thus, in order to be able to reimburse an amount equal to or greater than 10,000 euros (or its equivalent in foreign currency) for the costs of covered contingencies that the Insured has paid in cash outside Spain, **EUROP ASSISTANCE** will require that a bank receipt be provided for the withdrawal of cash outside Spain or that it has been declared in accordance with the provisions of article 34 of Law 10/2010 on Prevention of money laundering.

I.4.3.10. Warranties covered

A. Claim for damages
EUROP ASSISTANCE will manage the amicable or legal claim to an identifiable third party for the damages caused to the Insured.
Within this limit, all expert costs and expenses of any kind necessary to assess the damage and/or loss are included.
No results are guaranteed as a result of these efforts. This service will be provided from 9 a.m. to 7 p.m. from Monday to Friday, except holidays.

Guaranteed limits and spending
The maximum sum insured to cover all guaranteed expenses is set at €300 per claim and/or insurance annuity.

The following expenses are included:
• The fees, rights and legal costs arising from the processing of the covered proceedings.
• Attorney's fees and expenses.
• The rights and supplies of the procurator, when intervention is mandatory.
• Notary fees and the granting of powers of attorney for lawsuits, as well as the minutes, requirements and other acts necessary for the defense of the Insured's interests.
• The necessary expert fees and expenses.
• The establishment, in criminal proceedings, of the bonds required to obtain the provisional release of the insured, to guarantee his presence at the trial, as well as to answer for the payment of legal costs, excluding compensation and fines.

Exclusions
• In general, expenses that have not been previously communicated to the Insurer are excluded.
• Events that occurred before the contract came into force.
• Consultations and judicial proceedings whose resolution entails the application of foreign law, and those relating to the claim of rights and benefits that assist the Beneficiary before the corresponding Association.
• When the event has been caused in bad faith or deliberately by the Beneficiary, including claims related to vehicles owned by the Beneficiary.
• Expenses arising from unfounded claims, as well as those that are raised with manifest disproportion in relation to the damages suffered. This exclusion will not apply when, after the exercise of the corresponding legal actions, the Beneficiary obtains a favourable resolution estimating the total amount of the corresponding compensation.
• Compliance with the obligations imposed on the Beneficiary by Judgment or Administrative Resolution. The payment of fines and penalties, as well as their interest or surcharges.

B. Handyman Service

Scope of Warranty

The reinsurer sending a professional to the Insured of the Ceding Policy's Death Policy to carry out the non-urgent work listed below and previously requested by the policyholder or insured.

The service will be provided from 9 a.m. to 7 p.m. from Monday to Friday (except holidays) and includes an annual insurance intervention and this intervention includes travel and two hours of labor. Materials are not included.

The client may request as many services as he/she wishes, in which case preferential rates will be applied.

All the work carried out by the professionals of **EUROP ASSISTANCE**, within the "Handyman Service", has a guarantee of 6 months.

Jobs included:
- Hang curtains, paintings, clotheslines, bathroom accessories, mirrors, coat racks, closet rods.
- Placement of:
  • Shower Holder, Telephone & Connection Shelves, Shelves
  • Thermofluids without the need for electrical modification
  • Termination Plates:
  a. floor trim (joint cover at the junction of 2 different floors)
  b. wall corner protector
- Window insulation:
  • only put weather stripping between sheet and frame
  • fixing glass with silicone
- Repair or installation of roller blinds without mechanism and not hidden in drawer.
- Replacement or installation on wooden interior doors of:
  • Handles
  • Levers
  • Springs
  • Small latches
- Changing hinges on small doors of kitchen, bathroom and auxiliary wooden furniture.
- Assembly of kit-type furniture.
- Gluing of wooden chairs, tables and beds.
- Placement or change of:
  • plug and switch trims;
  • light bulbs, neon tubes, fluorescents, and primers.
- Installation of lamps, wall lights or ceilings as long as there is no need to modify wiring.
- Adjustment of loose taps and change of shoes if equipped.
- Radiator flushing.
- Silicone sealing of:

- bathtub
- shower
- bathroom sink
- kitchen sink.

- Plugging of small holes in the untiled wall, produced by drilling (by hanging pictures, accessories...).

Jobs not included:
- Installation of lamps, wall lights or ceilings requiring a new light point.
- Halogen installation.
- Changing plugs, plugs and switches having to manipulate electrical wiring.
- Installation of glass-ceramic plug.
Recommended professional to carry out these jobs: electrician.
- Repairs of blinds (including change of tape, slats) with rope, crank or electric mechanism, recessed in drawers and metal blinds (commercial closure).
Recommended professional to carry out these jobs: blinds.
- Installation of skirting boards
Recommended professional to carry out these jobs: carpenter or bricklayer.
- Installation or replacement of glass
Recommended professional to carry out these jobs: glass or window technician
- Grouting
- Covering of cracks
Recommended professional to carry out these jobs: bricklayer.
- Interior Door Locks
- Friction on windows or doors
Recommended professional to carry out these jobs: carpenter or aluminum carpenter.
- Door brushing
Recommended professional to carry out these jobs: carpenter.
- Cleaning filters and drains of any type of appliance (including air conditioning)
Recommended professional to carry out these jobs: appliance technician.
- Metal welding: Everything related to access doors to the home (locks, latches, closures, handles...)
Recommended professional to carry out these jobs: locksmith.

C. Telepharmacy service

The service will consist of the presence of a EUROP ASSISTANCE collaborator (duly identified) at the address determined for this purpose by the Insured, in order to collect the Social Security prescription, health card or prescription from a private doctor, if necessary, and purchase the corresponding medicine. Subsequently, it will be delivered by hand to the Insured, who will pay the amount of the invoice for the product purchased on the spot. Checks, promissory notes or cards will not be accepted.

The Insured must provide in all cases the commercial name of the product and the type of presentation (tablets, ampoules, capsules, emulsions, etc.). Cases of abandonment of the manufacture of the medicine or lack of availability of it in the usual distribution channels in Spain are expressly excluded, as well as medicines that require the ID card for their acquisition and those included in the special prescription book for narcotics.

D. Telephone tax advice

EUROP ASSISTANCE will respond to any tax query raised by the Insured regarding their personal scope and circumscribed by Spanish legislation.

Among others, the following queries can be made:
- General Tax Law Tax
- Procedures and Penalties
- General tax information and information on new tax legislation
- Taxpayer calendar in the field of State Taxes
- Information on tax exemptions, deductions and rebates and settlements of Corporate Income Tax, Personal Income Tax, Patrimony and VAT
- Personal Income Tax Return (this point is excluded in contracts for communities and businesses).
- General information on taxes: IAE (Business Taxes), IBI (Real Estate Taxes), INR (Non-Resident Income Tax), IP (Wealth Tax), IRPF (Personal Income Tax), IS (Corporate Income Tax), ISD (Inheritance and Gift Tax), ITP and AJD (Transfer Tax and Stamp Duty), VAT (Value Added Taxes), IVTM (Taxes on Mechanical Traction Vehicles).

These services will be provided orally and by telephone, excluding the drafting of reports or opinions.

This service will be provided at the request of the Beneficiary and from 9:00 a.m. to 6:00 p.m. from Monday to Friday (except national holidays). (Spanish Peninsular Time). There will be a maximum response period of 24 hours (except holidays and weekends) and this will always be by telephone.

I.4.4. LEGAL SERVICES: "ACTIVE EMPLOYMENT"

A. The Lawyer

The beneficiary will be able to consult all legal doubts with registered lawyers, who will provide them with personalised attention, advice and guidance so that they can resolve their problems in the best possible way. In order to help him / her better, the Legal Department of YO TENGO ABOGADO may request that the beneficiary send them the legal documentation.

SERVICES PROVIDED

The advice will deal with the relationship of the employee or self-employed person.
Types of employment contract.
- Pay slips.
- Extension.
- The applicable Collective Bargaining Agreement.
- The senior management contract.
- Holidays, working hours,
- Geographical transfer and functional transfer.
- Termination of the contract.
- Resignation of the employee.
- Dismissal (unfair, fair and null and void).
- Proceedings before the SMAC.
- Legal proceedings.
- Compensation.
- Settlement or termination.
- Judicial claim of amounts.
- Wages for processing.
- Bankruptcy of the company.
- Claims before the FOGASA.
- Early retirement.
- Penalties for the worker and the employer.
- Claims procedure.
- Infringements.
- Suspension of employment and salary.
- Disciplinary dismissal.
- Economic sanctions.
- Employment regulation proceedings.
- Procedure.
- Intervention of trade union representatives (staff delegates or works council).
- Intervention of the Labour Authority.
- Accidents at work and occupational illnesses.
- Accidents occurring at the workplace or when travelling for work purposes.
- Incapacity and occupational disability.
- Judicial procedure for their declaration.
- Social Security benefits.
- Retirement
- Unemployment.
- Maternity.
- Temporary disability, permanent disability.
- Application procedure. Amount. Duration. Termination. Taxation.
- Withholdings.
- Salary in kind (vehicle, stock options).
- Irregular income from work.
- Travel, allowances
- Contributions to pension plans and social welfare systems.
- Unemployment benefits.
- Compensation.

I. Immediate Legal Advice

The Beneficiary will be able to count on the advice of YTA's lawyers by telephone, WhatsApp or email to consult on legal issues that arise in their personal and family sphere and on the matters listed below. YTA reserves the right to reply only verbally, and even if the resolution of the query is made in writing, the drafting of reports or opinions are expressly excluded from the service.

II. Personal Assistance at a Law Firm

When YTA observes that due to the nature and viability of the matter, as set out in these terms and conditions, the matter must be dealt with in person at a Law Firm, it will provide the USER with the NATIONAL NETWORK OF LAW FIRMS, referring the USER to the Law Firm

that corresponds to the speciality according to the procedure in question. The service provided by the referred Law Firm will be provided according to the budget and the order form formalised with the BENEFICIARY of the Service.

The professional assignment by the Beneficiary of the Service to one of the collaborating Law Firms of the National Network entails the establishment of a legal relationship different and independent from that described in these general conditions, which the USER will maintain directly with the professional firm to which the assignment is made under a system of leasing of services typical of the lawyer-client relationship, with YTA remaining outside this relationship and the BENEFICIARY being held harmless from any damage that may be caused to YTA.
These services will have a special discount of 25% on the rates of the corresponding Bar Association.

Provision of the service:
The beneficiary will be able to choose the channel of his/her preference:
- By phone: **856 396 118**
- By WhatsApp: **686 864 978**
- By email: clientes@yotengoabogado.es

The Legal Department is open from Monday to Friday (except for national, Madrid and local holidays) from 09:00 to 19:00

I.4.5. ACTIVE DENTAL SERVICE

ACTIVE SEGUROS provides its policyholders with access to a wide range of dental services that can be accessed through the web: www.activeseguros.com.

The guarantee 'Specific Dental Service' provided by the dental service provider **GIRA DENTAL**, for the insured persons of ACTIVE SEGUROS allows them access to dental services, always in preferential conditions, both economically and in time saving.

This guarantee can be used by any insured, regardless of age or pre-existing medical conditions; there are no waiting lists or waiting periods. We have thought about dental health for the whole family, from the youngest to the oldest.

I.4.5.1. Service features

Easy and convenient access: By calling **915 589 973**, or by accessing the website https://activeseguros.giradental.com/, from your computer, tablet or mobile phone by simply entering your ID number in 'Insured Access', more than 1,900 dental clinics at your service throughout Spain. Guaranteed maximum prices in all the clinics in the network, significantly lower than those on the market. Free services at your disposal in the entire network of clinics:
• An annual dental cleaning on healthy periodontium (detartration).
• First consultation, examination, diagnosis and estimate.
• Emergency visit. Check-up visit.
• Removal of stitches.
• Amalgam polishing.
• Extractions (excluding wisdom teeth or included teeth).
• Oral hygiene education and brushing technique.

Up to 23 additional free services depending on the clinic you have selected. Promotions and advanced dentistry treatments.
Specially designed content and support for improved policyholder support and guidance, printable, downloadable and certifiable by the clinics:

• Patients' rights.
• Code of Good Practice.
• Glossary of dental terms.
• Quality questionnaires.
• Definition and content of each gratuity.
• Details of the maximum applicable prices for dental specialities, procedures and treatments.
• Definition and content of offers and promotions.
• Definition and content of advanced dentistry treatments and guarantee commitments.

Extensive and detailed information content so that insured persons can select the dental clinics they wish to visit: location, opening hours, specialties, description of the clinics, opening on Saturdays, holiday periods.

With the exception of the gratuities accepted by each clinic, the insured person will be responsible for the payment of the professional fees corresponding to the dental clinic for the dental services and treatments that it has carried out.
ACTIVE SEGUROS does not assume any responsibility derived from the provision of dental services by the clinics that have treated the insured person, such responsibility corresponding in all cases to the clinic providing the service.

I.4.6 MEDICAL SERVICES: "TU SALUD" MEDICAL GUIDANCE

The insured will be able to consult all their health doubts with registered doctors, who will provide them with personalized attention, advice and guidance so that they can resolve their health problems in the best possible way. To help you better, HealthMotiv's Medical Department can ask you to send your medical documentation.

In addition, if the insured person needs it, the doctors will closely monitor his/her case to explain things that he/she does not understand (interpretation of medical reports, analyses, explanations of medical tests...), help him/her to prepare for new consultations, or resolve any other doubts that may arise.

I.4.6.1. Service request:
• Through your Personal Space on www.healthmotiv.com/activeseguros/
• By e-mail by filling in the form www.healthmotiv.com/form/activeservicios
• By telephone on 962 645 711

Beneficiaries can make use of the telephone medical advice service 24 hours a day, every day of the year.
Service requests made through the form or the platform will be attended to as soon as possible during working hours, from Monday to Friday, except for public holidays, from 09:00 to 18:00.

I.4.6.2. Provision of the service:
The insured person may choose the channel of his preference:
• By telephone,
• Via their Personal Area at www.healthmotiv.com/activeseguros/
• By e-mail,
• By video call

I.4.6.3. Coronavirus special care and guidance service
With the **specific service on Coronavirus**, the insured will be able to resolve any doubts about COVID-19 (symptoms, available tests, protocols for confinement and return to school, after-effects...). Furthermore, for peace of mind, if the insured has been infected with Coronavirus, HealthMotiv's Medical Department will closely monitor his/her evolution until complete recovery.

I.4.6.4. Dispensing electronic prescriptions
With this service, the doctor attending the insured person will be able to renew his/her chronic medication prescriptions or prescribe some treatments that he/she may need, always at the discretion of the doctor who has treated the insured person.

The REMPe system will be used, approved by the Organización Médica Colegial. The insured person will receive the prescription by e-mail and will be able to pick up the medication at any pharmacy on presentation of his/her ID card.

I.4.6.5. Digital Medical Folder Lite/Premium
The insured can store their medical reports and tests in a Personal Area by accessing a secure intranet located on the HEALTHMOTIV web portal at www.healthmotiv.com/activeseguros/

In the event that the insured suffers from a complex, serious, degenerative health problem or one that substantially affects their quality of life, a doctor will manage their documentation and prepare a summary of their medical history. If necessary, the insured person can request the translation of his or her medical summary into English.

From the Premium Digital Medical Folder, the insured person's Personal Physician will carry out a personalized follow up over time if their situation requires it, in order to help them with anything they need.

The insured must provide all their medical information to HealthMotiv and update it with the results of new consultations and tests.

I.4.6.6. Health Services

I.4.6.6.1.Psychological counselling (Unlimited free consultations):
This is a psychological consultation service that allows the insured person to access advice and guidelines with which they can overcome or face, in the best possible way, specific situations in their daily life, or answer any doubts about their mental or emotional health.

The objective is to provide a specific, quick and precise orientation in the event of a problem that affects their psychological and/or emotional wellbeing.

In order to better understand the particular circumstances of the insured person and to offer a more personalised response, you may need to fill in a brief initial questionnaire.

I.4.6.6.2. Service request:
• Through your Personal Space on www.healthmotiv.com/activeseguros/
• By e-mail by filling in the form www.healthmotiv.com/form/activeservicios
• By telephone on 962 645 711
The opening hours are from Monday to Friday (except public holidays), from 09:00 to 18:00 h.

I.4.6.6.3. Provision of the service:
Once the necessary information has been received, queries will be answered via the technological platform or by email, within 4 hours during working hours.

I.4.6.6.4. Optional contracting: Personalised Psychological Assistance:
If the insured person's problem is too complex to be solved with simple counselling, the insured person can contract personal, non-face-to-face sessions, at a discounted price.
It is a personalised service of psychological help, through which, after an initial assessment with one of our psychologists, a therapeutic process for change and personal growth is initiated.

It is designed for people with psychological, behavioural or emotional problems that cannot be solved autonomously and that are an obstacle to achieving their life goals:
• Depression
• Anxiety
• Sleep problems
• Apathy
• Behavioural disorders
• Addictions
• Eating disorders
• Family or relationship problems

In order to provide more personalised assistance, the insured person must fill in a questionnaire that will collect information on various aspects that may influence the psychological problems (level of studies, work and professional situation, family situation, relevant medical history...).

The sessions may take place by telephone or video-call, depending on the preferences of the insured person, at a time agreed between the professional and the insured person.
At the request of the insured person, a personalised estimate for the treatment will be prepared.

The sessions must be paid for in advance. If, once the personalised session has been scheduled, the insured person needs to change the date or time of the session, he/she must give at least one day's notice, during working hours. Otherwise, the consultation will be considered to have been carried out.
No refunds are made.

I.4.6.6.5. Nutritional counselling. Nutritional guidance (Unlimited free consultations):
This is a service whose objective is to help the insured person to achieve healthy eating habits or to improve them. The insured person will be able to make specific consultations about their diet or food. In order for the recommendations of our nutrition professionals to be more personalised, the insured person may be asked to fill in a brief initial questionnaire about their dietary and lifestyle habits at the beginning of the service.

I.4.6.6.6. Service request:
• Through your Personal Space on www.healthmotiv.com/activeseguros/
• By e-mail by filling in the form www.healthmotiv.com/form/activeservicios
• By telephone on 962 645 711
The opening hours are from Monday to Friday (except public holidays), from 09:00 to 18:00 h.

I.4.6.6.7. Provision of the Service
Once the necessary information has been received, queries will be answered via the technological platform or by email, within 4 hours during working hours.

I.4.6.6.8. Optional contract: Personalised Nutritional Counselling
This is a highly personalised service in which, after an initial assessment in a personal session, a professional nutritionist will design a nutritional plan according to the insured person's lifestyle and eating habits, individual needs, objectives and culinary preferences. Guidelines will also be provided so that your diet is complete, varied, balanced and covers your energy needs, examples of menus and recipes will be proposed and your progress will be closely monitored, periodically reviewing your achievements and recommendations.

The individual sessions can be carried out by telephone or video consultation. At the request of the insured person, a personalised budget will be prepared. The contracted sessions or plan must be paid for in advance.

If, once the personalised session has been scheduled, the insured person needs to change the date or time of the session, he/she must give at least one working day's notice. Otherwise, the consultation will be considered to have been carried out.
No refunds are made.

I.4.6.6.9. Fitness. Sports orientation (Unlimited free consultations):
The insured person may seek advice from our team of physical trainers if he/she has specific doubts about a physical activity, a training session or the execution of an exercise. They may be asked to complete a short initial questionnaire in order to better understand their particular circumstances and to provide a more personalised response.

I.4.6.6.10. Service request:
• Via your Personal Space on www.healthmotiv.com/activeseguros/
• By e-mail by filling in the form www.healthmotiv.com/form/activeservicios
• By calling 962 645 711
The opening hours are from Monday to Friday (except public holidays), from 09:00 to 18:00 h.

I.4.6.6.11. Provision of the service:
Once the necessary information has been received, queries will be answered via the technological platform or by e-mail, within 4 hours during working hours.

I.4.6.6.12. Optional contracting: Personalised fitness training
Whether the insured person wants to take up a sport, is a confirmed sportsperson or is in a process of recovery, a personal trainer will design a training programme adapted to his physical condition and his objectives. They will also provide you with clear guidelines to help you improve and avoid injury, monitor your progress and motivate you to achieve your goal.

Individual sessions can be conducted by telephone or video consultation.

At the request of the insured, a personalised quote will be prepared. The contracted sessions or plan must be paid for in advance.

If, once the personalised session has been scheduled, the insured person needs to change the date or time of the session, they must give at least one working day's notice. Otherwise, the consultation will be considered to have been carried out.
No refunds are made.

I.4.6.7. Tools

I.4.6.7.1. Health Diary
This is a tool that allows the insured person to conveniently register their health data in the same secure environment and share them by sending a link to their records by e-mail. The insured person will be able to use his/her Health Diary after registering at www.healthmotiv.com/activeseguros/ and schedule reminders, which will be sent to him by e-mail, with a link that will allow him to add new records, without having to enter his Personal Area.

At present, records can be made of:
• Blood glucose levels: If the insured person enters a blood glucose value that is above or below the values considered 'normal', an alert will be triggered.
• Blood pressure: The insured person can enter his heart rate, systolic and diastolic values. An alert will be triggered if this value is above or below the values considered 'normal'.
• Weight: The insured person can enter their weight and height (only the first time unless it is a child). Their Body Mass Index will be calculated and they will see what their ideal weight is according to their age, height and sex (not reliable data for certain groups such as pregnant women, high performance athletes...).
• Physical activity: The insured can enter data (time and intensity) of the physical activity they have done: walking, running, cycling, swimming. An approximate calculation is also made of the calories consumed depending on the physical activity, intensity and weight of the user.

No particular device is required.
At no time can these tools replace the personal assessment of the insured person's treating physician. The alerts are only informative for the user of the services.

I.4.6.7.2. Pain diary
If the insured person suffers from chronic pain (lasting more than six months), this tool will allow him/her to conveniently record, at the frequency of his/her choice, all the data related to his/her pain and to indicate how it affects his/her quality of life. This data can be shared with the treating physicians.
The Chronic Pain Diary takes into account the gender and age of the patient.

I.4.6.8. How to contact us. How to apply for services
Services can be requested:
• From Your Personal Space at www.healthmotiv.com/activeseguros/

• By e-mail by filling in the form www.healthmotiv.com/form/activeservicios
• By calling 962 645 711
The opening hours are Monday to Friday, from 09:00 to 18:00, except national and Madrid public holidays.

I.4.7. CLUB ACTIVE MAS!

Active Seguros, through the company Inspiring Benefits S.L., offers all policyholders access to offers and promotions in associated shops. The insured, after registering in the platform: https://activemas.contigomas.com/, will be able to make use of all of them, being able to choose between three types of discount:

I. Direct discounts: through the supplier's online shop or by means of a digital coupon.
II. Indirect discount or cashback in piggy bank: The discount is accumulated in the user's personal piggy bank, with various methods of reimbursement: bank account, donation or redemption by Amazon cheque.

Detailed information on the Terms and Conditions of use of the platform can be found at: https://activemas.contigomas.com/terms

In case of doubt or query, Inspiring Benefits offers policyholders the following email address: atencion.cliente@inspiringbenefits.com, telephone: 910 085 904 (opening hours, from 9:00 to 14:00 h) and online chat.

SECTION II. TRAVEL ASSISTANCE COVER PROVIDED BY ARAG

II.1. Preliminary information provided to the policy holder before taking out the insurance
The policy holder, before entering into this contract, acknowledges that they have received the following information from the insurance company, in compliance with what is established in article 96 of Law 20/2015, of 14 July, on the planning, oversight and solvency of insurance and reinsurance companies and in articles 122-126 of its regulations.

- The insurer of the policy is ARAG S.E., a German company whose business address is in Düsseldorf, ARAG Platz no.1, the Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin) is responsible for the control and oversight of its activity. It is authorised to operate in Spain under the right of establishment through its branch ARAG S.E., a branch in Spain, holder of Tax ID Number W0049001A, based in Madrid, Calle Núñez de Balboa, 120, registered in the Administrative Registry of the General Directorate of Insurance and Pension Funds under code E-210.

It is stated that in the event of the liquidation of the insurance company, Spanish legislation on liquidation will not be applied.

- The legislation that applies to the insurance contract is Spanish legislation, in particular Law 50/1980 of 8 October, on insurance contracts.
- The policy holder or insured person can, in the event of a dispute with the insurer, go to arbitration and to the ordinary Spanish courts of justice.
It is stated that ARAG SE, the Spanish branch provides its policy holders with the following Customer Service contact telephone numbers according to the procedures they wish to carry out:
- For modifications and/or enquiries about the policy taken out, you can call the telephone number 93 485 89 07 - 91 566 16 01 or send an email to atencioncliente@arag.es
- ARAG S.E., the Spanish branch has a Customer Service Department (Calle Roger de Flor, 16, 08018 - Barcelona, email: dac@arag.es, web: www.arag.es) in order to handle and resolve complaints and claims that policy holders present, relating to their interests and legally recognised rights, which will be handled and resolved within a maximum period of one month from when they are presented.
- If there is disagreement with the resolution adopted by the Customer Service Department, or if a period of one month has elapsed and no response has been obtained, the claimant can contact the Claims Service of the General Directorate of Insurance and Pension Funds (Paseo de la Castellana, 44, 28046 - Madrid, or the website: www.dgsfp.mineco.es)
- You can access the report on the financial situation and solvency of the insurer at: https://www.arag.com/company/financial-figures.
- By providing bank details for payment of the insurance premium, the Policy Holder/Insured person agrees and authorises that their amount will be charged to the account that is provided and included in this document or that which, during the life of the contract, is outlined to the Insurer for that purpose."

INFORMATION ABOUT DATA PROTECTION

Controller	ARAG SE, Spanish Branch Calle Núñez de Balboa 120 28006.- MADRID Tax ID Number W00490001A atencioncliente@arag.es www.arag.es
Contact details of the Data Protection Officer	dpo@arag.es Calle Roger de Flor 16 08018 Barcelona

Purpose of the processing	Signing and performance of the insurance contract
Legitimisation	Performance of the insurance contract
Recipients	Data will not be disclosed to third parties, unless there is prior consent, a regulatory obligation, or legitimate interest.
International transfers	They may be required, in specific assistance services, for the performance of the contract.
Rights of people	People can access their data, rectify it or delete it, oppose its processing and request its limitation or portability, by sending their request to the email address: lopd@arag.es
Additional information	You can consult additional and detailed information about data protection on our website: http://www.arag.es

We will also process your personal data to inform you about our products and control the levels of quality in the provision of the guarantees of your insurance contract.

We will not disclose your personal data to third parties except in the following cases: a regulatory obligation that applies to us, legitimate interest or prior consent from the data subject.

Your data will be accessible to third party collaborators of ARAG SE, Spanish Branch, who are involved in procedures deriving from both taking out the insurance and the effective provision of its guarantees.

If you require assistance and are outside the European Union, it may be necessary to transfer your personal data to third countries in order to effectively fulfil the guarantees of your insurance contract.

Your data will be stored during the term of the insurance contract. After it ends, the data will be stored blocked for the periods legally required to handle potential liabilities resulting from its processing. Following the statutory period of limitation, the data will be deleted.

Legitimisation
The legal grounds for processing your personal data is the performance of the insurance contract that you have concluded with this insurance company. It is essential to provide your data to execute this insurance contract, it is not possible without it.

The legal grounds for processing for the purposes of direct marketing and satisfaction surveys is the legitimate interest in being able to better serve your expectations as a client and boost the quality of the service received. You can, at any time, oppose this type of processing in the form described in the Rights section.

The legal grounds for the transfer of data to third parties is established by the provisions of insurance legislation which, either protects the legitimate interest of the company or imposes specific obligations on it for the implementation of its activity, both in relation to the insurance contract (Law 50/1980 on Insurance Contracts), and in legislation on planning, oversight and solvency (Law 20/2015 on the planning, oversight and solvency of insurance and reinsurance companies) and other regulatory legislation for the activity.

The legal grounds for transferring your data to a country outside of the EU is the need to enforce the guarantees outlined in your policy.

Rights of people
You have the right to access your personal data that is subject to processing, and to request the rectification of inaccurate data or, where applicable, request its deletion when the data is no longer necessary for the purposes for which it was collected. You can also exercise the rights of opposition, restrictions on processing and the portability of data.

You can exercise your rights by writing to the controller, ARAG SE, Spanish Branch, via the email address lopd@arag.es or if you prefer, via mail sent to Calle Roger de Flor, 16, 08018, Barcelona (it is advisable to state the reference “Data protection” on the envelope). In all cases it will be essential to attach a copy of your national ID document or passport. In the event that you are not satisfied with the exercise of your rights, you can submit a complaint to the Spanish Data Protection Agency (www.agpd.es).

Personal data of third parties
With regard to the personal data relating to individuals that, as a result of this policy it is necessary to provide to ARAG SE, Spanish Branch, before disclosing this data it is necessary to inform them of the points in the paragraphs above.

II.1.1. Applicable Legislation Member State, Supervisory Authority (Art. 96 LOSSEAR)
The General and Particular Conditions of this insurance contract are governed by the provisions of Law 50/1980 of 8 October on Insurance Contracts, by Law 20/2015 of 14 July on the regulation, supervision and solvency of insurance and reinsurance companies and by Royal Decree 1060/2015 of 20 November, which develops it with regard to death insurance as a branch of service provision. **Clauses limiting the rights of the Insured that have not been expressly accepted in writing by the Policyholder and which are specially highlighted in bold type shall not be valid.**

The Member State where the risk is located is Spain and the authority responsible for the control of the insurance company is the DIRECTORATE GENERAL OF INSURANCE AND PENSION FUNDS (DGSFP).

II.1.2. Internal and external instances for claims and dispute resolution
In compliance with the provisions of articles 96 of Law 20/2015, of 14 July, on the Regulation, Supervision and Solvency of Insurance and Reinsurance Entities and 123 of its implementing regulations (Royal Decree 1060/2015, of 20 November, on the Regulation, Supervision and Solvency of Insurance and Reinsurance Entities), the Insurer reports on the following issues:

Internal claim instances:
Should you wish to submit a complaint or claim related to your legally recognised interests and rights, you may address it, in writing, to:

CUSTOMER SERVICE
Head of Service: Iván Algas Martin
Calle Roger de Flor 16
08018 Barcelona
Telephone: 934857419
Email: dac@arag.es

In all cases, please quote your policy number and/or claim number.
Once we receive your complaint, we will send you a written acknowledgement of receipt, which will establish the regulatory deadlines for the resolution of your complaint.
The regulations applicable to this procedure are Order ECO/734/2004, of 11 March, on customer service departments and services and the customer ombudsman of financial institutions. The Operating Regulations of the Customer Care Service are available to customers at ACTIVE's registered office.

External claim instances:
In the event of a dispute, the Insured may file a claim before the Court of First Instance corresponding to their domicile in accordance with Article 24 of the Insurance Contract Act.

Likewise, the parties may voluntarily submit their differences to arbitration under the terms of articles 57 and 58 of the revised text of the General Law for the Defence of Consumers and Users and other complementary laws, approved by Royal Legislative Decree 1/2007, of 16 November. In any case, and except in those cases in which consumer and user protection legislation prevents it, they may also submit disputes to arbitration, in accordance with the terms of Law 60/2003, of 23 December, on Arbitration.
Likewise, they may submit their disputes to a mediator under the terms set out in Law 5/2012, of 6 July, on mediation in civil and commercial matters.

Furthermore, and notwithstanding the actions to be brought before the Courts, Policyholders, Insured Parties and Beneficiaries, in the event of not obtaining a response from the Insurer's Customer Care Service within two months of filing the complaint or claim, or in the event of disagreement with the decision handed down, or if they consider that the Insurer has violated their rights under the insurance contract, they may file a claim under Article 119 of Law 20/2015, 14 July, on the regulation, supervision and solvency of the insurance policy, or if they consider that the insurer has violated their rights under the insurance contract, they may claim, by virtue of Article 119 of Law 20/2015, of 14 July, on the regulation, supervision and solvency of insurance and reinsurance companies, and in accordance with Order ECC/2502/2012, of 16 November and other applicable regulations, before the Directorate General of Insurance and Pension Funds. The contact details are as follows:

Dirección General de Seguros y Fondos de Pensiones (Servicio de Reclamaciones)
Paseo de la Castellana 44, 28046 Madrid - Spain
Tel: 952 24 99 82
https://www.sededgsfp.gob.es/SedeElectronica/Reclamaciones/Reclamacion.asp
https://www.sededgsfp.gob.es/es/Paginas/Procedimiento.aspx?p=18

To file such a complaint, you must have previously filed a complaint with the insurer's customer service and not received a response within two months of filing the complaint, or you can file such a complaint if the decision was contrary to your requests and you are still dissatisfied.

If you have purchased your insurance online, you can also file a complaint through the EU's Online Dispute Resolution (ODR) platform. The website of the ODR platform is www.ec.europa.eu/odr.
By taking out this Active Death insurance, you immediately benefit from the Travel Assistance coverages of this Section, provided by **ARAG**:

II.2. Temporary validity:
In order to benefit from the guarantees covered, the time spent by the Insured away from their habitual residence must not exceed 90 consecutive days, due to travel or trip.

II.3. Territorial Scope:
The guarantees described are valid for events occurring in Spain and Abroad in accordance with what is specified in the statement of each of

the guarantees.
The rest of the benefits covered by this Policy shall take place when the Insured is more than 30 km away from their habitual residence.

Excluded from the coverage provided by this policy are those countries which during the trip or journey of the Insured are in a state of war or siege, insurrection or warlike conflict of any kind or nature, even when they have not been officially declared.

It is expressly agreed that the Insurer's obligations deriving from the coverage of this policy shall end when the Insured has returned to his/her habitual home or has been admitted to a health center located at a maximum distance of 25 km from said home (10 km in the Balearic and Canary Islands).

II.4. Guarantees

II.4.1. Repatriation and transport of the deceased insured person
In the event of death in Spain at a distance of more than 30 km from the habitual residence or abroad, the Insurer shall organize and take care of the transport of the body to the place of burial in Spain.
Post-mortem conditioning shall be carried out in accordance with the legal requirements.
Burial and ceremony expenses shall not be included.

II.4.2. Travel of an accompanying person
When the previous guarantee is being applied and the body of the deceased insured has to be transferred or repatriated, the Insurer shall provide a relative of the deceased with a plane ticket from the place of residence in Spain to the place where the body is located and return to the place of burial of the same.

The guarantee of this article will be applicable exclusively when the death of the insured person takes place outside the Spanish peninsular territory or abroad.

II.4.3. International transfer in the event of the death of the Insured abroad
In the event of the death of the Insured outside Spain, the Insurer shall be responsible for carrying out, under the same conditions as in the previous guarantee, the procedures and expenses necessary for the transfer of the deceased Insured to the place within Spain which is their habitual residence, which must coincide with that stated in the policy or, if applicable, if the relatives so wish, to any other place in Spain.

The transfer to Spain of the Insured deceased abroad is subject to prior authorization by the competent authorities and provided that there are no force majeure causes.

II.4.4. Right to accompany the deceased Insured during the transfer
The relatives of the Insured who has died abroad and whose transfer is to be made to any point in Spain may voluntarily designate a person who shall be entitled to a return flight ticket or the most suitable means of transport in order to travel to the place of the Insured's death and return to Spain accompanying the deceased.

In the event that the companion should have to remain at the place of death of the Insured as a result of the processing of the transfer of the Insured to Spain, the Insurer shall cover the costs of the companion's stay and subsistence, against appropriate supporting documents, **for an amount of up to €90 per day, with a maximum of 10 days and with a total limit of €900.**

II.4.5. Repatriation or medical transport of the injured or sick abroad
In the event of accident or unexpected illness of the Insured, the Insurer shall pay for:
a) The cost of transfer by ambulance to the nearest clinic or hospital.
b) The control by its Medical Team, in contact with the doctor attending the injured or ill Insured, to determine the measures appropriate for the best treatment to be followed and the most suitable means of transfer to another more suitable hospital or to the Insured's home.
c) the cost of transporting the injured or sick person, by the most appropriate means of transport, to the prescribed hospital or to his usual place of residence.

The means of transport used in each case will be decided by the ARAG Medical Team according to the urgency and severity of the case. Exclusively in Europe, and always at the discretion of the Insurer's Medical Team, a specially equipped medical aircraft may be used.

If the Insured should be admitted to a hospital not close to their home, the Insurer shall pay for the subsequent transfer to the hospital.

II.4.6. Repatriation or medical transport of the injured or sick in Spain
In the event of accident or unexpected illness of the Insured more than 30 km from their habitual residence, the Insurer shall pay for the expenses arising from the transport by ambulance of the Insured from the place where they are to the nearest medical center where the necessary assistance can be provided.

II.4.7. Medical expenses abroad
Up to the limit indicated in the Particular Conditions of the policy, the Insurer shall pay the expenses corresponding to the intervention of the medical professionals and establishments required for the care of the Insured, ill or injured.

The following services are expressly included, without this list being restrictive in nature and provided that the severity of the case so requires:
a) Care by emergency medical teams.
b) Complementary medical examinations.
c) Hospitalisations, medical treatment and surgical interventions.
d) Provision of medicines in hospitalisation, or reimbursement of their cost in the case of injuries or illnesses that do not require hospitalisation.
e) Care for acute dental problems, understood as those which, due to infection or trauma, require emergency treatment.

The Insurer shall pay the expenses corresponding to these benefits up to a limit of 15,000 euros per Insured.

II.4.8. Repatriation or transport of the other Insured parties
When under the coverage for 'Repatriation or medical transport of the injured or sick' one of the Insured has been repatriated or transferred due to illness or accident and this prevents their spouse, ascendants or descendants in the first degree or siblings from continuing the journey by the means initially planned, the Insurer shall pay for the transport of the latter to their home or place of hospitalisation.

II.4.9. Repatriation or transport of minors or handicapped persons
If the Insured repatriated or transferred under the coverage for 'Repatriation or medical transport of the injured or sick' travels in the sole company of disabled children or children under the age of fifteen, the Insurer shall organise and pay for the return trip of a flight attendant or a person designated by the Insured in order to accompany the children on their return to their home.

I.4.10. Travel of a family member in the event of hospitalisation abroad
If the condition of the Insured who is ill or injured requires hospitalisation for a period of more than five days, the Insurer shall provide a family member of the Insured or the person designated by the Insured with a return ticket by plane (economy class) or train (1st class) so that he/she may accompany him/her.

If the hospitalisation takes place abroad, the Insurer shall also pay up to 100 euros per day and for a maximum period of 10 days for the expenses of the companion's stay on presentation of the corresponding invoices.

II.4.11. Convalescence in a hotel abroad
If the sick or injured Insured is unable to return home due to medical prescription, the Insurer shall pay for the hotel expenses arising from the extension of the stay, up to 100 euros per day and for a maximum period of 10 days.

II.4.12. Early return due to the death of a family member
If any of the Insured should have to interrupt their trip due to the death of their spouse, first-degree ascendant or descendant, or sibling, the Insurer shall pay for their return transport by plane (economy class) or train (1st class) from the place where they are staying to the place of burial in Spain.

Alternatively, at their choice, the Insured may opt for two airline tickets (economy class) or train tickets (1st class) to their habitual residence.

II.4.13. Early return from abroad due to hospitalisation of a family member
In the event that one of the Insured should have to interrupt their trip due to the hospitalisation of their spouse, ascendant or descendant in the first degree, or sibling, as a result of an accident or serious illness requiring hospitalisation for a minimum period of 5 days, and this has occurred after the start date of the trip, the Insurer shall pay for the transport to the place where the Insured has their habitual residence in Spain.

Furthermore, the Insurer shall pay for a second ticket for the transport of the person who accompanied the Insured who anticipated his/her return on the same trip, provided that this second person is insured by this policy.

II.4.14. Searching for, locating and sending lost luggage
In the event of the loss of luggage on a scheduled flight, the Insurer shall use all the means at its disposal to locate it, inform the Insured of any new developments in this respect and, where appropriate, have it delivered to the beneficiary free of charge.

II.4.15. Early return due to serious damage to the Insured's home or business premises
The Insurer shall provide the Insured with a transport ticket for their return to their home in Spain in the event that they have to interrupt their trip due to serious damage to their main residence or the professional premises of the Insured, provided that the latter is the direct operator or exercises a liberal profession therein. Such damage is caused by fire, provided that this has given rise to the intervention of the fire brigade, consummated robbery and reported to the police authorities, or serious flooding, which makes their presence indispensable, and these situations cannot be resolved by direct relatives or persons of their trust, provided that the event has occurred after the date of commencement of the trip. Likewise, the Insurer shall pay for a second ticket for the transport of the person accompanying the Insured who returned early.

II.4.16. Shipment of forgotten or stolen objects during the trip
The Insurer shall organise and bear the cost of sending objects stolen and subsequently recovered or simply forgotten by the Insured up to a limit of 120 euros, provided that the total cost of said objects exceeds this amount.

II.4.17. Transmission of urgent messages
The Insurer shall be responsible for the transmission of urgent messages requested by the Insured Parties as a result of claims covered by these guarantees.

II.4.18. Shipping of medicines abroad
In the event that the Insured, while abroad, needs a medicine that cannot be purchased there, the Insurer shall arrange for it to be located and sent to them by the quickest possible means and subject to local legislation.
Cases of abandonment of manufacture of the medicine and its unavailability in the usual channels of distribution in Spain are excluded.

The Insured shall reimburse the Insurer for the cost of the medicine upon presentation of the purchase invoice for the aforementioned medicine.

II.4.19. Advance of monetary funds abroad
In the event that the Insured is unable to obtain monetary funds by the means initially foreseen, such as travel cheques, credit cards, bank transfers or similar, and this makes it impossible for them to continue their trip, the Insurer shall advance them up to a limit of 1500 euros, provided that they are given a guarantee or surety to ensure collection of the advance. In any event, the sums must be repaid within a maximum period of thirty days.

II.4.20. Management costs due to the loss or theft of documents
The duly justified expenses incurred by the Insured for the loss or theft of credit cards, bank cheques, traveller's cheques, petrol, transport tickets, passports or visas, which occur during the trip and stays, up to a limit of 60 euros, are covered.
Damages arising from the loss or theft of the aforementioned objects or their improper use by third parties are not covered by this coverage and, consequently, no compensation shall be paid.

II.4.21. Information service
When the Insured requires any information regarding the countries they are going to visit, such as entry formalities such as visas and vaccinations, economic or political regime, population, language, health situation, etc., the Insurer shall provide this general information, if requested, by means of a collect telephone call, if desired, to the telephone number indicated in this policy.

II.4.22. Theft and material damage to luggage
Compensation for material damage and loss of the Insured's luggage or personal effects is guaranteed in the event of theft, total or partial loss due to the carrier or damage as a result of fire or aggression, occurring during the course of the trip, **up to a maximum of 600 euros.**
Cameras and accessories for photography, radio, sound or image recording, as well as their accessories, are covered up to 50% of the sum insured for the luggage as a whole.

This compensation will always be in excess of that received from the transport company and of a complementary nature, and in order to collect it, proof of having received the corresponding compensation from the transport company must be presented, as well as a detailed list of the luggage and its estimated value.
Theft and simple loss due to the Insured Person's own fault are excluded, as well as jewellery, money, documents, valuables and sports and computer equipment.

For the purposes of the aforementioned exclusion, the following definitions shall apply:
- Jewellery: all objects made of gold, platinum, pearls or precious stones.
- Valuables: all silver objects, paintings and works of art, all types of collections, and fine furskins.

In order to claim the benefit in the event of theft, a report must first be lodged with the competent authorities.

II.4.23. Travel cancellation fees
The Insurer covers up to the **limit of 600 euros**, and subject to the exclusions mentioned in these General Conditions, the reimbursement of the expenses for trip cancellation which are incurred at the Insured Party's expense and which are invoiced to them in accordance with the general conditions of sale of the Agency or of any of the suppliers of the trip. This is provided that they cancel the trip before it commences and for one of the following reasons that occur after the insurance policy has been taken out:

a) Due to the death or hospitalisation, for at least one night, of:
- Insured, spouse, ascendant or descendant of any degree, or sibling.
- Professional substitute.
- Person in charge of the custody of minors, elderly or handicapped persons.

b) Due to the occurrence of a serious matter affecting the property of the Insured and making their presence in the following indispensable:
- Primary residence.
- Professional or business premises.

c) Due to the dismissal of the Insured from work. Under no circumstances shall this cover come into force due to termination of the employment contract, voluntary resignation or failure to pass the probationary period. In any case, the insurance must have been taken out

prior to the written notification by the Company to the employee.

d) Due to the incorporation of the Insured to a new job in a different company with an employment contract of more than one year, provided that the incorporation takes place after the registration of the trip and, therefore, the subscription of the insurance policy.

e) Due to the summoning of the Insured as a party or witness in a judicial or labour court.

f) Cancellation of the person who is to accompany the Insured on the trip, registered at the same time as the Insured and covered by this same contract, provided that the cancellation is due to one of the causes listed above and as a result the Insured has to travel alone.

II.5. Exclusions:

The agreed guarantees do not include:
a) Events voluntarily caused by the Insured or those in which there is malice or gross negligence on the part of the Insured.
b) Illnesses, chronic, congenital and/or pre-existing illnesses, as well as the consequences thereof, suffered by the Insured prior to the start of the trip.
d) Illnesses or pathological states caused by the ingestion of alcohol, psychotropic drugs, hallucinogens or any drug or substance of similar characteristics.
e) Cosmetic treatments and the supply or replacement of hearing aids, contact lenses, glasses, ortheses and prostheses in general, as well as expenses arising from childbirth or pregnancy and any type of mental illness.
f) Injuries or illnesses derived from the participation of the Insured in bets, competitions or sporting events, the practice of skiing and any other type of winter sports or those known as adventure sports (including hiking, trekking and similar activities), and the rescue of people at sea, in the mountains or in desert areas.
g) Those cases arising, directly or indirectly, from events produced by nuclear energy, radioactive radiation, natural catastrophes, acts of war, riots or terrorist acts.
h) Any type of medical or pharmaceutical expenses of less than 9 euros.
i) Death caused by epidermal morbidity.

II.6. Additional provisions

II.6.1. The guarantees described above shall only be effective for people who have their habitual residence in Spain and the time spent outside the country does not exceed 90 days per trip or journey.
II.6.2. When assistance is requested by telephone for the guarantees defined above, the name of the Insured, policy number, location, telephone number and type of assistance required must be stated.

II.6.3. Failure to notify or to comply with the formalities stipulated for cases of death or accident shall be understood as an express waiver of the benefit of the covers, preventing the Insurer from demanding any replacement benefit.

II.6.4. Under no circumstances may the Insured Person claim reimbursement of expenses incurred directly by him/her without prior authorisation from the Insurer, except in cases of vital medical emergencies and transfer to the nearest medical center, **provided that the Insurer is notified within the following 48 hours.**

II.6.5. The Insurer shall not be liable for delays and non-compliance due to force majeure or the special administrative or political circumstances of a country. In any event, if direct intervention is not possible, the Insured shall be reimbursed on their return to Spain, or in the event of necessity, even if they are in a country where the aforementioned circumstances do not apply, for the expenses incurred and which are always guaranteed against the corresponding supporting documents.

II.6.6. Medical services and medical transport must be provided with the prior agreement of the doctor at the hospital attending the Insured with the Insurer's medical team.

II.6.7. If the Insured is entitled to reimbursement of the part of the ticket not used up when making use of the repatriation cover, this reimbursement shall revert to the Insurer.

II.6.8. The indemnities set out in the guarantees **shall in all cases be complementary to any contracts that the Insured may have covering the same risks,** to social security benefits or to any other collective pension scheme.

II.6.9. The Insurer shall be subrogated in the rights and actions that may correspond to the Insured for events that have given rise to the intervention of the former and up to the total amount of the services provided or paid for.

II.6.10. The General Conditions of the Funeral Expenses policy shall apply insofar as they do not oppose the provisions hereof.

SECTION III. LIFE UNDER SURNE'S CHARGE

As an Active customer, if you wish, you can take out a life insurance policy with SURNE on an entirely voluntary basis, in accordance with the conditions set out below.

III.1. Preliminary Information
III.1.1. Preliminary information provided to the policy holder prior to taking out the policy.
In accordance with article 96 of LOSSEAR and 122, 123 and 125 of ROSSEAR, the Policyholder acknowledges having received the information referred to in this section from the insurer prior to taking out the insurance:

III.1.2. Applicable Law Member State, Supervisory Authority (Art. 96 LOSSEAR)
The General and Particular Conditions of this insurance contract are governed by the provisions of Law 50/1980 of 8 October on Insurance Contracts, by Law 20/2015 of 14 July on the regulation, supervision and solvency of insurance and reinsurance companies and by Royal Decree 1060/2015 of 20 November which develops it with regard to death insurance as a branch of service provision. **Clauses limiting the rights of the Insured that have not been expressly accepted in writing by the Policyholder and which are specially highlighted in bold type shall not be valid.**

The Member State where the risk is located is Spain and the authority responsible for the control of the insurance company is the DIRECTORATE GENERAL FOR INSURANCE AND PENSION FUNDS (DGSFP).

III.1.3. Internal and external bodies for claims and dispute resolution
In compliance with the provisions of articles 96 of Law 20/2015, of 14 July, on the Regulation, Supervision and Solvency of Insurance and Reinsurance Entities and 123 of its implementing regulations (Royal Decree 1060/2015, of 20 November, on the Regulation, Supervision and Solvency of Insurance and Reinsurance Entities), the Insurer informs on the following issues:

Internal Complaint instances:
In the event that you would like to submit a complaint or claim related to your legally recognised interests and rights, you may address it, in writing, to:

Customer Service Department
Cardenal Gardoqui, 1-bajo
48008 Bilbao
Telephone: 94 479 22 05 Fax.: 94 416 19 55
Email: reclamaciones@surne.es

Customer Advocate
Marqués de la Ensenada, 2 28004 Madrid
Telephone: 91 310 40 43 Fax.: 91 308 49 91
Email: reclamaciones@da-defensor.org

In all cases, please quote your policy number and/or claim number.
Once we receive your complaint, we will send you a written acknowledgement of receipt, which will establish the regulatory deadlines for the resolution of your complaint.

The regulations applicable to this procedure are Order ECO/734/2004, of 11 March, on customer service departments and services and the customer ombudsman of financial institutions. The Operating Regulations of the Customer Service Department are available to customers at ACTIVE's head office.

External claim instances:
In the event of a dispute, the Insured may claim before the Court of First Instance corresponding to their domicile in accordance with Article 24 of the Insurance Contract Act.

In addition, the parties may voluntarily submit their differences to arbitration under the terms of articles 57 and 58 of the revised text of the General Law for the Protection of Consumers and Users and other complementary laws, approved by Royal Legislative Decree 1/2007, of 16 November. In any case, and except in those cases in which consumer and user protection legislation prevents it, they may also submit litigious matters to arbitration, in accordance with the terms of Law 60/2003, of 23 December, on Arbitration.

They may submit their disputes to a mediator under the terms set out in Law 5/2012, of 6 July, on mediation in civil and commercial matters.

Furthermore, and notwithstanding the actions to be brought before the Courts, Policyholders, Insured Parties and Beneficiaries, in the event of not obtaining a response from the Insurer's Customer Care Service within two months from the filing of the complaint or claim, or in the event of disagreement with the decision handed down, or if they consider that the Insurer has violated their rights under the insurance contract, they may file a claim, pursuant to Article 119 of Law 20/2015, of July 20, on the regulation, supervision and solvency of insurance

companies. If they consider that the insurer has violated their rights by virtue of the insurance contract, they may claim, by virtue of Article 119 of Law 20/2015, of 14 July, on the regulation, supervision and solvency of insurance and reinsurance companies, and in accordance with Order ECC/2502/2012, of 16 November and other applicable regulations, before the Directorate General of Insurance and Pension Funds. The contact details are as follows:

Dirección General de Seguros y Fondos de Pensiones (Servicio de Reclamaciones)
Paseo de la Castellana 44, 28046 Madrid – Spain
Tel: 952 24 99 82
https://www.sededgsfp.gob.es/SedeElectronica/Reclamaciones/Reclamacion.asp
https://www.sededgsfp.gob.es/es/Paginas/Procedimiento.aspx?p=18

To file such a complaint, you must have previously filed a complaint with the insurer's customer service and not received a response within two months of filing the complaint, or you can file such a complaint if the decision was contrary to your requests and you are still dissatisfied.

If you have purchased your insurance online, you can also file a complaint through the EU's Online Dispute Resolution (ODR) platform. The website of the ODR platform is www.ec.europa.eu/odr.

III.2. Definitions of the elements of the contract

For the purposes of this contract, the following definitions apply:

III.2.1. Mutual Insurance Company
SVRNE, Mutua de Seguros y Reaseguros a Prima Fija (Svrne, Mutual Insurance and Fixed Premium Reinsurance Company), the legal entity that assumes the risk contractually agreed in this policy, in exchange for the premium.

III.2.2. Policyholder-Mutualist
The natural or legal person who, together with the Mutual Insurance Company, takes out this contract. He/she is responsible for the obligations arising from the contract, except for those which by their nature must be fulfilled by the Insured and/or Beneficiary(ies).

III.2.3. Insured
The natural person on whose life the insurance is taken out and who, in the absence of the Policyholder-Mutualist, assumes the obligations deriving from the contract.

III.2.4. Beneficiary
In the event of the death of the Insured, the Beneficiary shall be the natural person or legal entity designated in the Particular Conditions of the policy and, failing this, the person established in these General Conditions as the holder of the right to compensation. In the event of the Insured's disability, the Beneficiary shall be the Insured.

III.2.5. Policy
The document that materialises the insurance contract and contains the conditions governing the insurance. The following form an integral part of the policy:
• The Application for Membership and the Health Declaration.
• The General Conditions of the Contract that regulate the coverage subscribed and the operation of the contract.
• The Particular Conditions that individualise the risk and contain the clauses that by will of the parties complete or modify the General Conditions.
• The Special Conditions, if applicable, and the Appendices or Supplements that are issued to the policy to complete or modify it.

III.2.6. Claim
Any event for which indemnity is payable under the policy.

III.2.7. Guaranteed Capital Sum
This is the amount, fixed in the Particular Conditions of the policy, which the Mutual Insurance Company must pay to the beneficiary/s in the event of a claim, either as a single sum or in periodic payments, as the case may be, for each of the covers guaranteed.

III.2.8. Actuarial age
The age of the Insured on their nearest birthday, in excess or default, on the effective date of the policy.

III.2.9. Premium
The price of the insurance. The receipt shall also contain the surcharges and taxes that are legally applicable at any given time.

III.3. Purpose of the Insurance
The Mutual Insurance Company guarantees the payment of the compensation provided for in the Particular Conditions of this policy:

Insured guarantee:
• Death due to any cause (Death due to accident or illness).

III.4. Events excluded from the insurance policy
The following shall not be considered as events susceptible to benefit and, therefore, under no circumstances are they covered:

- Conscious or unconscious suicide and self-harm, in both cases occurring during the first year of validity of the policy.
- In the event that the Beneficiary or Beneficiaries of the policy intentionally cause a claim, the part corresponding to the Beneficiary or Beneficiaries at fault will be invalidated, without the loss of the rights corresponding to the rest of the Beneficiaries.
- When the death takes place in countries in a state of war, whatever the nature of the war, in which the insured person has his/her residence.
- The risks classified as extraordinary, according to the legislation in force at any given moment by the Insurance Compensation Consortium, among them:

a) Those of a political or social nature, as well as those that are a consequence of riots and uprisings or popular tumults, revolts or commotions and revolutions.
b) Those occurring on the occasion of civil or international war, whether declared or not, invasion, uprising, sedition, rebellion, as well as measures of a military nature.
c) Those resulting from volcanic eruptions, hurricanes, earthquakes, tremors or landslides and other seismic, meteorological, atmospheric or geological phenomena.

III.5. Risk statements
This policy has been taken out on the basis of the declarations made by the Policyholder-Mutualist and/or the Insured, in the Application for Membership and the Health Declaration, which have determined the acceptance of the risk by the Mutual Insurance Company and the calculation of the corresponding premium. The aforementioned documents include the personal details, the profession, data relating to the state of health and, if applicable, the medical tests and reports derived from the information provided by the applicant which, in the opinion of the Mutual Insurance Company, are necessary for the determination of the risk. These documents form an integral part of the policy and constitute a unitary whole, the basis of the insurance, which only covers, within the agreed limits, the capital, persons and risks specified therein.

The Policyholder-Mutualist and/or Insured has the duty, before the conclusion of the contract, to declare to the Mutual Insurance Company, in accordance with the questionnaire submitted to him by the latter, all the circumstances known to him that may influence the assessment of the risk. He shall be exempted from this duty if the Mutual Insurance Company does not submit a questionnaire to him or if, even if it is submitted to him, it concerns circumstances which may influence the assessment of the risk and which are not included in the questionnaire. The Mutual Insurance Company may cancel the contract by means of a declaration addressed to the Policyholder and/or Insured within one month of becoming aware of the Policyholder's and/or Insured's reservation or inaccuracy, and the Mutual Insurance Company shall be liable for the premiums for the period in progress at the time of making this declaration, unless there is fraud or gross negligence on its part. If the loss occurs before the Mutual Insurance Company makes the above declaration, the payment of the latter shall be reduced proportionally to the difference between the agreed premium and that which would have been applied had the true extent of the risk been known. If there was fraud or gross negligence on the part of the Policyholder-Mutualist, the Mutual Insurance Company shall be released from the payment of the benefit.

If the content of the policy differs from the insurance proposal or the agreed clauses, the Policyholder- mutualist and/or Insured may file a claim with the Mutual within a period of one month from the delivery of the policy in order to correct the existing divergence. Once this period has elapsed without a claim being made, the provisions of the policy shall apply.

III.6. Obligation to provide information during its validity. Aggravation/decrease of risk.

III.6.1. The Policyholder-Mutualist and/or the Insured person has the obligation to notify the Mutual Insurance Company, as soon as possible, during the course of the contract, of all those circumstances that aggravate the risk. If they had been known at the moment of the perfection of the contract, they would not have resulted in the conclusion of the contract or it would have been concluded under more onerous conditions. The Policy holder or the insured person is not obliged to notify the variation of the circumstances relating to the state of health of the insured person, which in no case will be considered as an aggravation of the risk.

In this case, the Mutual Insurance Company may propose an amendment to the conditions of the contract within a period of two months from the day on which the aggravation of the risk was declared. The Policyholder-Mutualist and/or Insured will have 15 days from receipt of this proposal to accept or reject it. In the event of rejection or silence, the Mutual Insurance Company may, after this period has elapsed, terminate the contract by giving the Policyholder a further 15 days to reply, after which it shall notify the Policyholder of the definitive termination within the following 8 days. The Mutual Insurance Company may also terminate the contract by notifying the Policyholder and/or Insured in writing within one month from the day on which it became aware of the worsening of the risk.

In the event that the Mutual or the insured have not made their declaration and a claim occurs, the Mutual Insurance Company will be released from its obligation if the latter has acted in bad faith. Otherwise, the benefit of the Mutual Insurance Company will be reduced proportionally to the difference between the agreed premium and that which would have been applied had the true extent of the risk been known.

The Policyholder and/or Insured may, during the course of the contract, bring to the attention of the Mutual Insurance Company any circumstances that reduce the risk and are of such a nature that, had they been known to the Mutual Insurance Company at the time of the conclusion of the contract, it would have concluded it under more favourable conditions for the Policyholder and/or Insured.

In this case, at the end of the current period covered by the premium, the Mutual Insurance Company shall reduce the amount of the future premium by the corresponding amount.

If the Mutual Insurance Company does not agree to this premium reduction, the Policyholder and/or Insured may demand the termination of the contract, as well as the refund of the difference between the premium paid and the premium that would have been payable, calculated from the time of notification of the reduction in risk.

III.7. Individuals excluded from Insurance

III.7.1. People under 14 years of age or legally disabled persons are not insurable, in accordance with the provisions of Article 83 of Law 50/1980 on Insurance Contracts.

III.7.2. Persons who are 65 years of age at the moment of contracting the insurance policy are not insurable.

III.7.3. When the insured person reaches the age of 65, the guarantees of this policy will be automatically extinguished, applying the premium to the main guarantee.

III.8. Territorial Scope
The guarantees of the policy are effective worldwide.

III.9. Perfection, effects and duration of the contract.

III.9.1. The contract is perfected by consent, expressed by the contracting parties signing the policy. The insurance contract and its modifications must be formalised in writing. The contracted coverage and its modifications or additions shall not take effect until the premium has been paid, unless otherwise agreed in the Particular Conditions.
The guarantees of the policy come into force on the date indicated in the Particular Conditions.

III.9.2. This contract is made for the period of time established in the Particular Conditions of the policy, and on its expiration, it shall be tacitly extended for periods not exceeding one year, and so on. Nevertheless, either of the contracting parties may oppose the extension by means of a written notification to the other party, made at least one month before the end of the current insurance period when the Policy holder opposes the extension and two months when the insurer opposes it, indicating his wish not to maintain the current insurance policy.

The tacit extension is not applicable to policies contracted with a duration of less than one year. In these cases, the Policyholder-Mutualist may request the extension of the policy prior to its expiration and, if accepted by the Mutual Insurance Company, it will be implemented by means of a supplement to the particular conditions and will take effect from the moment the new premium has been paid.

III.10. Payment of premiums

III.10.1. Time period for payment of premium receipts:
The Policyholder-Mutualist is obliged to pay the premiums in accordance with the General and Particular Conditions of this policy. The parties may agree to pay the premium in instalments. In this case, the first premium shall be due at the moment of the perfection of the contract. The successive premium receipts shall be payable on their corresponding due dates.

III.10.2. Direct debit of premium receipts:
Premiums shall be paid by direct debit of premium receipts. The following rules apply:
a) The Policyholder-Mutualist shall provide the Mutual Insurance Company with a letter addressed to the Financial Institution, Bank or Savings Bank giving the appropriate order to this effect.
b) The premium shall be deemed to have been paid on its due date, unless, after attempting to collect it within the month following its due date, there are insufficient funds. In this case, the Mutual Insurance Company shall notify the Policyholder that the receipt is available to him/her at the Mutual's address, and he/she shall be obliged to pay the premium at that address.

III.10.3. Effects of non-payment of the first premium:
In accordance with articles 14 and 15 of the Insurance Contract Law, the first premium or fraction thereof shall be due, once the contract has been signed. If, due to the fault of the Policyholder-Mutualist, the first premium or the single premium, as the case may be, has not been paid when due, the Mutual Insurance Company shall be entitled to terminate the contract or to demand payment of the premium due through enforcement proceedings on the basis of the policy. In any case, and unless otherwise agreed in the Particular Conditions, if the premium has not been paid before the claim occurs, the Mutual Insurance Company shall be released from its obligation.

III.10.4. Consequences of non-payment of successive premiums:
In the event of non-payment of one of the premiums following the first, the Mutual's coverage will be suspended one month after the due

date. If a claim occurs during that month, the Mutual may deduct from the amount to be indemnified the amount of the premium due for the current period. If the Mutual does not claim payment within six months following the expiry of the premium or fraction thereof, the contract shall be deemed to be terminated, without the need for any notice or demand on its part. In any case, the Mutual, when the contract is suspended, may only demand payment of the premium for the current period.

In the event of non-payment of premium fractions other than the first premium fraction, the same regime shall apply as for non-payment of successive premiums.

If the contract has not been cancelled or terminated in accordance with the preceding paragraphs, the coverage takes effect again twenty-four hours after the day on which the policyholder paid the premium.

III.11. Payment of compensation
Compensation will be paid by the Mutual Insurance Company at the end of the investigations necessary to establish the existence of the claim and its consequences.

The date of occurrence of the claim shall be understood to be the following: Death coverage: date of death.

The Policyholder-Mutualist and/or Insured or the Beneficiary must notify the Mutual Insurance Company of the occurrence of the loss within 15 days from the date on which the loss occurred, unless otherwise agreed, and the Mutual Insurance Company may claim for damages and losses caused by not having made this declaration unless it is proven that it was made aware of the loss by another means. Likewise, the Policyholder-Mutualist and/or the Insured must mitigate the consequences of the loss, using the means within their reach to achieve the prompt recovery of the Insured. Failure to comply with this obligation with the manifest intention of harming or deceiving the Mutual Insurance Company shall release the latter from any obligation deriving from the claim.
When the loss has been caused by bad faith on the part of the Policyholder-Mutualist and/or the Insured, the Mutual Insurance Company shall also be released from any obligation deriving from the same.

In order to obtain payment, the Beneficiary must send to the Mutual Insurance Company the supporting documents indicated below, as appropriate:

Death:
• National ID card of the Beneficiary/s.
• Medical certificate of death of the Insured and literal certificate of death issued by the Civil Registry.
• Certificate from the General Register of Last Wills and Testaments and, where applicable, a copy of the last will and testament, of the Act of Notoriety or of the Judicial Declaration of Heirs.
• When the Policyholder-Mutualist and the Beneficiary are different persons, Letter of payment of Inheritance and Gift Tax or the declaration of exemption.
• At the request of the Mutual Insurance Company, the Beneficiary must show the original of all the documents referred to in the previous paragraphs.
• Any other document that the Mutual Insurance Company deems necessary to assess the appropriateness of the payment of the Benefit.

Beneficiaries
In the event of death and in the absence of an express designation of Beneficiaries, the following will be designated for the purposes of this contract, in strict order of preference:
1st Spouse not legally separated by virtue of a final judgement on the date of the death of the insured person or common-law partner.
The existence of a common-law partner will be accredited by means of a certificate of inscription in one of the specific registers existing in the autonomous communities or town halls of the place of residence or by means of a public document in which the constitution of said partnership is stated.
2nd Children in equal shares.
3rd Parents, in equal shares, or the survivor of both.
4th In the absence of these, to whomsoever is entitled by law.

III.12. Termination of the contract
The Policy holder/Mutualist of the insurance policy has the power to cancel the contract within thirty days of the date on which the insurer delivers the policy to him. The unilateral power of termination must be exercised in writing and will take effect from the day of its issue, ceasing the coverage of the risk and entitling the Policy holder/Mutualist to the refund of the premium paid, except for the part corresponding to the time during which the contract was in force.

II.13. Termination, nullity and prescription of the contract
The guarantees of the policy shall terminate on the date indicated in the Particular Conditions.
The policy is automatically terminated in the event of a claim covered by any of the guarantees subscribed and the Mutual Insurance Company has the right to take possession of the unearned premium.

The contract shall be null and void if at the time of its conclusion the risk did not exist or the claim had occurred.
The actions derived from the contract shall expire five years after the date on which they could have been exercised.

III.14. Expert proceedings

In accordance with the expert procedure foreseen in articles 38 and 39 of the Insurance Contract Law, in the event of discrepancies regarding the causes of the claim or its refusal, and the assessment of the indemnity, the Policyholder-Mutualist may appoint a medical expert by notifying the Mutual Insurance Company in writing. This communication must state the acceptance of said expert, and the institution must be expressly requested to appoint its own within eight days of receiving such communication. If the Mutual Insurance Company does not make the appointment, it will be understood that it accepts the opinion issued by the insured person's medical expert and will be bound by it.

In the event that the experts reach an agreement, it will be reflected in a joint report in which the causes of the claim, the assessment of the damage, and the other circumstances that influence the determination of the compensation will be stated. If there is no agreement between the experts, a third expert shall be appointed by mutual agreement, or such appointment shall be requested from the judge of first instance. In accordance with Article 39 of the Insurance Contract Act, each party shall pay the fees of his expert and those of the third expert, in the event of his appointment, shall be paid in half.

III.15. Communications

All communications to the Mutual Insurance Company shall be made at the registered office of the latter, as indicated in the policy. Likewise, communications from the Mutual shall be made to the address of the interested parties, as stated in the policy, unless they have notified the Mutual of a change of address.

This insurance contract includes indissolubly the above General Conditions and the Particular Conditions and the Appendices that include the modifications agreed by the parties. The Policyholder-Mutualist/Insured declares that he/she has read and understood all the limitations and exclusions contained in this policy and expressly accepts them.

III.16. Processing of personal data

In compliance with the provisions of the General Data Protection Regulation of the European Union ('GDPR'), we hereby provide you with the following information regarding the processing of the personal data of the applicant, policyholder, insured and/or beneficiary provided to Svrne, Mutual Insurance and Fixed Premium Reinsurance Company during the pre-contractual and/or contractual relationship, including health data.

Basic information on data protection	
Responsible entity	Svrne, Mutual Insurance and Fixed Premium Reinsurance ("SVRNE")
Purpose	• Management of the pre-contractual relationship and/or the insurance contract. • Carrying out commercial actions and sending commercial communications, including by electronic means, about other products marketed by SVRNE, as well as by any of the entities of the SVRNE Group. • Retain personal data in the event that the contractual relationship is not formalised, in order to manage future requests that may be made.
Standing (legal basis)	• Execution of the pre-contract and/or insurance contract. • Legitimate interest, so that the entity can offer you a more complete service and increase your degree of satisfaction. • Legitimate interest to manage and satisfy your possible queries or requests in the future.
Recipients	• Reinsurance entities for reinsurance purposes. Insurance brokers. • Medical professionals. • Public bodies. They may also have access to your data as data processors, their own agents (Group companies) or third-party agents, commercial service providers, professional services (e.g., expert firms, external lawyers), and IT service providers, as well as any other processor whose services are required for any additional management of the contract that may be necessary, including the management of the eventual performance that may be required.
International transfers	Your personal data will not be subject to any international data transfer.
Data categories and origin	• The personal data to be processed (including health data) are those provided within the framework of the pre-contract and/or insurance contract. • The data processed may relate to the policyholder and/or insured person, as well as to any third party natural person related to the insurance contract (i.e. third party insured persons, beneficiaries or injured parties).
Rights	You may exercise your rights of access, rectification, erasure, objection, restriction of processing and portability as indicated in the additional information.
Additional information	Further and detailed information on the processing of your data can be found at http://www.surne.es/es/privacidad.htm

III.17. Consortium Clause

Clause of compensation by the Insurance Compensation Consortium for losses arising from extraordinary events in personal insurance.
In accordance with the provisions of the revised text of the Legal Statute of the Insurance Compensation Consortium, approved by Royal Legislative Decree 7/2004, of 29th October, the policyholder of an insurance contract of those that must obligatorily include a surcharge in favour of the aforementioned public business entity has the power to agree on the coverage of extraordinary risks with any insurance company that meets the conditions required by current legislation.

The compensation derived from claims arising from extraordinary events occurring in Spain or abroad, when the insured person has his habitual residence in Spain, will be paid by the Insurance Compensation Consortium when the policy holder has paid the corresponding surcharges in his favour and any of the following situations occur:

a) That the extraordinary risk covered by the Insurance Compensation Consortium is not covered by the insurance policy taken out with the insurance company.
b) That, although covered by the said insurance policy, the obligations of the insurance company could not be fulfilled due to its having been declared judicially declared bankrupt or being subject to a liquidation procedure, intervened or assumed by the Insurance Compensation Consortium.
The Insurance Compensation Consortium will adjust its actions to the provisions of the aforementioned legal Statute, in the Law 50/1980, of the 8th October, on Insurance Contracts, in the Regulations of the Insurance Contracts Act, and in the Regulations of the insurance of extraordinary risks, approved by the Royal Decree 300/2004, of the 20th of February, and in the complementary provisions.

Summary of legal regulations:

III.17.1. Covered extraordinary events

a) The following natural phenomena: earthquakes and tidal waves; extraordinary floods, including those produced by sea; volcanic eruptions; atypical cyclonic storms (including extraordinary winds with gusts of more than 120 km/h and tornadoes); and falling sidereal bodies and aerolites.
b) Those caused violently as a consequence of terrorism, rebellion, sedition, riot and civil commotion.
c) Acts or actions of the Armed Forces or of the Security Forces and Corps in peacetime.
Atmospheric and seismic phenomena, volcanic eruptions and the fall of sidereal bodies shall be certified, at the request of the Insurance Compensation Consortium, by means of reports issued by the State Meteorological Agency (AEMET), the National Geographic Institute and other public bodies competent in the matter. In cases of events of a political or social nature, as well as in the event of damage caused by events or actions of the Armed Forces or of the Security Forces or Corps in peacetime, the Insurance Compensation Consortium may request information from the competent jurisdictional and administrative bodies on the events that occurred.

III.17.2. Excluded risks

a) Those that do not give rise to compensation according to the Insurance Contract Law.
b) Those caused to persons insured by an insurance contract other than those in which the surcharge in favour of the Insurance Compensation Consortium is obligatory.
c) Those produced by armed conflicts, even if the official declaration of war has not been preceded.
d) Those arising from nuclear energy, without prejudice to the provisions of Law 12/2011, of 27 May, on civil liability for nuclear damage or damage caused by radioactive materials.
e) Those caused by natural phenomena other than those indicated in section 1.a) above and, in particular, those caused by a rise in the water table, movement of hillsides, landslides or settlement of land, rock falls and similar phenomena, unless these were clearly caused by the action of rainwater which, in turn, had caused a situation of extraordinary flooding in the area and occurred at the same time as such flooding.
f) Those caused by riotous actions occurring in the course of meetings and demonstrations carried out in accordance with the provisions of Organic Law 9/1983, of 15 July, regulating the right of assembly, as well as during the course of legal strikes, unless the aforementioned actions could be classified as events other than those indicated in section 1.b) above.
g) Those caused by bad faith on the part of the insured person.
h) Those corresponding to losses occurring before the payment of the first premium or when, in accordance with that established in the Law of Insurance Contracts, the coverage of the Insurance Compensation Consortium is suspended or the insurance is terminated due to non-payment of premiums.
i) Losses which, due to their magnitude and seriousness, are classified by the National Government as a 'national catastrophe or calamity'.

III.17.3. Extension of coverage

III.17.3.1. The cover of extraordinary risks shall extend to the same persons and the same insured sums as have been established in the insurance policies for the purposes of ordinary risk coverage.

III.17.3.2. In the life insurance policies that, in accordance with the provisions of the contract, and in accordance with the regulations governing private insurance, generate a mathematical provision, the coverage of the Insurance Compensation Consortium will refer to the capital at risk for each insured person, that is to say, to the difference between the sum insured and the mathematical provision that the issuing insurance company must have constituted. The amount corresponding to the mathematical provision will be paid by the aforementioned insurance company.

III.17.4. Notification of damage to the Insurance Compensation Consortium

III.17.4.1. The request for compensation of damages whose coverage corresponds to the Insurance Compensation Consortium, will be made by means of a notification to the same by the policy holder, the insured person or the beneficiary of the policy, or by whoever acts on behalf and in the name of the above, or by the insurance company or the insurance intermediary with whose intervention the insurance has been managed.

III.17.4.2. The notification of the damage and the obtaining of any information related to the procedure and the state of processing of the claims can be carried out:
- By calling the Insurance Compensation Consortium Call Center (900 222 665).
- Through the website of the Insurance Compensation Consortium (www.consorseguros.es).

III.17.4.3. Assessment of the damage: The assessment of the damage that may be compensated in accordance with insurance legislation and the contents of the insurance policy will be carried out by the Insurance Compensation Consortium, without the latter being bound by the assessments which, where appropriate, may have been carried out by the insurance company covering the ordinary risks.

III.17.4.4. Payment of compensation: The Insurance Compensation Consortium will make the payment of the compensation to the beneficiary of the insurance by means of a bank transfer.

SECTION IV. ACCIDENTS AT SURNE'S EXPENSE

GENERAL CONDITIONS

IV.1. Preliminary Information
The preliminary information contained in Section III of this document applies.

IV.2. Definitions
In addition to the definitions contained in Section III, the following definitions apply to this Section IV:

IV.2.1. Absolute permanent disability due to accident
The irreversible physical situation that determines the total disability of the Insured for the permanent maintenance of any remunerated profession or trade, declared or recognised by the competent public body.

IV.2.2. Accident
The supervening bodily injury resulting from a violent, sudden, external and unintentional cause beyond the control of the Insured. In any event, all events classified as such by the competent Official or Jurisdictional Bodies in their corresponding Resolutions or final Judgements, including in the Social and Labour spheres, shall be considered to be accidents.
Consequently, the classification of an event as an accident and the degree of permanent disability shall be determined by the regulations of the Social Security and/or by the competent Official or Jurisdictional Bodies in their corresponding Resolutions or final Judgements, except in the case of temporary disability.

IV.3. Purpose of the Insurance
The Mutual Insurance Company guarantees the payment of the compensation foreseen in the Particular Conditions of this policy, in the event of the occurrence of any of the events described below within the year following the occurrence of the accident. **In the event of a later occurrence, it must be reliably accredited that it was a consequence of the same.**

Main Coverage: • Death by Accident

Complementary Coverage:
• Absolute Permanent Disability due to accident.
• Partial Disability due to accident. The compensation to be paid in this case shall be that resulting from applying the percentages indicated in ANNEX I to the capital agreed in the contract.

In the event of death or disability occurring after the payment of the compensation for Partial Permanent Disability, the part of the compensated Partial Disability shall be deducted.
The payment for Absolute Permanent Disability entails the extinction of any further obligation with respect to that insured person.

IV.4. Events excluded from insurance

IV.4.1. For death and absolute permanent disability guarantees, the exclusions of the policy are as follows:

- Non-accidental traumatic injuries, such as: pulls, tears or tears and muscle strains, contractures, tendonitis, overexertion, sprains and sprains, in general, all those injuries that do not meet the definition of accident (trauma due to violent, external, sudden causes beyond

the will of the insured.
- Events that are not considered accidents as stipulated in the definition of an accident, as well as those that violate any legal provision.
- Accidents due to the voluntary use of drugs or narcotics or drunkenness, in the terms described above, or occurring in a state of mental derangement or somnambulism.
- Self-harm, and suicide or its attempt.
- Events resulting from nuclear reaction or radiation, interventions in high-voltage electrical currents, as well as radioactive contamination.
- Those events that are legally considered extraordinary. Risks classified as extraordinary, according to legislation in force at any given time by the Insurance Compensation Consortium.
- The consequences of wars or operations of a similar nature
- Accidents caused as a result of practicing any sport as a professional. For these purposes, the professional practice of a sport is understood to be the individual or collective practice under the organization and supervision of a sports federation, body or club that constitutes, for the person who performs that sport, his or her means of living. Exercise of risky sports. The following are considered risky:

Martial arts, boxing, karate and body fighting,
Aerial sports in general (parachuting, ballooning, hang-gliding, ultra-lights, gliding, and similar). Diving with the use of breathing apparatus.
motor racing and motorcycling
Mountaineering, climbing, including glacier crossing and caving, rafting and bungee jumping. Bullfighting and running of the bulls.
Horse riding and polo.
Big game hunting.

- Illnesses of any nature, including myocardial infarction and cerebrovascular events, as well as bodily injuries that may occur as a result thereof and consequent to operations carried out by the Insured on himself/herself.
- Sunstroke, frostbite or other effects of atmospheric temperature, unless they are the consequence of an accident.
- Aneurysms, varicose veins, all kinds of hernias and their consequences, as well as muscular and cervical distensions and lumbago, whatever the cause.
- Poisoning or intoxication due to the ingestion of foodstuffs in general.
- Infectious diseases (unless the penetration of the virus into the body is due to an injury caused by an accident covered in the policy)**, including sleeping sickness, , malaria, yellow fever, and syncope, fainting, fits of apoplexy or epilepsy, as well as the injuries that may occur as a consequence thereof.**
- Injuries caused by X-rays, radium and its compounds, unless they are the result of treatment applied to the Insured as a consequence of an accident covered by this contract.
- Accidents caused by the participation of the Insured in duels, challenges, bets or fights, unless, in the latter case, the Insured is acting in legitimate self-defence **(and this has been declared by a final judicial decision). Injuries caused by criminal acts of the Insured or as a result of recklessness or serious negligence are also excluded.**
- Neuropathies and pain that do not give rise to objective symptoms.

Some of the risks excluded above may be included under the coverage of this insurance contract, if this is expressly stipulated in the Particular Conditions and the corresponding additional premium is paid.

IV.5. Risk Disclosure
This policy has been taken out on the basis of the declarations made by the Policyholder-Mutualist and/or the Insured, in the Application for Insurance and the Health Declaration, which have determined the acceptance of the risk by the Mutual and the calculation of the corresponding premium. The aforementioned documents include the personal details, the profession, data relating to the state of health and, if applicable, the medical tests and reports derived from the information provided by the applicant which, in the opinion of the Mutual, are necessary for the determination of the risk. These documents form an integral part of the policy and constitute a unitary whole, the basis of the insurance, which only covers, within the agreed limits, the capital, persons and risks specified therein.

before the conclusion of the contract, the Policyholder-Mutualist and/or Insured has the duty to declare to the Mutual Insurance Company, in accordance with the questionnaire that the latter submits, all the circumstances known to him/her that may influence the assessment of the risk. He shall be exempted from this duty if the Mutual Insurance Company does not submit a questionnaire to him or if, even if the questionnaire is submitted to him, it concerns circumstances which may influence the assessment of the risk and which are not covered by the questionnaire. The Mutual Insurance Company may cancel the contract by means of a declaration addressed to the Policyholder and/or Insured within one month of becoming aware of the Policyholder's and/or Insured's reservation or inaccuracy, and the Mutual Insurance Company shall be liable, unless there is fraud or gross negligence on its part, for the premiums for the period in progress at the time of making this declaration. If the claim occurs before the Mutual Insurance Company makes the above declaration, the benefit of the latter shall be reduced proportionally to the difference between the agreed premium and that which would have been applied had the true extent of the risk been known. If the Policyholder is guilty of malice or gross negligence, the Mutual Insurance Company shall be released from its liability.

If the content of the policy differs from the insurance proposal or the agreed clauses, the Policyholder-Mutualist and/or the Insured may claim against the Mutual Insurance Company during a period of one month from the delivery of the policy in order to rectify the existing divergence. Once this period has elapsed without a claim being made, the provisions of the policy shall apply.

IV.6. Information obligation during its duration. Aggravation/decrease of risk

IV.6.1. Aggravation of the risk during the contract: The Policyholder-Mutualist and/or the Insured person has the obligation to notify the Mutual Insurance Company, as soon as possible, during the course of the contract, of all those circumstances that aggravate the risk and which, due to their nature, if they had been known at the moment of the perfection of the contract, would not have given rise to its conclusion or it would have been concluded under more onerous conditions. The Policy holder or the insured person is not obliged to communicate the variation of the circumstances relating to the state of health of the insured person, which in no case will be considered as an aggravation of the risk:

By way of example, the following are considered to be circumstances that aggravate the risk:
a) The change of occupation or professional activity of the Insured, even of a temporary nature, which implies a greater probability of the occurrence of the claim.
b) Permanent disability or incapacity and chronic illnesses resulting from events not covered by this policy.

In the event that the Policyholder and/or the Insured informs the Mutual Insurance Company of the occurrence of a circumstance that aggravates the risk, the latter may propose a modification of the conditions thereof within a period of two months from the day on which the aggravation of the risk was declared and the Policyholder and/or the Insured shall have 15 days from the receipt of this proposal to accept or reject it. In the event of rejection or silence, the Mutual Insurance Company may, after this period has elapsed, terminate the contract after warning the Policyholder, giving him/her a new period of 15 days to reply, after which and within the following 8 days, it will notify the Policyholder of the definitive termination.

The Mutual Insurance Company may also terminate the contract by notifying the Policyholder and/or Insured in writing within one month of the day on which it became aware of the aggravated risk.

In the event that the Policyholder / Mutualist or the insured person has not made his/her declaration and a claim arises, the Mutual Insurance Company shall be released from its obligation if he has acted in bad faith. Otherwise, the benefit of the Mutual Insurance Company shall be reduced proportionally to the difference between the agreed premium and that which would have been applied had the true extent of the loss been known.

IV.6.2. Diminution of risk during the course of the contract
The Policyholder and/or Insured may, during the course of the contract, inform the Mutual Insurance Company of any circumstances that reduce the risk and are of such a nature that, if they had been known to the Mutual Insurance Company at the time of the conclusion of the contract, it would have concluded the contract under more favorable conditions for the Policyholder and/or Insured.

In such a case, at the end of the current period covered by the premium, the Mutual shall reduce the amount of the future premium by the corresponding amount.

If the Mutual Insurance Company does not agree to this premium reduction, the Policyholder and/or Insured may demand the termination of the contract, as well as the refund of the difference between the premium paid and that which would have been payable, calculated from the time of notification of the reduction in risk.

IV.7. Persons excluded from the insurance
Persons over 65 years of age are not insurable. If the Insured reaches the age of 70 while the contract is in force, the guarantees of the policy shall be automatically extinguished.
Likewise, for the risk of death due to accident, persons under 14 years of age are not insurable.

Territorial scope
The guarantees of the policy are effective worldwide.

IV.8. Coverage options

• Full Coverage:
The accidents that the insured person may suffer during the 24 hours of the day are guaranteed.

IV.9. Perfection, effects and duration of the contract

IV.9.1. The contract is perfected by consent, expressed by the contracting parties signing the policy. The insurance contract and its modifications must be formalized in writing. The contracted coverage and its modifications or additions shall not take effect until the premium has been paid, unless otherwise agreed in the Particular Conditions.
The guarantees of the policy come into force on the date indicated in the Particular Conditions.

IV.9.2. The present contract is made for the period of time established in the Particular Conditions of the policy, and on its expiry it shall be tacitly extended for periods not exceeding one year, and so on successively. Nevertheless, any of the contracting parties may oppose the extension by means of a written notification to the other party, made at least one month before the end of the current insurance period

when the Policy holder opposes the extension and two months when the insurer opposes it, indicating his wish not to maintain the insurance policy in force.

IV.10. Payment of premiums

IV.10.1. Period of time for payment of premium receipts:
The Policyholder-Mutualist is obliged to pay the premiums in accordance with the General and Particular Conditions of this policy. The parties may agree to pay the premium in instalments. In this case, the first premium shall be due at the moment of the perfection of the contract. The successive premium receipts must be paid in their corresponding instalments.

IV.10.2. Direct debit of premium receipts:
Premiums shall be paid by direct debit of premium receipts.
The Policyholder-Mutualist shall provide the Mutual with a letter addressed to the Financial Institution, Bank or Savings Bank giving the appropriate order to this effect.

IV.10.3. Effects of non-payment of the first premium:
If due to the fault of the Policyholder-Mutualist the first premium or the single premium, as the case may be, has not been paid when due, the Mutual shall be entitled to terminate the contract or to demand payment of the premium due in enforceable proceedings based on the policy. In any case, unless otherwise agreed in the Particular Conditions, if the premium has not been paid before the claim occurs, the Mutual Insurance Company shall be released from its obligation to pay the premium.

IV.10.4. Consequences of non-payment of successive premiums:
In the event of non-payment of one of the premiums following the first, the Mutual Insurance Company coverage shall be suspended for one month after the due date. If a claim occurs during that month, the Mutual Insurance Company may deduct from the amount to be indemnified the amount of the premium due for the current period. If the Mutual Insurance Company does not claim payment within six months following the expiry of the premium or fraction thereof, the contract shall be deemed to be terminated, without the need for any notice or demand on its part.

In any case, the Mutual Insurance Company, when the contract is suspended, may only demand payment of the premium for the current period. **For the non-payment of fractions of premiums other than the first, the same regime shall apply as for the non-payment of successive premiums.**

If the contract has not been cancelled or terminated in accordance with the preceding paragraphs, the coverage shall take effect again twenty-four hours after the day on which the Policyholder-Mutualist paid the premium.

IV.11. Payment of compensation
Compensation shall be paid by the Mutual Insurance Company upon completion of the investigations necessary to establish the existence of the claim and its consequences.

Date of occurrence of the claim: shall be the date of the accident. Therefore, the consequences of accidents occurring prior to the date of the first effect of this policy shall not be compensated.

Obligation to provide information: The Policyholder-Mutualist and/or Insured or the Beneficiary must notify the Mutual Insurance Company of the occurrence of the loss within 15 days from the date on which the loss occurred, and the Mutual Insurance Company may claim for damages and losses caused by not having made this declaration unless it is proven that the Mutual Insurance Company had knowledge of the loss by another means. Likewise, the Policyholder-Mutualist and/or the Insured must mitigate the consequences of the claim, using the means within their reach to achieve the prompt recovery of the Insured. Failure to comply with this obligation with the manifest intention of harming or deceiving the Mutual Insurance Company shall release the latter from any obligation deriving from the claim.
When the claim has been caused by bad faith on the part of the Policyholder-Mutualist and/or the Insured, the Mutual Insurance Company shall also be released from all obligations deriving from the same.

The payment of the death benefit or Permanent Disability benefit, except for Partial Permanent Disability, implies the automatic termination of the contract, exempting the Mutual Insurance Company from any further obligation.

The condition **of Beneficiary** shall correspond to the persons in whose favor the benefits covered are generated. In the event of permanent disability, the beneficiary shall be the Insured.

• In the event of death, and in the absence of express designation of beneficiaries, the following will be considered as such, in order of preferential and exclusive priority:

1. Spouse not legally separated by virtue of a final judgement on the date of the death of the insured person or legally constituted common-law partner.
The existence of a common-law partnership will be accredited by means of a certificate of inscription in one of the specific registers existing in the autonomous communities or town halls of the place of residence or by means of a public document in which the constitution of the

said partnership is stated.
2. Children or descendants of the insured person in equal parts.
3. Parents or ascendants of the insured person in equal parts.
4. In the absence of these, to the heirs of the Insured.

IV.12. Formalities and documentation to be provided in the event of a claim

IV.12.1. Death due to Accident/ Death due to Traffic Accident.
a) Original or certified photocopy of the literal death certificate.
b) National Identity Card of the Insured and of the Beneficiaries.
c) Court proceedings and/or Attestation issued by the competent authority.
d) Photocopy of the autopsy and toxicology report, if it was carried out. Certificate from the Register of Last Wills and, if applicable, a copy of the will. In certain cases, a declaration of heirs 'ab intestato' may be requested.
e) Letter of payment of Inheritance and Gift Tax or declaration of exemption.
f) Current account of each of the Beneficiaries using IBAN.

IV.12.2. Absolute Permanent Disability resulting from an accident.
a) Identity card of the Insured.
b) Documentation accrediting the date of the accident and the circumstances of the same (this may be, but is not limited to, the accident at work report, acceptance by the Mutual Insurance Company for Accidents at Work, legal proceedings, etc.).
c) Resolution issued by the Board for the Evaluation of Disabilities of the INSS or by the competent Jurisdictional Body, where appropriate, accrediting the Total/Absolute Permanent Disability/Great Disability derived from the accident. In the event that the insured person is not assessed by the I.N.S.S, he/she must undergo an examination by the medical team designated by the Mutual Insurance Company, which will determine whether or not he/she suffers the injuries and disabilities that entitle him to the payment of compensation.
d) Form 145: Form for notifying the payer of the personal and family situation of the recipient of earned income.
e) Current account of the Insured using the IBAN.

IV.12.3. Partial Permanent Disability resulting from Accident.
a) Identity card of the Insured.
b) Documentation accrediting the date of the accident, as well as an explanation of the circumstances of the accident.
c) Detailed medical report informing of the definitive sequelae and Resolution of the INSS, if applicable. In the event that the insured person is not assessed by the INSS, he/she must undergo an examination by the medical team designated by the Mutual Insurance Company, which will determine whether or not he suffers the injuries and disabilities that entitle him to the payment of compensation.
d) Current account of the Insured using IBAN.

IV.13. Termination of the contract
The Policy holder/Mutualist of the insurance policy has the right to cancel the contract within thirty days of the date on which the insurer delivers the policy to him. The unilateral power of termination must be exercised in writing and will take effect from the day of its issue, ceasing the coverage of the risk and entitling the Policy holder/Mutualist to the refund of the premium paid, except for the part corresponding to the time during which the contract was in force.

IV.14. Termination, nullity and prescription of the contract
The guarantees of the policy will be extinguished on the date indicated in the Particular Conditions, unless the policy is extended. In any event, **the guarantees are extinguished at the end of the annuity in which the insured person reaches the age of 70 years,** unless otherwise stated in the Particular Conditions.

The policy is automatically terminated in the event of a claim covered by any of the guarantees subscribed, other than the temporary disability, **and the Mutual Insurance Company has the right to take back the unused premium.**

The contract shall be null and void if at the time of its conclusion the risk did not exist or the claim had occurred. **Actions arising from the contract shall expire five years after the date on which they could have been exercised.**

IV.15. Expert's procedure
In the event of discrepancies regarding the causes of the claim or its refusal, and the valuation of the compensation, the Policyholder-Mutualist may appoint a medical expert by notifying the Mutual Insurance Company in writing. This communication must state the acceptance of said expert, and the institution must be expressly requested to appoint its own within eight days of receiving such communication. If the Mutual Insurance Company does not make the appointment, it will be understood that it accepts the opinion issued by the insured person's medical expert and will be bound by the same.

In the event that the experts reach an agreement, it will be reflected in a joint report in which the causes of the claim, the valuation of the damage, and the other circumstances that influence the determination of the compensation will be stated. If there is no agreement between the experts, a third expert shall be appointed by mutual agreement, or such appointment shall be requested from the judge of first instance. In accordance with Article 39 of the Insurance Contract Act, each party shall pay the fees of his expert and those of the third expert, in the event of his appointment, shall be paid in half.

IV.16. Communications

Notifications to the Mutual Insurance Company shall be made to the registered office of the Mutual Insurance Company as indicated in the policy. Likewise, communications from the Mutual Insurance Company shall be made to the address of the interested parties, as stated in the policy, unless they have notified the Mutual Insurance Company of a change of address.

This insurance contract indissolubly comprises the General Conditions that precede and the Particular Conditions and the Appendices that include the modifications agreed by the parties. The Mutual Policyholder/Insured declares that he/she has read and understood all the limitations and exclusions contained in this policy and expressly accepts them.

IV.17. Processing of personal data

In compliance with the provisions of the General Data Protection Regulation of the European Union ('GDPR'), we provide you with the following information regarding the processing of the personal data of the applicant, policyholder, insured and/or beneficiary provided to Svrne, Mutual Insurance and Fixed Premium Reinsurance Company during the pre-contractual and/or contractual relationship, including health data.

Basic information on data protection	
Responsible entity	Svrne, Mutual Insurance and Fixed Premium Reinsurance ("**SVRNE**")
Purpose	• Management of the pre-contractual relationship and/or the insurance contract. • Carrying out commercial actions and sending commercial communications, including by electronic means, about other products marketed by SVRNE, as well as by any of the entities of the SVRNE Group. • Retain personal data in the event that the contractual relationship is not formalised, in order to manage future requests that may be made.
Standing (legal basis)	• Execution of the pre-contract and/or insurance contract. • Legitimate interest, so that the entity can offer you a more complete service and increase your degree of satisfaction. • Legitimate interest to manage and satisfy your possible queries or requests in the future.
Recipients	• Reinsurance entities for reinsurance purposes. Insurance brokers. • Medical professionals. • Public bodies. They may also have access to your data as data processors, their own agents (Group companies) or third-party agents, commercial service providers, professional services (e.g., expert firms, external lawyers), and IT service providers, as well as any other processor whose services are required for any additional management of the contract that may be necessary, including the management of the eventual performance that may be required.
International transfers	Your personal data will not be subject to any international data transfer.
Data categories and origin	• The personal data to be processed (including health data) are those provided within the framework of the pre-contract and/or insurance contract. • The data processed may relate to the policyholder and/or insured person, as well as to any third party natural person related to the insurance contract (i.e. third party insured persons, beneficiaries or injured parties).
Rights	You may exercise your rights of access, rectification, erasure, objection, restriction of processing and portability as indicated in the additional information.
Additional information	Further and detailed information on the processing of your data can be found at http://www.surne.es/es/privacidad.htm

IV. 18. Consortium Clause

Clause of compensation by the Insurance Compensation Consortium for losses arising from extraordinary events in personal insurance.

In accordance with the provisions of the revised text of the Legal Statute of the Insurance Compensation Consortium, approved by Royal Legislative Decree 7/2004, of 29th October, the policyholder of an insurance contract of those that must obligatorily include a surcharge in favour of the aforementioned public business entity has the power to agree on the coverage of extraordinary risks with any insurance company that meets the conditions required by current legislation.

The compensation derived from claims arising from extraordinary events occurring in Spain or abroad, when the insured person has his habitual residence in Spain, will be paid by the Insurance Compensation Consortium when the policy holder has paid the corresponding surcharges in his favour and any of the following situations occur:

a) That the extraordinary risk covered by the Insurance Compensation Consortium is not covered by the insurance policy taken out with the insurance company.
b) That, although covered by the said insurance policy, the obligations of the insurance company could not be fulfilled due to its having been

declared judicially declared bankrupt or being subject to a liquidation procedure, intervened or assumed by the Insurance Compensation Consortium.

The Insurance Compensation Consortium will adjust its actions to the provisions of the aforementioned legal Statute, in the Law 50/1980, of the 8th October, on Insurance Contracts, in the Regulations of the Insurance Contracts Act, and in the Regulations of the insurance of extraordinary risks, approved by the Royal Decree 300/2004, of the 20th of February, and in the complementary provisions.

IV.18.1 Summary of legal regulations:

IV.18.1.1. Covered extraordinary events
a) The following natural phenomena: earthquakes and tidal waves; extraordinary floods, including those produced by sea; volcanic eruptions; atypical cyclonic storms (including extraordinary winds with gusts of more than 120 km/h and tornadoes); and falling sidereal bodies and aerolites.
b) Those caused violently as a consequence of terrorism, rebellion, sedition, riot and civil commotion.
c) Acts or actions of the Armed Forces or of the Security Forces and Corps in peacetime.

Atmospheric and seismic phenomena, volcanic eruptions and the fall of sidereal bodies shall be certified, at the request of the Insurance Compensation Consortium, by means of reports issued by the State Meteorological Agency (AEMET), the National Geographic Institute and other public bodies competent in the matter. In cases of events of a political or social nature, as well as in the event of damage caused by events or actions of the Armed Forces or of the Security Forces or Corps in peacetime, the Insurance Compensation Consortium may request information from the competent jurisdictional and administrative bodies on the events that occurred.

IV.18.2. Excluded risks
a) Those that do not give rise to compensation according to the Insurance Contract Law.
b) Those caused to persons insured by an insurance contract other than those in which the surcharge in favour of the Insurance Compensation Consortium is obligatory.
c) Those produced by armed conflicts, even if the official declaration of war has not been preceded.
d) Those arising from nuclear energy, without prejudice to the provisions of Law 12/2011, of 27 May, on civil liability for nuclear damage or damage caused by radioactive materials.
e) Those caused by natural phenomena other than those indicated in section 1.a) above and, in particular, those caused by a rise in the water table, movement of hillsides, landslides or settlement of land, rock falls and similar phenomena, unless these were clearly caused by the action of rainwater which, in turn, had caused a situation of extraordinary flooding in the area and occurred at the same time as such flooding.
f) Those caused by riotous actions occurring in the course of meetings and demonstrations carried out in accordance with the provisions of Organic Law 9/1983, of 15 July, regulating the right of assembly, as well as during the course of legal strikes, unless the aforementioned actions could be classified as events other than those indicated in section 1.b) above.
g) Those caused by bad faith on the part of the insured person.
h) Those corresponding to losses occurring before the payment of the first premium or when, in accordance with that established in the Law of Insurance Contracts, the coverage of the Insurance Compensation Consortium is suspended or the insurance is terminated due to non-payment of premiums.
i) Losses which, due to their magnitude and seriousness, are classified by the National Government as a 'national catastrophe or calamity'.

IV.18.3. Extension of coverage

IV.18.3.1. The cover of extraordinary risks shall extend to the same persons and the same insured sums as have been established in the insurance policies for the purposes of the cover of ordinary risks.

IV.18.3.2. In the life insurance policies that, in accordance with the provisions of the contract, and in accordance with the regulations governing private insurance, generate a mathematical provision, the coverage of the Insurance Compensation Consortium will refer to the capital at risk for each insured person, that is to say, to the difference between the sum insured and the mathematical provision that the issuing insurance company must have constituted. The amount corresponding to the mathematical provision will be paid by the aforementioned insurance company.

IV.18.3.3. The request for compensation of damages whose coverage corresponds to the Insurance Compensation Consortium, will be made by means of a notification to the same by the policy holder, the insured person or the beneficiary of the policy, or by whoever acts on behalf and in the name of the above, or by the insurance company or the insurance intermediary with whose intervention the insurance has been managed.

IV.18.3.4. The notification of the damage and the obtaining of any information related to the procedure and the state of processing of the claims can be carried out:
- By calling the Insurance Compensation Consortium Call Center (900 222 665).
- Through the website of the Insurance Compensation Consortium (www.consorseguros.es).

IV.18.3.5. Assessment of the damage: The assessment of the damage that may be compensated in accordance with insurance legislation and the contents of the insurance policy will be carried out by the Insurance Compensation Consortium, without the latter being bound by the

assessments which, where appropriate, may have been carried out by the insurance company covering the ordinary risks.

IV.18.3.6. Payment of compensation: The Insurance Compensation Consortium will make the payment of the compensation to the beneficiary of the insurance by means of a bank transfer.

ANNEX I: PARTIAL SCALE

Partial Disability according to the scale:

This is considered to be the compensation that, if contracted in the Particular Conditions, is granted by the Mutual Insurance Company in the event that the Insured suffers a definitive partial disability as a result of an accident covered by the policy.

The compensation to be paid in these cases will be the one that results from applying the following percentages to the capital agreed in the contract:

DESCRIPTION	% Right	% Left
Total loss of the arm or hand	60	50
Total loss of shoulder movement	25	20
Total loss of elbow motion	20	15
Total loss of wrist movement	20	15
Loss of thumb and index finger of the hand	30	15
Total loss of three fingers, including the thumb and index finger	30	15
Total loss of two of these last fingers	15	12
Total loss of three fingers other than the thumb or index finger	25	20
Complete loss of the thumb and finger other than the index finger	25	20
Complete loss of the index finger and finger other than the thumb	20	15
Total loss of index finger only of the hand	15	10
Total loss of the middle finger, ring finger, or pinky finger of the hand	10	8
Total loss of a leg or foot	50	
Partial amputation of a foot, including all the toes	30	
Lower jaw ablation	30	
Total loss of one eye or reduction of binocular vision by half	25	
Complete and incurable deafness of both ears	40	
Complete deafness of one ear	10	
Complete loss of movement of a hip, knee, or ankle	20	
Shortening of at least five centimeters of a lower limb	15	
Total loss of the toe	10	
Total loss of the other toe	3	

In the event that after the payment of the compensation for Partial Disability, the Insured Person dies or becomes Permanently Disabled, the amounts paid by the Mutual Insurance Company will be considered to have been paid on account of the total sum insured for these concepts.

SECTION V. GENERAL AND SPECIAL CONDITIONS OF ORPHAN'S INCOME INSURANCE

GENERAL CONDITIONS

Preliminary Information
The preliminary information contained in Section III of this document applies.

V.1. Definitions

V.1.1. Accident
Bodily injury resulting from a sudden, fortuitous, external violent event beyond the insured's intentions, which directly produces bodily harm confirmed by a legally qualified doctor and which temporarily or permanently disables the insured.

V.1.2. Insured
The person on whom the insurance is established, who meets the corresponding conditions of adhesion required and who, in the absence of the Policyholder-Mutual Insurance Company, assumes the obligations arising from the contract.

V.1.3. Beneficiary
The natural or legal person designated as the holder of the right to compensation. The beneficiary will be the insured himself, unless expressly agreed otherwise in the Specific Conditions of the Policy.

V.1.4. Limits
The age limit for contracting is 60 years old and the warranty ends at 65 years old.

V.1.5. Actuarial age
The age of the Insured on their nearest birthday, in excess or default, on the effective date of the policy.

V.1.6. Illness
A supervening cause not derived from an accident involving a bodily injury confirmed by a legally qualified doctor, which requires medical assistance and which temporarily or permanently incapacitates the Insured to carry out a professional activity.

V.1.7. Congenital disease
Any disease with which the Insured is born, because it was contracted in the womb or because it has a genetic origin. A congenital condition may manifest and be recognized immediately after birth, or may be discovered later, at any period of the Insured's life.

V.1.8. Pre-existing disease
Any illness of the Insured suffered prior to taking out this insurance, whether or not diagnosed by a doctor.

V.1.9. Effective Date
This is the date on which the coverage agreed in the policy will come into force. In no case will the coverage come into force prior to the moment in which the Policyholder has paid the first premium, and both parties must comply with the terms and conditions established in Law 50/1980 of 8 October on Insurance Contracts.

Unless expressly agreed otherwise, the coverage will come into force at zero hours from the effective date and will end at the time of the loss or at zero hours from the expiration date.

V.2. Purpose
In the event of the death of the insured during the term of the policy, the Mutual Insurance Company is obliged to pay a monthly annuity, payable in arrears, for the annual amount expressed in the specific conditions until the date on which the beneficiary of this benefit has reached 23 years of age, or until the date of his death if this is before that age.

The Insurer undertakes to pay the Beneficiary the insured benefit in the event that the foreseen event occurs in the period established as the duration of the contract, which appears in the Particular Conditions.

The Insurer assumes the obligations of such payment in accordance with the General, Special and Particular Conditions of the policy.

V.3. Duration
The duration agreed for this policy is until the beneficiary(s) reach 23 years of age, unless the policyholder communicates in advance their desire to cancel the contract with one month's notice at its immediate annual expiry.

V.4. Excluded risks
The orphan's annuity benefit due to death will not take effect and the following risks are therefore excluded from coverage:

a) Suicide during the first year of the Insurance.
b) Air accidents, when the Insured is part of the crew and parachute descents that are not the result of an emergency situation.
c) Underwater navigation or exploration trips or high mountain expeditions.
d) Nuclear catastrophe, the consequence of nuclear reaction or radiation or radioactive contamination, and in the event of civil or international war, declared or not.

V.5. Conditions of adhesion
The conditions of membership will be those that appear in the registration document signed by the MUTUAL INSURANCE COMPANY and accepted by the policyholder. Compliance with the aforementioned conditions will be verified through the health questionnaire and, where appropriate, medical examination and other tests requested by the MUTUAL INSURANCE COMPANY.

V.6. Indisputability
This policy is indisputable commencing one year from its entry into force. Likewise, each of the upward modifications of the benefits of the contract are indisputable one year after its taking effect. However, when a medical examination is required as an essential requirement for

the issuance of the policy, the policy will be indisputable from the date of issue.

In the event of an inaccurate indication of the insured's age, the MUTUAL INSURANCE COMPANY may only challenge the relationship if his or her true age at the time of the entry into force of the policy exceeded the admission limits.

Otherwise, if as a result of an inaccurate declaration of age, the contribution paid is less than that which would be payable, the compensation will be reduced in proportion to the contribution paid. If, on the other hand, the instalment paid is higher than that which should have been paid, the MUTUAL INSURANCE COMPANY is obliged to refund the excess of the instalments received without interest.

V.7. Insured benefits

The amount of the insured annuities will be updated annually by the percentage established in the specific conditions. If nothing is indicated, it will be understood that they are constant.
Their amount will also be updated annually by the percentage established in the insurance application during the period of payment of the rent, in the event of a claim.

V.8. Payment of compensation

In the event of the death of the insured, the claim for compensation shall be accompanied by the following supporting documents:

a) Death certificate of the Insured.
b) Certificate from the doctor who has assisted the Insured indicating the origin, evolution and nature of the disease or accident that caused the death, or, where appropriate, testimony of the judicial proceedings or documents that prove the Death by Accident.
c) Certificate from the Registry of Last Will and, if applicable, a copy of the will or Judicial Act of Declaration of Heirs.
d) Document accrediting his/her status as a Beneficiary (ID card and Tax ID, Passport or similar).
e) Letter of settlement, total or partial, or declaration of exemption from Inheritance and Gift Tax.

The MUTUAL INSURANCE COMPANY reserves the right to request all kinds of additional information or evidence, including directly procuring it, to assess the appropriateness of the payment of compensation. The Insured's doctors are exempt from professional secrecy face to face with the Insurer with regard to the accident or illness that was the direct or indirect cause of death.

V.9. Processing of personal data

In compliance with the provisions of the General Data Protection Regulation of the European Union ('GDPR'), we provide you with the following information regarding the processing of the personal data of the applicant, policyholder, insured and/or beneficiary provided to Svrne, Mutual Insurance and Fixed Premium Reinsurance Company during the pre-contractual and/or contractual relationship, including health data.

Basic information on data protection	
Responsible entity	Svrne, Mutual Insurance and Fixed Premium Reinsurance ("**SVRNE**")
Purpose	• Management of the pre-contractual relationship and/or the insurance contract. • Carrying out commercial actions and sending commercial communications, including by electronic means, about other products marketed by SVRNE, as well as by any of the entities of the SVRNE Group. • Retain personal data in the event that the contractual relationship is not formalised, in order to manage future requests that may be made.
Standing (legal basis)	• Execution of the pre-contract and/or insurance contract. • Legitimate interest, so that the entity can offer you a more complete service and increase your degree of satisfaction. • Legitimate interest to manage and satisfy your possible queries or requests in the future.
Recipients	• Reinsurance entities for reinsurance purposes. Insurance brokers. • Medical professionals. • Public bodies. They may also have access to your data as data processors, their own agents (Group companies) or third-party agents, commercial service providers, professional services (e.g., expert firms, external lawyers), and IT service providers, as well as any other processor whose services are required for any additional management of the contract that may be necessary, including the management of the eventual performance that may be required.
International transfers	Your personal data will not be subject to any international data transfer.

Data categories and origin	• The personal data to be processed (including health data) are those provided within the framework of the pre-contract and/or insurance contract. • The data processed may relate to the policyholder and/or insured person, as well as to any third party natural person related to the insurance contract (i.e. third party insured persons, beneficiaries or injured parties).
Rights	You may exercise your rights of access, rectification, erasure, objection, restriction of processing and portability as indicated in the additional information.
Additional information	Further and detailed information on the processing of your data can be found at http://www.surne.es/es/privacidad.htm

V.10. Consortium Clause
Clause of compensation by the Insurance Compensation Consortium for losses arising from extraordinary events in personal insurance.

In accordance with the provisions of the revised text of the Legal Statute of the Insurance Compensation Consortium, approved by Royal Legislative Decree 7/2004, of 29th October, the policyholder of an insurance contract of those that must obligatorily include a surcharge in favour of the aforementioned public business entity has the power to agree on the coverage of extraordinary risks with any insurance company that meets the conditions required by current legislation.
The compensation derived from claims arising from extraordinary events occurring in Spain or abroad, when the insured person has his habitual residence in Spain, will be paid by the Insurance Compensation Consortium when the policy holder has paid the corresponding surcharges in his favour and any of the following situations occur:

a) That the extraordinary risk covered by the Insurance Compensation Consortium is not covered by the insurance policy taken out with the insurance company.
b) That, although covered by the said insurance policy, the obligations of the insurance company could not be fulfilled due to its having been declared judicially declared bankrupt or being subject to a liquidation procedure, intervened or assumed by the Insurance Compensation Consortium.

The Insurance Compensation Consortium will adjust its actions to the provisions of the aforementioned legal Statute, in the Law 50/1980, of the 8th October, on Insurance Contracts, in the Regulations of the Insurance Contracts Act, and in the Regulations of the insurance of extraordinary risks, approved by the Royal Decree 300/2004, of the 20th of February, and in the complementary provisions.

V.11. Summary of legal regulations:

V.11.1. Covered extraordinary events
a) The following natural phenomena: earthquakes and tidal waves; extraordinary floods, including those produced by sea; volcanic eruptions; atypical cyclonic storms (including extraordinary winds with gusts of more than 120 km/h and tornadoes); and falling sidereal bodies and aerolites.
b) Those caused violently as a consequence of terrorism, rebellion, sedition, riot and civil commotion.
c) Acts or actions of the Armed Forces or of the Security Forces and Corps in peacetime.

Atmospheric and seismic phenomena, volcanic eruptions and the fall of sidereal bodies shall be certified, at the request of the Insurance Compensation Consortium, by means of reports issued by the State Meteorological Agency (AEMET), the National Geographic Institute and other public bodies competent in the matter. In cases of events of a political or social nature, as well as in the event of damage caused by events or actions of the Armed Forces or of the Security Forces or Corps in peacetime, the Insurance Compensation Consortium may request information from the competent jurisdictional and administrative bodies on the events that occurred.

V.11.2. Excluded risks
a) Those that do not give rise to compensation according to the Insurance Contract Law.
b) Those caused to persons insured by an insurance contract other than those in which the surcharge in favour of the Insurance Compensation Consortium is obligatory.
c) Those produced by armed conflicts, even if the official declaration of war has not been preceded.
d) Those arising from nuclear energy, without prejudice to the provisions of Law 12/2011, of 27 May, on civil liability for nuclear damage or damage caused by radioactive materials.
e) Those caused by natural phenomena other than those indicated in section 1.a) above and, in particular, those caused by a rise in the water table, movement of hillsides, landslides or settlement of land, rock falls and similar phenomena, unless these were clearly caused by the action of rainwater which, in turn, had caused a situation of extraordinary flooding in the area and occurred at the same time as such flooding.
f) Those caused by riotous actions occurring in the course of meetings and demonstrations carried out in accordance with the provisions of Organic Law 9/1983, of 15 July, regulating the right of assembly, as well as during the course of legal strikes, unless the aforementioned actions could be classified as events other than those indicated in section 1.b) above.
g) Those caused by bad faith on the part of the insured person.
h) Those corresponding to losses occurring before the payment of the first premium or when, in accordance with that established in the Law of Insurance Contracts, the coverage of the Insurance Compensation Consortium is suspended or the insurance is terminated due to non-payment of premiums.

i) Losses which, due to their magnitude and seriousness, are classified by the National Government as a 'national catastrophe or calamity'.

V.11.3. Extension of coverage
a) The cover of extraordinary risks shall extend to the same persons and the same insured sums as have been established in the insurance policies for the purposes of the cover of ordinary risks.
b) In the life insurance policies that, in accordance with the provisions of the contract, and in accordance with the regulations governing private insurance, generate a mathematical provision, the coverage of the Insurance Compensation Consortium will refer to the capital at risk for each insured person, that is to say, to the difference between the sum insured and the mathematical provision that the issuing insurance company must have constituted. The amount corresponding to the mathematical provision will be paid by the aforementioned insurance company.

V.11.4. Notification of damages to the Insurance Compensation Consortium
a) The request for compensation of damages whose coverage corresponds to the Insurance Compensation Consortium, will be made by means of a notification to the same by the policy holder, the insured person or the beneficiary of the policy, or by whoever acts on behalf and in the name of the above, or by the insurance company or the insurance intermediary with whose intervention the insurance has been managed.
b) The notification of the damage and the obtaining of any information related to the procedure and the state of processing of the claims can be carried out:
- By calling the Insurance Compensation Consortium Call Center (900 222 665).
- Through the website of the Insurance Compensation Consortium (www.consorseguros.es).

c) Assessment of the damage: The assessment of the damage that may be compensated in accordance with insurance legislation and the contents of the insurance policy will be carried out by the Insurance Compensation Consortium, without the latter being bound by the assessments which, where appropriate, may have been carried out by the insurance company covering the ordinary risks.
d) Payment of compensation: The Insurance Compensation Consortium will make the payment of the compensation to the beneficiary of the insurance by means of a bank transfer.

SECTION VI. HOSPITALISATION AT SURNE'S EXPENSE

This Extract is for information purposes only and for any conflict or litigation the provisions of the General, Particular and Special Conditions, where applicable, of the Group Policy of the reinsurance contract will apply.

This insurance is contracted with the company SURNE, which will take charge, under the terms established in these conditions, of the claims covered by this policy that may occur.

VI.1. Insurer
The insurer of this section is the insurance company SURNE MUTUA DE SEGUROS y REASEGUROS a PRIMA FIJA which will be responsible, under the terms established in this Section, for the claims covered by this policy that may occur.

VI.2. Mediator
The one designated in the Particular Conditions

VI.3. Insured
The insured persons who make up the insured group of this policy and who have taken out this guarantee will be considered to be insured in this coverage.

VI.4. Accident
Bodily injury resulting from a sudden, fortuitous, external violent event beyond the Insured's intentions, which directly produces bodily harm confirmed by a legally qualified doctor and which temporarily incapacitates the Insured for his or her professional activity.

VI.5. Illness
A supervening cause not derived from an accident involving a bodily injury confirmed by a legally qualified doctor, which requires medical assistance, and which temporarily incapacitates the Insured for his or her professional activity.

VI.6. Purpose of the Insurance

VI.6.1. Medical Hospitalisation Compensation
SURNE will pay the beneficiary the daily allowance established in the Particular Conditions, in the event that the Insured is hospitalized in a clinic or hospital for more than 24 hours. In no case will the benefit for medical hospitalisation exceed 90 DAYS counted by nights of stay in a Clinic or Hospital Center from the beginning of hospitalisation.

VI.6.2. Compensation for surgical hospitalisation
SURNE will pay the beneficiary the daily compensation established in the Particular Conditions, in the event that the Insured is hospitalized

in a clinic or hospital for more than 24 hours due to a surgical intervention. In no case shall the benefit for medical hospitalisation exceed 90 DAYS counted for nights of stay in a Clinic or Hospital Center from the beginning of hospitalisation.

VI.6.3. Exclusions
a) Illnesses or accidents due to the voluntary use of drugs or narcotics or the consumption of alcoholic beverages or in a state of mental derangement or sleepwalking, and accidents occurring when there is a breathalyzer, understood as such when the legally permitted rates for the driving of motor vehicles are exceeded.
b) Self-harm, caused consciously or unconsciously, as well as suicide or attempted suicide.
c) Non-essential therapeutic or surgical treatments of an aesthetic nature, such as water treatments, rest, cosmetic surgery and sequelae derived from them, oral and dental implants and corrections, eye interventions to reduce myopia, astigmatism, hyperopia, as well as any other treatments of a similar nature to those described above.
d) Events that are legally considered to be an extraordinary or catastrophic risk, as well as officially declared epidemics.
e) Claims arising as a result of: professional and/or competitive exercise of any type of sport, understood to be the exercise of a sport for which the Insured is registered with the corresponding federation.
f) Illnesses or accidents caused by the Insured's participation in duels, challenges, bets or quarrels, unless, in the latter case, the Insured acts in self-defence (and is so declared by a final court decision). Injuries caused by criminal acts of the Insured or resulting from reckless negligence or gross negligence are also excluded.
g) Leave derived from the Insured being in a state of pregnancy, childbirth or miscarriage or that is the result of menstrual or menopausal disorders.
h) Neuropathies and pain that do not give objectifiable symptoms, as well as psychic, mental and/or psychosomatic diseases.
i) Diseases resulting from human immunodeficiency virus (HIV) infection and all its consequences.
j) In the event of childbirth, provided that this guarantee has been contracted, a single payment of three times the daily amount contracted will be paid. In this case and only for coverage that comes from production policies, a waiting period of 10 months is established

VI.6.4. Persons excluded from Insurance
People over 65 years of age will not be insurable. If the Insured reaches the age of 70 while the contract is in force, the guarantees of the policy will be automatically extinguished.

VI.6.5. Territorial scope
The guarantees of the policy are effective worldwide.

VI.6.6. Insurance Beneficiaries
The insured himself/herself.

SECTION VII. OTHER SUPPLEMENTARY GUARANTEES PROVIDED BY EUROP ASSISTANCE

VII.1. PAYMENT PROTECTION

Background information
VII.1.1. Service provider: EUROP-ASSISTANCE SERVICIOS INTEGRALES DE GESTIÓN (hereinafter EASIG).

VII.1.2. Preliminary information:
In compliance with the provisions of Article 96.1 of Law 20/2015, of 14 July, on the regulation, supervision and solvency of insurance and reinsurance companies and in Royal Decree 1060/2015, of 20 November, approving its Implementing Regulations, it is expressly stated that the information contained in this clause has been communicated to the Policyholder prior to the conclusion of the contract:
• That this insurance contract is entered into under the right of establishment with the Spanish Branch of the French insurance company Europ Assistance, a French public limited company regulated by the French Insurance Code, with a share capital of 46,926,941 euros, registered under number 451 366 405 RCS Nanterre, and domiciled at 2 Rue de Pillet-Will, 75009 Paris, France.

• Europ Assistance S.A., Spanish Branch is registered in the Administrative Register of Insurance Companies of the Directorate General of Insurance and Pension Funds under code E-0243 and has its registered office at Paseo de la Castellana 130, Floor 2, 8046 Madrid.

• That, without prejudice to the powers of the Directorate-General for Insurance and Pension Funds (DGSFP), the Member State responsible for the control of the Insurance Company is France and, within that State, the Authority responsible for control is the Autorité de Contrôle Prudentiel et de Résolution (ACPR), with its registered office at 4, Place de Budapest, CS 92459, 75436 Paris Cedex 09, France.

VII.1.3. Preliminary Information
Applicable Law Member State, Supervisory Authority (Art. 96 LOSSEAR)
• The General and Particular Conditions of this insurance contract are governed by the provisions of Law 50/1980 of 8 October on Insurance Contracts, by Law 20/2015 of 14 July on the regulation, supervision and solvency of insurance and reinsurance companies and by Royal Decree 1060/2015 of 20 November which develops it with regard to death insurance as a branch of service provision. **Clauses limiting the rights of the Insured that have not been expressly accepted in writing by the Policyholder and which are specially highlighted in bold type shall not be valid.**

• The liquidation of Europ Assistance S.A. Spanish Branch is not subject to Spanish law. The report on the financial situation and solvency is available on the insurance company's website

The Member State where the risk is located is Spain and the authority responsible for the control of the insurance company is the DIRECTORATE GENERAL FOR INSURANCE AND PENSION FUNDS (DGSFP).

Internal and external bodies for claims and dispute resolution
In compliance with the provisions of articles 96 of Law 20/2015, of 14 July, on the Regulation, Supervision and Solvency of Insurance and Reinsurance Entities and 123 of its implementing regulations (Royal Decree 1060/2015, of 20 November, on the Regulation, Supervision and Solvency of Insurance and Reinsurance Entities), the Insurer informs on the following issues:

Internal Complaint instances:
In the event that you would like to submit a complaint or claim related to your legally recognised interests and rights, you may address it, in writing, to:

VII.1.4. Customer Service
EUROP ASSISTANCE provides Insured Persons with a Claims Service, the Regulations of which can be consulted on the www.europ-assistance.es website. Policyholders, insured parties, beneficiaries, injured third parties or successors of any of the above may file complaints, in the "Customer Defense" section of the website, or by writing to the
Complaints Service:
Claims Service
Address: Paseo de la Castellana, 130 – Floor 2. 28046 Madrid.

In all cases, please provide your policy number and/or claim number.
Once we receive your complaint, we will send you a written acknowledgement of receipt, setting out the statutory deadlines for resolving your complaint.

The regulations applicable to this procedure are Order ECO/734/2004, of 11 March, on customer service departments and services and the customer ombudsman of financial institutions. The Operating Regulations of the Customer Service are available to customers at ACTIVE's address.

External claim instances:
In the event of a dispute, the Insured may claim before the Court of First Instance corresponding to their domicile in accordance with Article 24 of the Insurance Contract Act.

In addition, the parties may voluntarily submit their differences to arbitration under the terms of articles 57 and 58 of the revised text of the General Law for the Protection of Consumers and Users and other complementary laws, approved by Royal Legislative Decree 1/2007, of 16 November. In any case, and except in those cases in which consumer and user protection legislation prevents it, they may also submit litigious matters to arbitration, in accordance with the terms of Law 60/2003, of 23 December, on Arbitration.

They may submit their disputes to a mediator under the terms set out in Law 5/2012, of 6 July, on mediation in civil and commercial matters.

Furthermore, and notwithstanding the actions to be brought before the Courts, Policyholders, Insured Parties and Beneficiaries, in the event of not obtaining a response from the Insurer's Customer Care Service within two months from the filing of the complaint or claim, or in the event of disagreement with the decision handed down, or if they consider that the Insurer has violated their rights under the insurance contract, they may file a claim, pursuant to Article 119 of Law 20/2015 of 14 July, on the regulation, supervision and solvency of insurance and reinsurance companies, and in accordance with Order ECC/2502/2012, of 16 November and other applicable regulations, before the Directorate General of Insurance and Pension Funds. The contact details are as follows:

Dirección General de Seguros y Fondos de Pensiones (Servicio de Reclamaciones)
Paseo de la Castellana 44, 28046 Madrid – Spain
Tel: 952 24 99 82
https://www.sededgsfp.gob.es/SedeElectronica/Reclamaciones/Reclamacion.asp
https://www.sededgsfp.gob.es/es/Paginas/Procedimiento.aspx?p=18

To file such a complaint, you must have previously filed a complaint with the insurer's customer service and not received a response within two months of filing the complaint, or you can file such a complaint if the decision was contrary to your requests and you are still dissatisfied. If you have purchased your insurance online, you can also file a complaint through the EU's Online Dispute Resolution (ODR) platform. The website of the ODR platform is www.ec.europa.eu/odr.

Information clause regarding the processing of personal data
WHO IS RESPONSIBLE FOR THE PROCESSING OF YOUR DATA?
Europ Assistance, S.A., Spanish Branch (hereinafter, the "Insurance Company")
CIF: W-2504100-E

Address: Paseo de Castellana, number 130, 28046 Madrid.
Data Protection Officer (DPO): you can contact the DPO by writing to the Address of the Insurance Company, indicating in the reference "Data Protection Officer", or by writing to the email address delegadoprotdatos@europ-assistance.es

FOR WHAT PURPOSES WILL YOUR PERSONAL DATA BE PROCESSED?:
The processing will be mixed (automated and non-automated processing) and for the following purposes:
- Carry out the fulfilment and development of the contractual relationship derived from the policy.
- Accounting, tax and administrative management of the policy.
- Collection of premiums and submission of other invoices.
- Carrying out direct debit orders from your account.
- Carrying out commercial and marketing actions of other products and services of the Insurance Company.
- Preparation of customer satisfaction studies.
- Preparation, drafting and issuance of insurance documentation.
- Carrying out risk and accident analysis.
- Carrying out the necessary assessments after the occurrence of a claim or event covered by the policy contracted.
- Carrying out internal expert reports or through third parties.
- Settlement of claims or performance of contractually agreed services.
- Carrying out any legally enforceable or contractually agreed obligation.
- Carrying out actions aimed at the prevention, detection or prosecution of fraud.
- In the event of non-payment, incorporation into solvency files and common files determined by the applicable sectoral regulations.
- Actuarial statistical collaboration for the preparation of insurance technique studies.

WHAT IS THE LEGITIMACY FOR THE PROCESSING?
- Execution of a contract between the Policyholder, the insured and/or beneficiaries and the Insurance Company.
- Legitimate Interest.
- Legal Obligation.

WHO ARE THE RECIPIENTS OF YOUR DATA?
- The companies of the Insurance Company Group, in the insurance sector.
- The bank of the Insurance Company and the companies of its Group and the bank of the owner of the data to make the direct debit order effective in accordance with current regulations.
- Entities that act as an insurance intermediary or distributor for the management of insurance policies processed by such entity.
- The providers chosen by the Insurance Company whose intervention is necessary for the management of the care covered by the policy.
- The SEPBLAC, in order to comply with the legally established requirements.
- The Directorate-General for Insurance and the Pension Fund, in accordance with the provisions established by law.
- The Tax Administration with competence in the matter for the fulfilment of strictly legal and fiscal purposes.
- The Public Administrations in relation to the powers attributed to them.
- In the case of death coverage insurance, the General Register of Last Wills, managed by the General Directorate of Registries and Notaries, in accordance with the applicable regulations on the matter.

COMMERCIAL COMMUNICATIONS
In accordance with the provisions of article 21.2 of Law 34/2002, of 11 July, on information society services and electronic commerce, you are informed that the Insurance Company may send you information and advertising about products or services marketed by it that are similar to the one you contracted. The interested party may object, at any time, to the sending of such electronic commercial communications, by sending an e-mail, indicating in the subject "UNSUBSCRIBE COMMUNICATIONS" to the following address: baja.cliente@europ-assistance.es

PROCESSING OF HEALTH DATA
The Insurance Company informs you that, in order to manage claims arising from the policy and the coverage included therein, it is necessary to process personal data relating to your health, whether obtained through the health questionnaire or any other that may be provided in the future during the term of the contractual relationship or that the Insurance Company may obtain from third parties (whether from public health centers or private or other health professionals, both national and international, of additional medical examinations or examinations that may be required by the Insurance Company or other public or private entities).

PROCESSING OF THIRD-PARTY DATA
In the event that data relating to third parties is provided, the policyholder must have obtained their prior authorisation in relation to the transmission of the data to the Insurance Company for the purposes agreed in this document.

HOW LONG WILL WE KEEP THE DATA?
The personal data provided will be kept for the time necessary to fulfil the purpose for which they were collected and to determine the possible responsibilities that may arise from the purpose.
In this regard, the criteria that Europ Assistance S.A, Sucursal en España uses to set the data retention periods are determined in accordance with the requirements established in the applicable legislation and regulations.

In particular, the legislation on the Prevention of Money Laundering and Terrorist Financing, if applicable, establishes the obligation to keep

data for a period of ten years and commercial regulations establish a retention period of six years from the termination of the contract entered into between the parties.

WHAT ARE YOUR RIGHTS?
The user, at any time and free of charge, may write to the address indicated in the header of this Privacy Policy or to the following email: delegadoprotdatos@europ-assistance.es, attaching a photocopy of their identity document, to:
• Access your personal data and obtain confirmation as to whether Europ Assistance S.A., Spanish Branch, is processing the user's personal data.
• Rectify inaccurate or incomplete data.
• Request the deletion of your personal data when the data is no longer necessary for the purposes for which they were collected, or object to processing.
• Obtain from Europ Assistance S.A, Spanish Branch, the limitation of the processing of the data in the cases provided for in the regulations.
• Request the portability of your data.
• Revoke, where appropriate, the consent given.
• Obtain human intervention, express their point of view and challenge automated individual decisions, including profiling, that produce legal effects on them or significantly affect them.
You can also file a complaint with the Spanish Data Protection Agency, in case you consider that your rights recognised by data protection regulations have not been respected, located at Calle Jorge Juan 6, 28001, Madrid.

VII.1.5. Definitions

VII.1.5.1. Insurance company
EUROP ASSISTANCE S.A. Spanish Branch (EUROP ASSISTANCE), acting as an Insurance Company (hereinafter the Insurer)

VII.1.5.2. Policyholder
The natural or legal person who, together with the Insurance Company, signs this Contract, and to whom the obligations arising from it correspond, except for those that by their nature must be fulfilled by the Insured and/or Beneficiaries.

VII.1.5.3. Insurable Group
A group of individuals who have some common characteristic that is extraneous to the purpose of insuring and who meet each of the conditions to be able to be Insured.

VII.1.5.4. Insured Group: Set of Insured Persons included in the Insurance.

VII.1.5.5. Insured
An individual residing in Spain (staying in Spanish territory for more than 183 days in a calendar year), beneficiary of the coverage of the Policy.

VII.1.5.6. Beneficiary
The natural or legal person or persons who are entitled to receive the insured benefits at the time of the contingency provided for in the Policy.

VII.1.5.7. Policy
It is the document that contains the regulatory bases of the Insurance, forming part of it, the General Conditions, Particular Conditions, Supplements and Annexes.

VII.1.5.8. Insured Amount
Amount of compensation in the event of a claim. This amount is set out in the Particular Conditions of the Policy.

VII.1.5.9. Premium
This is the total cost of insurance.

VII.1.5.10. Accident
Bodily injury that derives directly from a fortuitous, external, violent event beyond the Insured's intentions, which occurs during the term of the policy and gives rise to a situation guaranteed by the policy.
For the purposes of this policy, the following will be considered an Accident:

- Electric shocks and lightning.
- Poisoning, asphyxiation, burns or injuries caused by involuntary inhalation of gases or vapours, immersion or immersion or by ingestion of liquid, solid, toxic or corrosive matter.
- Infections, when the pathogenic agent has penetrated the body due to an injury caused by an accident covered by the policy, as long as the cause-effect relationship can be reliably demonstrated.
- Attacks that are not covered by the Insurance Compensation Consortium are also covered
- Flight Coverage, accidents that the Insured may suffer when traveling as a passenger of an air transport company, duly authorized, are covered, provided that the aircraft is piloted by personnel with a valid and valid pilot license and (I) that the aircraft is on a regular or "charter"

flight between airports conditioned for passenger traffic, or (II) that the aircraft is parked on the runways of the aforementioned airports, or (III) that the aircraft is performing any type of maneuver in them.

VII.1.5.11. Illness
Any alteration in the state of health whose diagnosis and confirmation is made by a legally recognised doctor, whose first manifestations occur during the term of the Policy and which requires the assistance of a medical doctor. Pregnancy, childbirth or miscarriage or complications arising from these concepts and the periods of voluntary and compulsory rest that may apply in the event of maternity or the situation of leave requested by the Insured will not be considered an illness for the purposes of this Insurance.

VII.1.5.12. Hospital
A legally authorized institution for the medical treatment of illnesses or bodily injuries, providing continuous medical and nursing assistance 24 hours a day for the care of the sick or injured. For the purposes of this guarantee, rest homes, hotels, asylums, convalescent homes, psychiatric hospitals or institutions dedicated to the internment or treatment of drug addicts or alcoholics will not be considered hospitals.

VII.1.5.13. Hospitalisation
An Insured is considered to be hospitalised when they are listed as a patient in a Hospital, as defined in the previous section, for a period of more than 24 hours.

VII.1.5.14. Unemployment
Situation in which those who, being able and willing to work for remuneration as an employee, lose their job and are deprived of their salary, according to the conditions established in the Policy.

VII.1.5.15. Temporary disability
Temporary physical situation caused by illness or accident determining the Insured's inability to exercise his profession or work activity.

VII.1.5.16. Waiting period
The waiting period is understood to be the time that must elapse from the date on which the Insurance takes effect until the start of the coverage of a guarantee.

VII.1.5.17. Deductible
Deductible is understood to be the period of time from the date of occurrence of the claim, during which the Insurance Company is exempt from payment of the insured capital.

VII.1.5.18. Employment relationship
Salaried work carried out by the Insured within the territory of the Spanish State under an employment contract carried out with an employer for a minimum of 16 hours per week and under the terms and conditions required by the applicable labour legislation.

VII.1.5.19. Insurance Annuity
It corresponds to the annual period counted from each renewal of the Contract. The first annuity will be from the effective date of this contract.

VII.1.5.20. Loss
Event that may give rise to the receipt of compensation for the coverage of the policy. The set of damages and/or losses derived from the same cause constitute a single and the same loss.

GENERAL CONDITIONS

VII.1.6. Basis of Contract
If the content of the policy differs from the insurance proposal or the agreed clauses, the Policyholder may request within one month of receipt of the policy that the Insurer correct the existing divergence. If this period has elapsed without making the claim, the provisions of this policy (Alt 8 LCS) will apply.

VII.1.7. Effective date and duration of the Contract
The contract is concluded with the consent of the contracting parties. The coverage contracted and its modifications will take effect on the date indicated in the Policy Conditions, provided that the receipt of the premium has been paid. In the event of delay in complying with this requirement, the obligations of the Insurance Company will begin 24 hours after the day on which the payment has been made.

VII.1.8. Insurance premium
The insurance premium will be charged to the means of payment provided by the policyholder for this purpose. The insurance premium will be as indicated in the Conditions of the Policy. **The Insurance Company reserves the right to revise the premium rate applied to this insurance contract, which will be communicated to the Policyholder in a timely manner.**

VII.1.9. Contracting rules
To form part of the insurable group

VII.1.10. Purpose and Guarantees of the Insurance
By this contract, the Insurance Company undertakes to pay the guaranteed benefit to the Beneficiaries, in the event of the occurrence of the covered risks. The Insurance offers the following guarantees:

VII.1.10.1. Unemployment Guarantee
This guarantee is applicable to all natural **persons, aged between 18 and 65 (both inclusive), who maintain an indefinite employment relationship, for a minimum of 16 hours per week and with a minimum of 12 months of seniority in the company, provided that they have been unemployed for at least 90 consecutive days. Civil servants dependent on any of the Public Administrations and workers with permanent discontinuous contracts are excluded. In the event of Unemployment of the Insured, the Insurance Company will pay the guaranteed capital for this coverage.**

To be entitled to receive this benefit, the limitations and exclusions specified in the "Excluded Risks" section must be met.
It is expressly stated that the waiting and grace periods established for this Guarantee in the Particular Conditions will apply.
The fact that the maximum benefit established for this guarantee has been paid entails the automatic termination of the coverage of the Policy and consequently the rest of the guarantees thereof. The right to the accrual of the compensation shall cease at the time when the Insured is able to resume his work, even partially, or begins to perform any other type of remunerated work.

VII.1.10.2. Temporary Disability Guarantee
This guarantee is applicable to all **people, aged between 18 and 65 (both inclusive), with paid employment who cannot be covered by Unemployment, and have been in a situation of temporary disability for at least 90 consecutive days.** In the event of Temporary Disability, the Insurance Company will pay the guaranteed capital for this coverage.

The Temporary Disability covered by the Policy must be diagnosed, both in its cause and in the resulting disability for the Insured:

a) By a competent Social Security doctor or similar, in the case of employed or self-employed workers who contribute to Social Security.
b) By a medical professional authorised by the Insurance Company for all other cases.

There may not be any type of family relationship between the issuer of the certificate and the insured unless authorised by the Insurance Company, and in no case may the insured himself be the issuer of the report. The Insured is obligated to submit to the examination of the doctors designated by the Insurer, if the latter deems it necessary, in order to complete the reports provided and to travel at the Insurer's expense to the corresponding place for such examination to be carried out. **The right to the accrual of compensation will cease as son as the Insured is able to resume his/her work, even partially and despite not having reached his full recovery or when the Insured begins to perform any other type of paid work.**

It is expressly stated that the waiting and grace periods established for this Guarantee in the Particular Conditions will apply.

Same Claim: In the event of new situations of Temporary Disability, **the Insured will only be entitled to new benefits if (I) they have been working for a minimum period of three months and, (II) provided that it is a different cause than the one that caused the previous loss. Otherwise, no amount will be paid due to a new situation of Temporary Disability, as it will be considered to be the same claim.**

The fact that the maximum benefit established for this guarantee has been paid entails the automatic termination of the coverage of the Policy and, consequently, of the rest of the guarantees of the same.

VII.1.10.3. Hospitalisation Guarantee
This guarantee is applicable to all **people, aged between 18 and 65 (both inclusive), without paid work who cannot be covered by either the Unemployment Guarantee or the Temporary Disability Guarantee.** When the Insured has to be admitted to a Hospital, for a minimum of 7 consecutive days, as a result of an Accident or Illness covered by the Policy, the Company will pay the guaranteed compensation. In the event of hospitalisation of the Insured, the Insurance Company will pay the guaranteed capital for this coverage.

It is expressly stated that the waiting and grace periods established for this Guarantee in the Particular Conditions will apply.

VII.1.10.4. Accidental Bone Fracture Guarantee

For the purposes of this contract, Accidental Bone Fracture is understood to be the complete break of bones produced as an immediate consequence of an Accident occurring during the term of the insurance, and **provided that the consequences of the Accident are manifested within 30 days from the date of the accident.**

An accident is understood to be any bodily injury that can be determined by doctors in a certain way suffered by the Insured regardless of his/her will, by the sudden and violent action of or with an external agent. For the purposes of the coverage of the policy, it is expressly stated that a complete break is one in which a fracture occurs where the bone is completely broken.

The Company will pay the contracted coverage, if during the Term of the Payment Protection Insurance, as a direct consequence of a covered Accident and **within thirty (30) days following the date of the same,** the Insured suffers any of the complete bone fractures mentioned below: Skull, Face Bones (except teeth), Cervical Spine, Thoracic and Lumbar Spine. Sacral and Coccyx Bones, Ribs, Sternum, Pelvis, Clavicle,

Shoulder Blade (Scapula), Humerus, Radius, Ulna, Carpal or Metacarpal Bones, Femur, Tibia and Fibula, Tarsal and Metatarsal Bones, Patella or Hip.

This guarantee only applies to people between the ages of 65 and 75.

It is hereby stated that there is no waiting or grace period for this guarantee.

VII.1.11. EXCLUDED RISKS

It is hereby stated that, unless expressly agreedor otherwise stipulated in the Particular Conditions of the Policy, and in addition to the exclusions that may be stipulated in said Conditions, claims due to any of the following causes are expressly excluded from the coverage of all the guarantees of the Policy:

a) Claims suffered by the Insured caused by reaction, nuclear radiation or radioactive contamination.
b) As a professional, any sport, and unless expressly agreed, as an amateur, ski mountaineering and/or water skiing, climbing, boxing, scuba diving, polo, equestrian competitions, big game hunting and any sport that involves air risk.
c) The consequences of illness or accident arising prior to the entry into force of this Insurance known to the Insured.
d) Direct participation of the Insured in civil or international war that takes place in national or foreign territory.
e) War risks and other extraordinary risks, classified as such by the Legal Statute of the Insurance Compensation Consortium, approved by Law 21/1990 of 19 December 1990 and complementary legislation.
f) Myocardial infarction is not considered an accident.
g) Human Immunodeficiency Virus (HIV) or any other form of Acquired Immunodeficiency Syndrome virus (AIDS).
h) Accidents suffered by the Armed Forces or the Security Forces and Corps during the exercise of their profession.
i) Claims intentionally caused by the Insured.
j) Any accident that occurs while the insured is under the influence of alcoholic beverages, drugs, narcotics, psychotropic substances, stimulants and other similar substances. For the determination of such influence, regardless of the type of accident in question, the limits set by the applicable legislation on the circulation of motor vehicles and road safety at the time of its occurrence shall be applied.
k) Those suffered by the Insured and derived from acts that could be classified as a crime or attempt to commit it, from races or bets, challenges or fights in which the Insured actively participates; unless the Insured, in the event of a fight, has acted in self-defence or in an attempt to rescue persons or property.

For the Unemployment Guarantee: Insured Persons who are in any of the following employment situations are excluded from this coverage and are not considered to be unemployed:
a) When they voluntarily cease work, except for the reasons provided for in articles 40 (geographical mobility), 41 (substantial modifications of working conditions) and 50 (termination by the worker's will) of the Workers' Statute (RDL 1/1995 of 24 March).
b) When they have been dismissed and do not file a due and timely complaint against the company's decision, except for termination of the contract or dismissals based on the objective causes provided for in article 52 of the Workers' Statute (ROL 1/1995 of 24 March) in which case such a claim is not necessary.
c) When the dismissal has been declared unfair or null and void by a final judgment and the employer has notified the date of return to work, this right is not exercised by the Insured or the actions provided for in current legislation are not used, where appropriate.
d) When reinstatement to the job is not requested within the appropriate period and time, provided that the choice between compensation or reinstatement corresponds to the worker, when he or she is a union delegate or legal representative of the workers, or is on leave and the period set for it has expired.
e) When the contract is terminated due to the expiration of the agreed time and/or performance of the work or service object of the contract.
f) When the contract is terminated due to the retirement of the employer of the Insured employee without there being continuity of the business activity, provided that the worker previously knew the date of retirement of the employer.
g) When there is a legally fair dismissal.
h) Permanent workers of a discontinuous nature in periods in which they lack effective employment.
i) If the employment relationship is with a company owned by his or her family, up to the second degree of consanguinity or affinity, as well as in cases where the Insured or a relative of his/hers up to the second degree of consanguinity or third degree of affinity is the director of the Company, and also if the Insured is a partner or shareholder with a direct presence in the company's administrative bodies.
j) If the Insured rejects an alternative position of similar characteristics offered by the same or another employer, taking into account the training, experience and location of said job.
k) If the Unemployment occurs after the Insured has reached the legal retirement age with respect to the activity carried out and meets all the legal requirements necessary to access the Retirement pension.
l) As long as the Insured receives or is entitled to receive a salary from the employer. Salary supplements agreed collectively in the contract suspension proceedings will be exempt from this case.
m) All situations of unemployment or inactivity of the Insured that do not constitute Unemployment as defined in these General and Particular Policy Conditions.
n) Likewise, the Insured is not entitled to receive unemployment benefits in any of the following cases:

1. If at the time of or before the effective date of the Insurance or within the Waiting Period, the Insured is aware of their possible transition to a situation of unemployment.

2. If immediately prior to the date of onset of unemployment, the Insured:
- Has not had an employment relationship for a continuous period of at least 12 months prior to taking out the policy, in the case of the first incident that occurred.
- Has been bound by an employment relationship in which dismissal is a regular or recurring feature.
- Knew or should have known about his/her immediate transition to unemployment.
o) If the insured's age is not included among those established for this Guarantee in the "Coverage" Article of the Particular Conditions.

For the Temporary Disability Guarantee: Claims that are consequences of or resulting from the following situations are excluded from this coverage:
a) Those that occur within the Waiting Period.
b) Injuries or illnesses that are self-inflicted or caused voluntarily by the Insured or by third parties with their connivance, whether in a state of sanity or dementia.
c) Observation periods and their assimilated or equivalent periods in cases of Illness when the person is not prevented from working under the terms described in the Policy.
d) Those produced when the Insured is under the influence of alcohol in the blood, toxic drugs or narcotics; those that occur in a state of mental disturbance, somnambulism or in defiance, struggle or quarrel, except in a proven case of self-defense, as well as those derived from a criminal act of the Insured declared judicially.
e) When the claim arises from any Illness, ailment, condition or injury for which the Insured has received medical consultation, diagnosis or treatment prior to the entry into force of the insurance guarantees.
f) Pathologies secondary to herniations and injuries derived from musculoskeletal alterations or defects such as: neck pain, back pain, low back pain, lumbosciatica or any other with the same origin unless they occur with trauma.
g) Psychiatric, mental, or nervous diseases, including stress, and similar conditions, even when such diseases and conditions have been diagnosed and treated by a medical specialist.
h) Surgical interventions and medical and/or dental treatments that are not essential for medical reasons and are demanded by the Insured for psychological, personal and/or aesthetic reasons, provided that they are not due to the sequelae of accidents occurring after the effective date of the insurance.
i) The consequences or psychic sequelae of an accident.
j) Those derived from or directly or indirectly related to officially declared epidemics.
k) Thermal or dietary rest cures.
l) If the Insured's age is not included among those established for this Guarantee in the "Coverage" Article of the Particular Conditions.

For the Hospitalisation Guarantee: Claims resulting from or resulting from the following situations are excluded from this guarantee:
a) Chronic, congenital and pre-existing diseases that have been known, treated or diagnosed prior to the contracting of said Policy.
b) Gynecological conditions.
c) Unless expressly agreed, gestation, miscarriage and its consequences.
d) Periodic or follow-up medical exams. Dental cure or prosthesis. Physiotherapy cure.
e) Cosmetic surgery operations, except those prescribed by a medical professional, authorized by the Company, as a result of an Accident.
f) Mental illnesses, nervous diseases, alcoholism or drug addiction, sleep or rest cures.
g) If the insured person's age is not included in those established for this Guarantee in the "Coverage" Article of the Particular Conditions.

For the Accidental Bone Fracture Guarantee: Cases in which the Bone Fracture derives from any of the circumstances excluded in the Temporary Disability coverage or occurs as an immediate or mediate consequence of osteoporosis are excluded.
Finally, it should be noted that for the purposes of this insurance, Illness will not be understood and therefore excluded from all coverages to be: pregnancy, childbirth or miscarriage or complications arising from these concepts and the periods of voluntary and compulsory rest that may apply in the event of maternity, or the situation of leave requested by the Insured.

VII.1.12. Payment of the insured benefit
If the Insured has another insurance policy that covers the same risks, they must inform the Insurance Company of this at the time of making their claim processing request.

Likewise, for the payment of any of the benefits guaranteed by the policy, the Insured person must present the documentation that proves his/her insured status.

Likewise, for each of the guarantees the following is established:

VII.1.12.1. UNEMPLOYMENT GUARANTEE
The period for reporting the claim to the Insurance Company established in the Conditions is 20 days from the start of the Unemployment, sending written notification of the facts on which the claim request is based. In the event of non-compliance, the Insurer may claim damages caused by the failure to declare.

Documentation to be submitted
For the payment of the corresponding benefit, the following documentation must be submitted:
a) Written communication to the Insurance Company.
b) Photocopy of the Insured's ID card.

c) Photocopy of the last contract of indefinite employment on the date of the accident.
d) CERTIFICATE OF EMPLOYMENT HISTORY from 30 days from the legal date of Unemployment.
e) Letter of communication from the Company stating Insured's termination from employment.
f) For unfair dismissal:
- Without SMAC (Mediation, Arbitration and Conciliation Service): Letter of communication from the Company acknowledging the unfairness of the dismissal, including the recognition of compensation.
- Before the SMAC (Mediation, Arbitration and Conciliation Service): Copy of the Conciliation Act.
- Before the Judge: Copy of the Claim and Court Judgment.
g) By Employment Regulation File:
- Copy of the Administrative Authorization for the file.
- Copy of the company's communication to the worker that he or she is going to be dismissed.
h) Document of acceptance of payment of unemployment benefit by the National Employment Service.

Continuity of the claim
The Insured or their legal representative must submit to the Insurance Company the documentation accrediting the Unemployment on which the claim is based.

In the event that the aforementioned documentation is NOT delivered, the Insurance Company will not continue to pay any benefit. The payment of the benefit will only be made once the Insurance Company has received and approved the corresponding documentation.
Once the payment of the benefit by the Insurance Company has begun, the Insured must submit documentation proving the continuity of the Unemployment situation on a monthly basis in order to be entitled to receiving the established monthly Benefit payment.

Conditions of payment of the benefit
When the Insurance Company has received the documentation proving that the Insured is unemployed, in accordance with these Policy Conditions, it will pay the insured amount. The limits of the aforementioned amount are those established in the Particular Conditions of the Policy. The latter may be updated on each anniversary of the insurance contract. The payment of the benefit will cease on:
- The date in which the Insurance Company has reached the maximum compensation limit for all the claims established in the Covered Risks section.
- The date in which the Insured reaches the age limit established in Particular Conditions for this guarantee.

VII.1.12.2. TEMPORARY DISABILITY GUARANTEE
The period for communicating the claim to the Insurance Company will be extended to 20 days from the date of diagnosis of the Temporary Disability, sending written notification of the facts on which the claim is based. In the event of non-compliance, the Insurer may claim damages caused by the failure to declare.

Documentation to be submitted
For the payment of the corresponding benefit, the following documentation must be submitted:
a) Written communication to the Insurance Company.
b) Photocopy of the Insured's ID card.
c) Initial sick leave report issued by the Social Security or Certificate of Sick Leave if you belong to a Mutual Insurance Company.
d) Medical reports related to the origin and development of the Temporary Disability.
e) Updated Certificate of Employment History.

The Insured must inform the Insurance Company about the circumstances and consequences of the claim and allow visits by the Insurer's doctors, as well as provide the Insurance Company with any information that the latter requests. If there is no agreement between the Insurance Company and the Insured on whether the Insured is in a situation of Temporary Disability, the divergence will be resolved in accordance with the provisions of Articles 17 and 38 of the LCS. The documents indicated in points c) and d) must be sent monthly.

Claim Continuity
The Insured or their legal representative must submit to the Insurance Company the documentation accrediting the Temporary Disability on which the claim is based. **In the event that the aforementioned documentation is NOT delivered, the Insurance Company will not continue to pay any benefit.**

The payment of the benefit will only be made once the Insurance Company has received and approved the corresponding documentation.
Once the payment of the benefit has been initiated by the Insurance Company, the Insured must submit documentation accrediting the continuity of the situation of Temporary Disability on a monthly basis, in order to be entitled to the payment of the established monthly benefit.

To achieve this, the Insured must provide monthly the Temporary Disability Continuation Report issued by the Social Security doctor or the doctor in charge of their cure (there may not be any type of family relationship between the issuer of the certificate and the insured unless authorised by the Insurance Company, and in no case may the Insured himself be the issuer of the report).

Conditions of payment of the benefit
In the event of an accident that entails the Temporary Disability of the Insured under the terms established in the policy, the Insured will be

entitled to payment of the benefits provided that the following conditions are met:

a) That the cause of the Temporary Disability is the Illness, Accident or injuries that begin or occur during the term of the coverage of this contract and before its end and that those causes occur when the Insured is working for pay in Spain.
b) That at the time of diagnosis the Insured is registered with the Social Security, Mutual Insurance Company, Montepío or similar institution that the legislation determines with coverage of the Temporary Disability risk.
When the Insurance Company has received the documentation proving that the Insured is in a situation of Temporary Disability, in accordance with these conditions of the Policy, it will pay the sum insured. The aforementioned amount will be limited to the amounts established in these Conditions.

The Insurance Company will pay the compensation provided, **until the first of the following dates:**

- The date on which the Insured ceases to be in a situation of Temporary Disability or ceases to provide the evidence requested by the Insurance Company that he or she is in such a situation.
- The date on which the Insurance Company has reached the maximum limit of compensation for the same claim in the Covered Risks section.
- The date on which the Insurance Company has reached the maximum compensation limit for all claims established in the Covered Risks section.
- The date on which the Insured reaches the age limit established in Particular Conditions for this guarantee.
- The date on which the worker begins to perform any other type of paid work, even partially.

VII.1.12.3. HOSPITALISATION GUARANTEE
The period for reporting the claim to the Insurance Company established in the Conditions is 20 days from the start of the Hospitalisation, sending written notification of the facts on which the claim request is based. In the event of non-compliance, the Insurer may claim damages caused by the failure to declare.

Documentation to be submitted
a) Request for compensation with all the Insured's identification data.
b) The medical certificate specifying the causes that forced hospitalisation.
c) The certificate from the Clinic or Hospital, indicating the dates of admission and discharge.

Claim Continuity
The Insured or his/her legal representative must provide the Insurance Company with the documentation accrediting the Hospitalisation in support of the claim.

In the event that the aforementioned documentation is NOT delivered, the Insurance Company will not continue to pay any benefit.

The payment of the benefit will only be made once the Insurance Company has received and approved the corresponding documentation.

Conditions of payment of the benefit
When the Insurance Company has received the documentation proving that the Insured is in a situation of Hospitalisation, in accordance with these Conditions of the Policy, it will pay the sum insured.

The maximum amount of the premium to be reimbursed by the Insurer will be 400 Euros and in no case may it exceed the premium paid in the previous year. In the event that the Insured does not remain for the minimum period described, the right to receive the benefit will not be generated.

The Insurance Company will pay the compensation provided, **until the first of the following dates:**
- The date on which the Insured is discharged from the hospital or fails to provide the supporting documents requested by the Insurance Company that they are in such a situation.
- The date on which the Insurance Company has reached the maximum compensation limit for the same claim established in the Covered Risks section.
- The date on which the Insured reaches the age limit established in Particular Conditions for this guarantee.

VII.1.13. Communications

VII.1.13.1. Communications to the Insurer shall be sent to the registered office of the same as stated in the Policy. Communications and payment of premiums made by the Policyholder to an Agent representing the Insurer shall have the same effects as if they had been made directly to the Insurer.

VII.1.13.2. Communications made by an Insurance Broker to the Insurer shall have the same effects as if they were made by the Policyholder himself, unless otherwise indicated by the Policyholder.

VII.1.13.3. Communications from the Insurer to the Policyholder, Insured or Beneficiary shall be made at the address of the same listed in the Policy.

VII.1.14. Insurance Bases – Reservation or Inaccuracy in Declarations
In the event of a reservation or inaccuracy in the statements of the Policyholder or the Insured or Insured Persons when completing the Insurance Application prepared by the Insurance Company, the Insurance Company may terminate the Contract within a period of one month from when it realices such reservation or inaccuracy, proceeding to send a written communication to this effect to the Policyholder and the Insured Parties.

VII.1.14.1 If the claim occurs before the Insurance Company makes the aforementioned communication, the benefit will be reduced in proportion to the difference between the agreed premium and the one that would have been applied if the true risk entity had been known. If there was fraud or serious negligence on the part of the Policyholder and/or Insured Parties, the Insurance Company will be released from the payment of the benefit.

VII.1.14.2. In the event that the Policyholder and/or Insured have acted with malice when making the declaration, the Insurance Company will be released from the payment of the principal in the event of a claim.

VII.1.14.3 In the event of inaccuracy in the age of the Insured person or persons, if the true age at the time of entry into force of the Contract exceeds the admission limits established by the Insurance Company. Otherwise, if, due to the inaccurately declared age, the premium paid is lower than that which would be payable, the benefit of the Insurance Company will be reduced in proportion to the premium received. If, on the other hand, the premium paid is higher, the Insurance Company will refund the excess premium received without interest.

VII.1.15 Alterations in the insured risk
The Policyholder or the Insured, during the course of the Contract, must communicate to the Insurance Company, as soon as possible, all circumstances that aggravate the risk and are of such a nature that if they had been known to the Insurance Company at the time of the conclusion of the Contract, it would not have entered into it or would have concluded it under more onerous conditions.

The following will be considered as aggravations of risk:

• **The change of activity or occupation of the Insured, even temporary, which means a greater risk with respect to the situation at the time of contracting.**
• Permanent disability and chronic illnesses arising from events **not covered by this Policy.**
• The aggravation of the risk may or may not be accepted by the Insurance Company and the rules established in the Insurance Contract Law will apply.

VII.1.16. Cancellation
The Policyholder and/or Insured may cancel the Policy within 30 days of taking it out, in which case, the Insurer will refund the Premium paid in full. If the Policyholder and/or Insured has notified a Claim during this period of 30 days, the Insurer will not refund the amount of the Premium. If, on the date of renewal of the Policy, the corresponding Premium has not been paid on the date of its expiry, the Insurer's coverage will be suspended one month after the aforementioned date, after which, without the corresponding payment of the premium, the Insurer will be released from its coverage obligations in the event of a claim. If the Insurer does not claim payment within six months of the premium due date, the Policy will be automatically cancelled. (Art. 15 LCS) Likewise, the policy will be automatically cancelled if the Insured does not return within a maximum period of 90 days the amounts advanced by the Insurer or its agent in the event of a Claim.

The Policy will also be automatically cancelled if the Policyholder and/or Insured at any time:

a) He/she misleads the Insurer by omitting information, providing it incorrectly or filing a false claim.
b) He/she reaches any kind of agreement with third parties that provides him/her with undue benefits, thus defrauding the Insurer.
c) He/she fails to comply with the terms and conditions of the Policy or fails to act in good faith.
The Policyholder and/or Insured must use the means at their disposal to reduce the consequences of the Claim. Failure by the Policyholder and/or Insured to comply with the above with the manifest intention of harming or deceiving the Insurer will release the Insurer from the benefit derived from the Loss (Art 17 LCS) and will entitle the Insurer to cancel the Policy, after notifying the Policyholder and/or Insured.
If the Insured has another insurance policy that covers the same risks, he or she must inform of this at the time of making the declaration of loss.

Likewise, the policy will be cancelled at the time of payment of the insured capital of the Death or Absolute Permanent Disability Guarantees due to accident, as well as when the maximum benefit established for the Unemployment or Temporary Disability guarantees has been paid.

VII.1.17. International Sanctions
We will not cover or assume any claims, nor will we provide benefits or services described in the policy that may expose us to any sanctions, prohibitions or restrictions under resolutions issued by the United Nations or trade or economic sanctions, laws or regulations of the European Union or the United States of America.

For more details, please visit the pages:
· https://www.un.org/securitycouncil/sanctions/information,
· https://sanctionsmap.eu/#/main,
· https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx

VII.1.18. Taxes and surcharges
All taxes and surcharges levied on this contract, its premiums and benefits, provided that they are legally chargeable, will be paid by the Policyholder, the Insured or the Beneficiary, as applicable.

VII.1.19. Competent jurisdiction
The competent judge for actions arising from this Policy shall be the judge of the domicile of the Insured, any agreement to the contrary being null and void, notwithstanding the provisions of the rules of Private International Law of the Spanish Legal System, which shall be applicable in the event that the Insured have their domicile outside Spain.

VII.1.20. Prescription
The actions derived from this Insurance Agreement shall prescribe within five (5) years. The time for the prescription will be counted from the day on which they could be exercised.

VII.2. DIGITAL END-OF-LIFE MANAGEMENT. Complementary guarantee

Digital End of Life Management is a complementary service to Active Seguros' death insurance, and as such it limits its use to policyholders who are registered as users in addition to the policyholder. In order to perform the work as selectively as possible, the following is required:
• Birth certificate of the deceased.
• Death certificate of the deceased.
• Identification data of the deceased.
• Photo (recent and old).
• Known common passwords (dates, pseudonyms, ID, pet... etc.).
• Information about the social networks with which the deceased worked.
• Document that authorizes us to take the necessary steps to delete accounts on the different social networks.

OPTIONALLY. If the family member wishes, they can deliver all devices, on which they wish to perform the data extraction, (PC, Tablet, Mobile, etc.), as well as the deletion of accounts and applications with external interaction: WhatsApp, Line, Mail Web, online games... etc. These will be returned to the family member at the end of the work with a report of it.

After 30 working days of receiving the data, a report is sent to the client with the result of the work and the confirmation of the deletion on the different social networks.

In no case is deletion guaranteed on all social networks, as there may be some that are not recognized and/or addressed by the user with an unknown and private alias.
The most commonly used networks on which digital fingerprint elimination is carried out are:

• **Facebook**	• **Tuenti**	• **Pinterest**	• **Picassa**	• **Vimeo**
• **Twitter**	• **Linkedin**	• **Instagram**	• **Myspace**	• **Skype**
• **Google +**	• **Xing**	• **Flickr**	• **Youtube**	• **Bloger**

This service is subject to restrictions and availability at the time of application, and the complete performance of the service is not guaranteed.

VII.3. BASIC AND EXTENDED PERSONAL ASSISTANCE. Complementary guarantee

VIP Service My Assistant

EUROP ASSISTANCE will make the following services available to Policyholders:

Booking transport tickets
EUROP ASSISTANCE will make the booking, following the information provided by the Insured Party and, where appropriate, the purchase and issuance of the ticket.

Hotel Reservations
EUROP ASSISTANCE will make the reservation at the chosen hotel, subject to room availability on the desired dates.

Booking of scheduled trips
EUROP ASSISTANCE will make the booking and, where appropriate, the purchase and issuance of the selected trip from among the wholesale offers.

Varied Gifts Delivery Service
At the request of the Insured Party and subject to local availability, EUROP ASSISTANCE will provide a selection of different types of gifts (chocolates, perfumes, etc.) to be delivered to the recipient indicated by the Insured, during the business hours of shops.

Information Service
EUROP ASSISTANCE will have a free and uninterrupted 24-hour service, every day of the year, for all Insured Persons to provide all types of national and, as far as possible, international information regarding:

All these services are at the expense of the Insured.
These services will be provided from 9 a.m. to 6 p.m. from Monday to Friday and from 10 a.m. to 6 p.m. on Saturdays, Sundays and holidays. (Spanish peninsular time)

Health Information
EUROP ASSISTANCE, at the request of the Insured, shall provide information regarding:

1. Addresses and telephone numbers of:
• National hospital and out-of-hospital centers, Professional associations, National associations and foundations:
• Public health bodies.
• National health academic institutions such as Faculties, Royal Academies, Schools.
• Pharmacies including on-call pharmacies.
• Vaccination centers: within the national territory authorized by the WHO.
• Health insurers.
• International health organizations located in national territory.

2. Addresses and telephone numbers of:
• Health entry requirements according to country of destination, for people of Spanish nationality.

Leisure Information
EUROP ASSISTANCE, at the request of the Insured, shall provide information regarding:

1. Addresses and telephone numbers of:
• National cinemas and theatres, art galleries, museums and monuments (national and international):
• Theme parks (national and international)
• Leisure centers, casinos (national and international), bingo halls.
• Restaurants (national and international) organised by name, category and/or, type of food.
• Bars, cafes, terraces, nightclubs.
• Telefood.
• Establishments of gastronomic specialties: Pastry shops, Ice cream parlours, Monastic cuisine, gastronomic specialties by region.

2. Festivals and Local Celebrations: information.

Miscellaneous Useful Information
EUROP ASSISTANCE, at the request of the Insured, shall provide information regarding:

1. Addresses and telephone numbers of:
• Spanish and foreign banks and savings banks in Spain, Spanish banks and savings banks abroad.
• Insurance companies.
• NGO.
• Utilities: gas, electricity, telephone, water, TV.
• Spanish Official Agencies and Bodies: Ministries, Official Registers, Police Stations, Consumer Bodies, Courts, Notaries, City Councils, Post Office.
• National educational centers such as Academies, Universities, Institutes, Colleges, Schools.
• Official white goods services (kitchen appliances) as well as brown goods (living room appliances, audio or image).
• Department Stores, Supermarkets, Hypermarkets, Shopping Centers, Shops.
• Telephone numbers of national card cancellation entities.

2. Usual opening hours of shops and banks in Spain and abroad
3. Dates and location of trade fairs and congresses in Spain.
4. Postal Codes

Sports Information
EUROP ASSISTANCE, at the request of the Insured, shall provide information regarding:

1. Stadiums and Sports Centers
2. Associations and Federations.
3. Sports clubs and centers (national and international).
4. Ski Resorts.
5. Golf courses (national and international).

6. Information on special mountain routes for bicycles, horseback riding, or mountain sports groups, bicycles.
7. Information on places where you can practice adventure sports such as diving, rafting, windsurfing, paragliding, hang gliding.

Information: Travel, Travel & Tourism
EUROP ASSISTANCE, at the request of the Insured, shall provide information regarding:

1. Addresses and telephone numbers of:
• Tourism Institutions and Entities: Ministries, Chambers, Provincial Councils, Tourist Offices (foreign in Spain and Spanish), Embassies and Consulates (foreigners in Spain and Spaniards abroad)
• Hotels and accommodation in Spain and internationally: Hotels, Rural hotels, Paradors, Hostels, Monastic accommodations, Camping, Spas: categories of hotel establishments will also be provided.
• Scheduled airlines and international airports.
• Spanish shipping companies and boat journeys (Spain).
• Car rental companies (national and international).
• Bus stations and companies in Spain.
• Train stations in Spain.

2. Related Administrative Procedures: Police, Entry, by Country: Information relating to administrative procedures required by the authorities for Spanish citizens travelling abroad.

3. Generic country information: geographical location, currency, language, Surface area, population, local holidays, religion, bank and business hours.

4. Means of transport from the airport to the city center (international).

Automobile Information
EUROP ASSISTANCE, at the request of the Insured, shall provide information regarding:

1. Addresses and telephone numbers of:
• Workshops and official dealerships, as well as services open 24 hours.
• Service stations. Insurance Companies.
• Vehicle Inspection Test centers.
• Provincial Traffic Headquarters.
• Toll roads (national).

Personal help at home
At the request of the Insured, EUROP ASSISTANCE offers a personal assistance service (day or night) through qualified personnel for needs that they require at home, hospital or place where they are, in situations of illness, post-surgery or accident.

The services provided are:
- Lifting/lying down from bed
- Personal hygiene, bathing, nail trimming and easy styling
- Meal Help
- Change of personal linen and bed
- Small walks, wheelchair transfers, mobility exercises

A limit of 16 hours per year per policy is established (3 months waiting period). The minimum time of the service is set at 4 continuous hours.

This service is available 24 hours a day, 365 days a year.
Insured persons may use additional hours at their own expense, both for the service and the commute.
This service is subject to local availability.

Home health workers
At the request of the Insured, and in situations of illness, post-surgery or accident, EUROP ASSISTANCE offers the service of sending health professionals (ATS, nursing assistants, physiotherapists, podiatrists) who provide the special care and treatment that the Insured requires, in order to assist and care for the Insured depending on their problems and their level of dependency or illness, in order to improve their quality of life and avoid displacement.

For the correct provision of this service, the medical report prescribing the specific treatment will always be requested.

The services provided are:
- Administration of special medication
- Monitoring vital signs
- Cures

- Rehabilitation of lower and upper limbs
- Speech and language rehabilitation.

A limit of 6 annual sessions per policy is established (3 months waiting period). The minimum time of the service is set at 4 continuous hours. This service will be provided 24 hours a day, 365 days a year.

The commute to and from the place of service is provided by EUROP ASSISTANCE.
Insured persons may make use of additional sessions at their own expense, both the service and the commute.
From the moment when the request is made for the service or the receipt of the documentation that, where appropriate, entitles the Insured to receive it free of charge, EUROP ASSISTANCE will have 24 to 72 hours to start providing the Service in provincial capitals and large towns. In the case of small towns, the period for the start of the provision of the Service could be extended to a maximum of 5 days, depending on the type of professional and availability in the area.
This service is subject to local availability.

Post-Partum Care at Home
At the request of the Insured, and in situations of caesarean section, EUROP ASSISTANCE offers the service of sending health professionals to attend to the evolution of the mother's postpartum, the baby's progress, help with breastfeeding and with hygiene of the mother and baby, care of the house, emotional support providing advice, information.

A limit of 30 hours per year per policy is established (9 months waiting period). The minimum time of the service is set at 3 continuous hours.

From the moment that the request is made for the EUROP ASSISTANCE service, the Insurer will have 24 to 72 hours to start providing the Service in provincial capitals and large towns. In the case of small towns, the period for the start of the provision of the Service could be extended to a maximum of 5 days, depending on the type of professional and availability in the area.
This service is subject to local availability.

Health & Wellness Phone Consultations
EUROP ASSISTANCE will provide the Insured with anonymous, unlimited and FREE telephone consultations to professionals who are experts in each field. Doctors, Psychologists, Pediatricians, Dietitians-Nutritionists or Social Experts.

Telepharmacy
The service will consist of the presence of a EUROP ASSISTANCE collaborator (duly identified) at the address determined for this purpose by the Insured, in order to collect the Social Security prescription, health card or prescription from a private doctor, if necessary, and acquire the corresponding medicine. It will then hand it over to the Insured, who will pay the amount of the invoice for the product purchased. Checks, promissory notes or cards will not be accepted.

The Insured must in all cases provide the commercial name of the product and the type of presentation (tablets, ampoules, capsules, emulsions, etc.). Cases of abandonment of the manufacture of the medicine or the lack of availability of the same in the usual distribution channels in Spain are expressly excluded, as well as medicines that require the ID card for their acquisition and those included in the special prescription book for narcotics.

A limit of 10 services per year per policy is established (3 months of waiting period). The minimum time of the service is set at 3 continuous hours.

This service will always be provided in situations of convalescence that prevent you from leaving your home, provided that it is accompanied by a certificate from your family doctor or specialist accrediting it.
The Insured may make use of additional services at his or her own expense, both the service and the travel.

Special services
At the request of the Insured, and for reasons of illness or convalescence (accredited on the recommendation of their general practitioner or specialist), EUROP ASSISTANCE will arrange for the search and delivery to their home of a professional of the requested service (hairdresser, podiatry, childcare, the elderly) who will travel with the necessary material to carry out the required work.
The costs corresponding to the fees of said professional, as well as the travel, will be borne by the Insured.

This service is subject to local availability.

Reimbursement of Expenses for Animal Residence or Hotel Stay
Only dogs and cats owned by the Insured that have an identification chip are considered pets, and will be the subject of this contract. For those Autonomous Communities in which the identification chip is not mandatory for cats, the Insured must provide the identification document that proves the ownership of the pet.
Only one animal per Insured is covered.

EUROP ASSISTANCE will reimburse the residence costs for the pet owned by the Insured, when the Insured is in a situation of illness, post-surgery or accident (accredited on the recommendation of their general practitioner or specialist) and there is no other person to take care of

the animal, up to a limit of 30 hours per year per policy, with a limit of 300 euros per policy/year (3 months waiting period).

For the reimbursement of any expense, it will be essential to present original invoices and receipts, as well as a copy of the pet's updated health card.
The Insured may make use of additional services at his or her own expense, both the service and the travel.

The conditions of the Services described above must always be stated in the policy. The mandatory or voluntary nature of its contracting by the policyholder will be determined according to the provisions of the coverage table.

VII.4. LEGAL ASSISTANCE of the complementary product "Scaled Medical Assistance" (limit 3,000 euros). Complementary Guarantee

EUROP ASSISTANCE will provide, through registered lawyers, assistance and legal direction for the legal defence (in criminal jurisdiction) of the Insured in their private and family life for misdemeanours and crimes of recklessness, incompetence or negligence.

The **maximum limit for this guarantee is 3,000 euros** per claim and year and includes lawyer, solicitor and notary fees for power of attorney. The amount of the order for costs and judicial bonds are excluded in criminal jurisdiction.
This warranty is excluded if the breach was committed before the entry into force of this contract.

EUROP ASSISTANCE will provide the Insured with legal assistance that will be limited to the objective existence of an emergency situation, such as, for example, a breathalyzer test, traffic accident, theft or deprivation of liberty.

TThis service will be provided verbally and by telephone, excluding the drafting of reports or opinions.

SECTION VIII. ASSISTANCE PETS BY CH PETS

CH MASCOTAS
TELEPHONE: 868 023 306
Web: www.chmascotas.es
e-mail: chmascotas@chmascotas.es

HEREBY DECLARES:
THE CORPORATE PURPOSE OF CH PETS, among others, is to provide services to the consumer through the issuance of digital cards that, after signing a binding contract and payment of the corresponding fee, allow the pet or pets (maximum THREE) of the owner of the same to obtain discounts or special scales on purchases made or services in commercial establishments, clinics or affiliated professionals.

VIII.1. Benefits for the pet owner
The owner may benefit from all the agreements obtained at CH MASCOTAS, in any of the related centers and hosted on our website: www.chmascotas.es.

Information regarding the scales or agreed prices can be obtained from the subsidised centers themselves, doctors or by calling 868 023 306 (Monday to Friday from 08:00 to 15:00 except national or local holidays in Murcia).

VIII.2. The holders or beneficiaries:
THEY WILL NOT HAVE ANY LIMITATION AS TO THE NUMBER OF PURCHASES OR VETERINARY VISITS OR TESTS THAT THEY DECIDE TO PERFORM.
NO AUTHORISATIONS FROM CH PETS ARE REQUIRED FOR SERVICES, CONSULTATIONS, HOSPITALISATIONS, TESTS, ETC.
THERE IS NO AGE LIMITATION.
THERE IS NO LIMITATION FOR DISEASES OR DISABILITIES CONTRACTED PREVIOUSLY.
THERE ARE NO WAITING PERIODS.
THEY WILL BE ABLE TO USE ALL SERVICES FROM DAY ONE, WHEREVER AND WHENEVER THEY WANT.

VIII.3. Terms and conditions
The conditions and the different contracting rates should be consulted at any of our commercial agencies or by calling 868 023 306. The hiring of CH PETS is limited to THREE PETS.
The cardholder accepts the annual revaluation of the cost of the card by virtue of the I.P.C.

VIII.4. Provisions
a) All those who request it may be holders of the CH MASCOTAS card, after completing and accepting the application form and these general conditions, as well as being up to date with the payment of the fee corresponding to the period of coverage at the time of use. Even so, CH MASCOTAS reserves the right of admission of the applicant or their relatives.

b) These General Conditions regulate the use of CH MASCOTAS in any of its versions.

c) The CH PETS card is personal and non-transferable; The use of the services will be limited to cardholders.

d) CH MASCOTAS, reserves the right to modify or cancel these General Conditions, giving notice, if possible, at least thirty (30) days in advance. In the event that they are modified, it shall indicate the date of entry into force.
e) CH MASCOTAS, reserves the right to modify, expand or reduce the list of collaborating companies, as well as the conditions established by them to be used by the affiliate, such as the amount of each of the scaled benefits and assistance. In all cases, the beneficiaries of CH MASCOTAS have the telephone number. 868 023 306 at their disposal, where they can consult the existence and established conditions or variations therein, of any subsidised center.

f) The receipt or digital download of the CH MASCOTAS card, as well as the enjoyment of the benefits, will be considered an express, voluntary and unreserved acceptance of all the General Conditions made available to the holder of the CH MASCOTAS card.

g) To be entitled to the benefits of the CH MASCOTAS card, the holder must present the valid card in any of the centers arranged by CH MASCOTAS, accompanied by the ID of the cardholder.

Where appropriate, the centers subsidised by CH MASCOTAS may request other requirements relating to their business dynamics.

h) The holder or beneficiary is responsible for the correct use and conservation of the CH MASCOTAS card that they have in their possession, as a deposit, which is the property of CH MASCOTAS. CH MASCOTAS reserves the right to cancel and withdraw the CH MASCOTAS card, and/or to terminate the enjoyment of the advantages or benefits by notifying the holder of the CH PETS card 15 days in advance and therefore financially refunding the holder the proportional part of the period paid and not enjoyed.

i) The validity of the CH MASCOTAS card expires at the expiration date designated on the card itself, unless the cardholder is not up to date with payments.

j) CH MASCOTAS does not assume any responsibility towards the cardholders in relation to: the veracity and accuracy of the information provided by the affiliated centers, the losses or defects in the quality and efficiency of the provision of services and/or products, or the deficiencies of the services and/or products offered or provided by the affiliated centers or professionals.

CH MASCOTAS will not be liable in the event of fraud for the damages that the cardholder or their pets may suffer as a result of or on the occasion of the enjoyment or lack of enjoyment of the advantages and/or access or lack of access to the advantages of the CH MASCOTAS card.

CH MASCOTAS, is not responsible for the acts or omissions, including the case of medical negligence, that may be incurred in the provision of health services to pets demanded by the beneficiary and provided by the doctor or contracted health centers.

k) **Personal Data** notwithstanding the application of the Organic Law of 15/1999 on personal data.
By accepting the General Terms and Conditions, the CH MASCOTAS cardholder expressly consents to CH MASCOTAS processing the data provided by the cardholder, as well as any other future information that may be communicated by its collaborating companies included in CH MASCOTAS and related to the use of the card (such as purchase information) or that was communicated by any other companies that offer special advantages to CH MASCOTAS card holders, in order to maintain the commercial relationship, as well as for the design and implementation of communications and commercial offers of the company that can best adapt to the purchasing habits of the CH MASCOTAS card holder, and for the realization of communications and commercial offers from said collaborating companies or from companies that offer special advantages.

The cardholder expressly consents to CH MASCOTAS communicating his/her personal data to its collaborating companies interested in offering special advantages to CH MASCOTAS cardholders. The activities carried out by these companies will cover the following sectors of activity: financial and insurance services and products, funeral services, assistance services in general, repair services in general, medical services, services and shops in general, telecommunications, electronics and household appliances services and products, services and products related to the media or communication channels, services and products in the computer and Internet sector, services and products in the beauty and hygiene sector, services and products in the textile, clothing and accessories sector, services and products in the automotive sector, services and products in the electrical sector, services and products in the distribution and catalog sales sector, food and beverages, services and products in the chemical and petrochemical sector, services and products in the electrical sector and services and products in the leisure and entertainment sector (such as, shows, hotels, trips or restaurants). By means of these General Conditions, the holder of the CH MASCOTAS card is informed of the first communication of their data and of the right to revoke their consent to CH MASCOTAS, for its communication.
The data will be kept in a confidential computerized file under the responsibility of CH MASCOTAS.

The holder of the CH MASCOTAS card may request access, rectification, cancellation and opposition by communicating it in writing, attaching a photocopy of their ID card on both sides, the request in which their application is specified, dated and signed, as well as their address for notification purposes.

l) For any communication that is necessary with CH MASCOTAS, the cardholder must contact the following email address: chmascotas@chmascotas.es or telephone 868 023 306 from 08:00 a.m. to 3:00 p.m. and from Monday to Friday, except national or local holidays in Murcia.

VIII.5. Funeral Assistance for Pets
Active Seguros, through CH MASCOTAS, makes available to its policyholders the provision of funeral services for their pets, offered at discounted prices or discounts, by companies authorized for this purpose, with the final beneficiaries paying the agreed prices directly to these professionals.

1. Types of Funeral Services for Pets

1.1. Individual service
- Collection of the pet at a private home or delivery of it to a funeral home.
- Transfer to a funeral home.
- Preparation for farewell in the reception room (only if the client wishes).
- Individual incineration and ash recovery.
- Biodegradable urn.
- Incineration certificate.
- Subsequent shipment of ashes to home or collection at the funeral home.
- Guidance and information for the processing of Microchip cancellation.

1.2. Collective service
- Collection of the pet at a private home or delivery of it to a funeral home.
- Transfer to a funeral home.
- Collective incineration and incineration certificate.
- Sending of incineration certificate to the customer.
- Guidance and information for the processing of Microchip cancellation

2. Protocol of action in the event of an accident
Funeral services will be provided according to the following operation:
I. The call from the Company is received and the necessary information about the claim is collected.
II. In a limited time of 5 minutes from the time the notice is received, the insured or customer is contacted.
III. After contacting the customer and collecting the information, the assigned crematorium is selected and the customer is informed of the incident.
IV. The assigned crematorium contacts the customer again to inform them that the service is on its way and the approximate waiting time.
V. The crematorium informs the client of the service to be provided, INDIVIDUAL OR COLLECTIVE, giving all necessary details.
VI. The crematorium will contact, if necessary, at another time with the client to agree on a time, day, farewell at the funeral home (if desired) for cremation.
VII. The assigned crematorium will monitor the incident until the urn is delivered.
VIII. Guidance and information for the processing of Microchip cancellation.

This service will be carried out exclusively through the telephone number: **868 023 306, 24 hours a day, 365 days a year.** The services to be provided will be carried out exclusively with the collection of the deceased pet at the customer's home, or through the delivery by the customer of the pet himself at the facilities provided by the customer service at the time of the claim. CH MASCOTAS is not responsible for the prices, nor does it guarantee the benefit, when the deceased pet has been deposited in a veterinary center.

CH PETS WILL NOT provide funeral services for pets in the Islands (Canary Islands and Balearic Islands).

SECTION IX. MEDICAL/LEGAL ASSISTANCE

IX.1. Complementary guarantee: Medical assistance
Active Seguros incorporates an innovative medical guarantee service to its death policy, consisting of a private medical assistance guide for the province in which the insured resides, which can be used whenever they wish, using a personalized card with their personal data.

With this medical guarantee service available as parto f the death insurance, if it has been contracted, all Insured persons in the same policy are covered by private medical assistance (through its scaled prices) by qualified medical professionals, in their locality and province, in all specialties of medicine (traumatology, surgery, anesthesiology, cardiology, gynecology, dermatology, ophthalmology, etc.). Even dental assistance and special services such as psychologists, podiatrists, dietetics and nutrition, aesthetic medicine, etc.

All this is reflected in a guide organised by specialties and localities to be chosen with ease.

Likewise, this guarantee also covers telephone legal assistance, as well as a 25% discount on the fees set by the Bar Association of each province in case of requiring a lawyer for judicial process.

IX.2. Legal assistance in claiming damages
EUROP ASSISTANCE will manage the amicable or judicial claim to an identifiable third party, for the damages caused to the Insured.

Within this limit, all expert costs and expenses of any kind necessary to assess the damage and/or harm are included.

No results are guaranteed as a result of these efforts. This service will be provided from 9 a.m. to 7 p.m. from Monday to Friday except holidays.

IX.3. Guaranteed limits and expenses
The maximum sum insured to cover all **the insured expenses is set at €300 per claim and/or annuity of the insurance.**

The following expenses are included:
a) The fees, rights and legal costs derived from the processing of the covered procedures.
b) Attorney's fees and expenses.
c) The rights and supplies of the solicitor, when intervention is mandatory.
d) Notary fees and the granting of powers of attorney for lawsuits, as well as the minutes, requirements and other acts necessary for the defense of the interests of the Insured.
e) The fees and expenses of necessary experts.
f) The constitution, in criminal proceedings, of the bonds required to obtain the provisional release of the Insured, to guarantee his appearance at the trial, as well as to respond to the payment of legal costs, excluding compensation and fines.

IX.4. Exclusions
a) Expenses that have not been previously communicated to the Insurer are generally excluded.
b) Events that occurred before the effective date of the contract.
c) Consultations and legal proceedings whose resolution entails the application of foreign law, and those related to the claim of rights and benefits that assist the Beneficiary before the corresponding Association.
d) When the event was caused in bad faith or deliberately by the Beneficiary, including claims related to vehicles owned by the Beneficiary.
e) Expenses arising from unfounded claims, as well as those that arise with manifest disproportion in relation to the damages suffered. This exclusion will not apply when, after the exercise of the corresponding legal actions, the Beneficiary obtains a favourable resolution estimating the total of the corresponding compensation.
f) Compliance with the obligations imposed on the Beneficiary by Administrative Judgment or Resolution. The payment of fines and penalties, as well as their interest or surcharges.

THE POLICYHOLDER DECLARES TO HAVE READ AND UNDERSTOOD ALL THE LIMITATIONS AND EXCLUSIONS CONTAINED IN THIS INSURANCE CONTRACT, EXPRESSLY ACCEPTING THEM BY SIGNING THE PARTICULAR CONDITIONS

The Policyholder **Insurance Company ACTIVE**

ACTIVE CONTACT GUIDE

963 51 98 85
atencion@activeseguros.com
activeseguros.com

ACTIVE SEGUROS
www.activeseguros.com
National Transfer
Repatriation
Residents
Tel.: 961 59 35 10

JURISLEG
www.jurisleg.com
Management and
Inheritance Procedures
Tel.: 956 70 07 49
625 69 38 69

HEALTHMOTIV
www.healthmotiv.com
TuSalud - Digital Health Service
Tel.: 962 64 57 11

CENTRIBAL
www.centribal.com
Technology Assistance
Tel.: 964 868 700

YO TENGO ABOGADO
www.yotengoabogado.es
Active Laboral - Legal Service
Tel.: 856 39 61 18
WhatsApp: 686 86 49 78

ARAG
www.arag.es
Travel Assistance
Tel.: 933 00 10 50

SURNE
www.surne.es
Life
Accidents
Hospitalisation
Orphan's Income Insurance
Tel.: 944 79 22 00

CH SALUD
www.chsalud.es
Medical and Legal Assistance
Tel.: 868 02 33 06

CS24
www.canalsalud24.com
Medical Assistance
Tel.: 917 371 708
Legal Assistance
Tel.: 915 14 99 30

GUIA AZUL
www.guiaazuldelasanidad.es
Medical and Legal Assistance
Tel.: 950 25 99 40

CH MASCOTAS
www.chmascotas.es
Pet Assistance
Tel.: 868 02 33 06

EUROP-ASSISTANCE
www.europ-assistance.es
Handyman Home Assistance
Tel. 915 14 14 62

Digital End of Life Management
Tel. 915 14 14 62

Personal Assistance
Tel. 915 14 14 62

Payment Protection
Tel.: 915 14 99 00

GIRA DENTAL
www.giradental.com
Dental Service
Tel.: 915 58 99 73

INSPIRING BENEFITS
activemas.contigomas.com
Club Active mas
Tel.: 910 085 904

Version N3-ENG-0125

The most complete **death insurance** for families

active seguros

Av. de las Cortes Valencianas, n. 17, Mezz. - Flat 8 - 46015 Valencia
Tel. 963 51 98 85 - email: atencion@activeseguros.com

ASSISTANCE 24H. 963 51 98 85