

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

EXPAT®36/60 US 1000 TARIFF

1.	INSURANCE COMPANY:	Mondial Assistance International AG, Niederlassung für Deutschland, Ludmillastraße 26, D-81543 München	
2.	POLICY HOLDER:	BDAE Dienstleistungsgesellschaft mbH	
3.	PARTIES ENTITLED TO INSURANCE:	Natural persons and legal entities	
4.	INDIVIDUALS INSURABLE:	Natural persons and employees of legal entities who are working or studying abroad as well as their family members up to the age of 65 years, if they are insurable according to the terms and conditions of insurance, part I, A, § 1. Family members are defined as partners and children who share the same household.	
5.	CONTRACTUAL BASIS:	Terms and conditions for limited health insurance and sickness daily allowance cover of the EXPAT®-series for long-term journeys part I and part II (EXPAT®36/60 US 1000).	
6.	AREA OF APPLICATION:	Worldwide except in the home country and Germany. Insurance cover is granted in the home country and Germany for three months (accumulated) per insurance year, for insurance for less than a year it is calculated proportionally.	
7.	START OF INSURANCE COVER:	At the time specified in the insurance confirmation document with consideration of the terms and conditions of insurance part I, A, § 4, but not before the stay abroad has begun.	
8.	INSURANCE YEAR:	From 1 January respectively to 31 December of a year.	
9.	DURATION OF INSURANCE RELATIONSHIP:	EXPAT®36 US 1000	EXPAT®60 US 1000
		Up to 36 months	Up to 60 months
10.	TERMINATION OF INSURANCE RELATIONSHIP:	1. The policyholder is obligated to inform the party entitled to insurance and the insured persons of notice of termination of the framework insurance agreement with two months notice before the termination takes effect. 2. The insurance relationship for individual insured persons may be terminated by the party entitled to insurance or the person insured at any time. It will then end with the expiry of the month following on notice of termination being given. The notice of termination has to be submitted in writing to the policy holder. 3. If the party entitled to insurance and the insured person are not identical, a notice of termination only becomes effective, if the insured person concerned by the termination has attained knowledge of the termination declaration. The policyholder has to prove this accordingly to the insurance company at deregistration from the framework insurance agreement. The insured person concerned is in this case entitled to continue the insurance contract under designation of a future party entitled to insurance. An appropriate declaration must be made with-in two months after receiving the notice of termination.	
11.	PREMIUM PAYMENTS:	The premium is an annual premium, which is made out in equal monthly instalments. It becomes due for payment in advance by the time of the end of each contractual year.	
12.	DATA ON INSURED PERSON'S STATE OF HEALTH:	None. Please observe the exclusion of benefits in the terms and conditions of insurance.	
13.	BENEFITS:	EXPAT®36/60 US 1000	
13.1	OUTPATIENT TREATMENT:	100% of the amount invoiced for medically necessitated outpatient treatment as a private patient, radiological treatment, light, and other physical treatments, if prescribed by a doctor.	
13.2	INPATIENT TREATMENT:	100% for medically necessitated inpatient treatment at a hospital and treatment necessitated accommodation, as well as for medically necessitated operations, X-rays, radiological treatment and diagnostics. As a private patient in a 2-bed room abroad and in a standard room in the native country (Please note VB Teil I, B, § 1, para. 6).	
13.3	PHARMACEUTICALS, BANDAGES AND MEDICINES:	100%, if prescribed by a doctor and medically necessitated.	
13.4	DENTAL TREATMENT:	100% of the invoiced amount for medically necessitated outpatient dental treatment in simple form. The insurance cover includes one annual checkup for preventive purposes, but does not include any prophylactic treatment.	
13.5	TOOTH REPLACEMENT / ORTHODONTIC TREATMENT:	No benefits.	
13.6	PREVENTIVE CHECKUPS:	No benefits.	
13.7	BENEFITS FOR PREGNANCY AND DELIVERY:	No benefits.	
13.8	MEDICAL AIDS:	No benefits.	

13.9	OTHER BENEFITS:	<p>a) 100% of the transport costs to the nearest suitable hospital for inpatient treatment and for first-aid after an accident to the nearest suitable doctor and back.</p> <p>b) For medically necessitated return transport or conveyance to the native country or permanent place of residence of the insured person, the insurance company will reimburse.</p> <ul style="list-style-type: none"> - up to EUR 5,000 within a continent. - up to EUR 10,000 between continents. <p>If for the return journey an authorised ambulance aeroplane should be called for, the restriction to the benefit amount no longer applies. The most economical means of transport is to be selected for the return journey, so long as this is possible from the medical point of view. Medical necessity for a return journey is given, if sufficient medical care is not available in the country of residence. To prove the medical necessity of return transport, a certificate of the doctor treating abroad must be submitted.</p>	
14.	WAITING PERIOD:	None	
15.	MONTHLY PREMIUM:	EXPAT*36 US 1000	EXPAT*60 US 1000
15.1	DEDUCTIBLE:	EUR 150	
16.	OTHER MATTERS:	<p>US \$ 1,000 per person and insurance year. The deductible for insurance cover which is required for less than one year is calculated proportionally.</p> <p>EUR 191</p> <p>Changing of modules or adding an additional module is not permitted. No pension reserve fund will be established. You are recommended to take out a deferred insurance policy scheme.</p>	

Stand: 01.08.2010

MEDICAL ASSISTANCE FOR PERSONS INSURED BY BDAE AND MEMBERS OF BDAE



For fast and smooth processing of medical services anywhere in the world, the BDAE GROUP has integrated an Assistance Programme into its insurance concept. The BDAE makes its Assistance services – i.e. the aid, emergency and service offer – available to its insured and members in collaboration with the Assistance specialist med con team. The following services to insured and members are included:

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

- Multilingual 24-hour Emergency Hotline,
- More than 172 alarm centres in more than 100 countries,
- Information about (dental) medicine service providers (e.g. names, addresses and telephone numbers as well as consulting hours for doctors and dentists, hospitals and clinics within the region of the current place of residence),
- Patient advice in routine cases and emergencies as well as during crises that may compromise safety in the country of residence,
- Help and support to family members by means of provision of country specific health care data and information,
- Assistance in arranging treatment appointments at hospitals and with doctors for outpatient treatment,
- Organisation of hospital admission in the event of illness,
- Support in the obtention and shipment of prescription medicines (insofar as statutorily permitted),
- Organisation of interpreting and translation services,
- Access to worldwide medical information in German and in English,
- Advice and support in the event of loss of important documents and means of payment.

In addition to the services listed above, the BDAE assumes the costs for the services it covers, for which med con team seeks authorisation directly from the BDAE and its risk carriers. These services include:

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

These services are available to persons insured by BDAE and members of BDAE 365 days a year, 24 hours a day. Generally, a scope of services of this kind can only be taken advantage by large companies. Because of the strategic partnership of the BDAE with med con team, private individuals, too, can benefit from the Safety Package. To ensure smooth processing in your dealings with the Assistance company, please always have your BDAE policy or membership number ready when you contact med con team.

MED CON TEAM
ONE OF THE WORLD'S LEADING ASSISTANCE COMPANIES

med con team is represented by partner companies in more than 100 countries worldwide, including the International Assistance Group (IAG). IAG is one of the largest Assistance networks worldwide, with 5,300 employees, 46 proprietary Alarm Centers and 74 million customers. Using the services of med con team simultaneously involves all the benefits of the IAG network. Overall, med con team has 36 flying ambulance providers in 16 countries, as well as 172 partner alarm centres and representative offices in more than 100 countries.

The Company was founded by Dr. Michael Weinlich, a surgeon and emergency medicine expert. On the basis of his long-time experience in the area of worldwide assistance and air rescue, Dr. Weinlich decided to make his expertise available to a wider public, and in faithful implementation of his leading principle: "The best possible medicine with simultaneous quality and cost transparency".

PATIENT LEGAL EXPENSES INSURANCE FOR BDAE CLIENTS



NEW: PATIENT LEGAL EXPENSES INSURANCE WORLDWIDE FOR THE FIRST TIME

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

WHAT IS INSURED?

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

The policy covers – subject to a deductible of 500 Euro per claim – legal cases up to One Million Euro, worldwide. ARAG accepts all costs for legal and court expenses up to this limit. If required, ARAG will also recommend a lawyer specialised in healthcare law.

WHAT ARE TREATMENT ERRORS AND AN INCORRECT CONSULTATION?

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

ABOUT ARAG

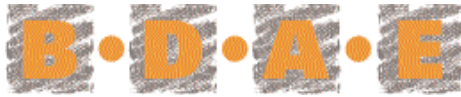
The ARAG Group is an internationally renowned independent provider of legal services and is the largest family-owned company in the insurance market. Apart from Germany, ARAG also operates in 12 European countries and in the USA, where it has taken a leading position in the legal insurance market. ARAG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

CHECKLIST FOR APPLICATION

WE KINDLY REQUEST THAT YOU REMEMBER THE FOLLOWING POINTS SO AS TO ENSURE THAT YOUR APPLICATION IS PROCESSED QUICKLY AND PROMPTLY

1.	THE APPLICATION MUST FILLED IN COMPLETELY AND IN BLOCK CAPITALS.
2.	PAYMENT METHOD DATA:
2.a	Bank transfer of the premium is only possible once a year or every six months.
2.b	A direct debit is only possible from a German account on a monthly, quarterly, six monthly or annual basis. As an alternative, you can also pay the premium by credit card using the same payment method as for a direct debit.
3.	THE APPLICATION MUST BE SIGNED BY THE APPLICANT AND ALL INSURED PERSONS WHO ARE OF FULL AGE.
4.	IF THE ACCOUNT HOLDER IS DIFFERENT FROM THE APPLICANT, THE SIGNATURE OF THE ACCOUNT HOLDER IS ALSO REQUIRED
5.	THE FOLLOWING MUST BE NOTED FOR THE RATES EXPAT GERMANY, EXPAT RETIRED, EXPAT 36/60 AND EXPAT 36/60 US 1000:
5.a	EXPAT GERMANY:
	A health certificate or evidence of a German previous insurance must be submitted if the insured person has been resident in Germany for longer than 31 days. The health certificate must not have been issued more than 14 days previously.
5.b	EXPAT RETIRED:
	Information on the health declaration as well as the additional declaration must be submitted with the application. A health certificate which has not been issued more than 3 months previously must be submitted for persons aged 60 and over.
5.c	EXPAT 36/60 UND EXPAT 36/60 US 1000:
	Please indicate the occupation you will pursue abroad.
6.	HEALTH CERTIFICATE EXPAT GERMANY AND EXPAT RETIRED:
6.a	The health certificates must be issued in German or English and be legible.
6.b	Each question must be answered.
6.c	Questions answered with yes or questions that indicate an abnormal result require an explanation.
6.d	The explanation in the presence of the doctor must be signed by the applicant and the doctor.
6.e	The last page of the certificate must also be signed by the doctor.
6.f	If the R-Dent or G-Dent tariff is selected, a dental report is required.
6.g	The first and last name must be specified on each page of the findings.
6.h	Always specify your GP using their full name and the exact address.
6.i	If any inpatient treatment has taken place, it would speed up the inspection if corresponding discharge reports and reports on findings were submitted to us along with the health certificate.
6.j	If there are any further inquiries, please adhere to the deadlines specified in the letter of request as acceptance is otherwise not possible.

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



B D A E G R U P P E

OVERSEAS HEALTH INSURANCE FOR OF UP TO 60 MONTHS

EXPAT®36/60 APPLICATION US 1000

APPLICANT / PARTY ENTITLED TO INSURANCE:

Surname:	First name(s):	Occupational activity overseas:
Address:		BDAE membership-no., if existing:
Phone:	Fax:	e-mail:

PAYMENT DETAILS:

Payment type*:	<input type="checkbox"/> annually	<input type="checkbox"/> every six months (+2%)	<input type="checkbox"/> quarterly (+3%)	<input type="checkbox"/> monthly (+5%)
Bank:	Account-no.:	Sort Code:		
Credit Card (+6%):	<input type="checkbox"/> Master-/Eurocard	<input type="checkbox"/> Visa	<input type="checkbox"/> Diners	Valid until: Card-No.:

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

INFORMATION ON ADDITIONAL HEALTH INSURANCE:

Do you have additional health insurance?*	<input type="checkbox"/> Non	<input type="checkbox"/> Yes, with:	Insurance no.:
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THE FOLLOWING PERSONS ARE TO BE INCLUDED IN THE INSURANCE: (Please consider applicant)

Surname, First name(s)	Nationality	Sex*		Date of birth	Planned country of residence	Tariff*		Monthly premium (EUR)	Start of insurance (Month / Year)
		m	f			EXPAT®US 1000 36	60		

(*please tick)

I / we hereby apply for insurance cover as outlined by the terms and conditions for limited health insurance and sickness daily allowance cover of the EXPAT®series for long-term journeys part I and part II (EXPAT®36/60 US 1000 tariff) for the persons listed above by registering them with the insurer as insured persons. The insured persons or their legal guardians permit the insurer to request any information from third parties at any time which may be necessary to establish the state of health of the insured persons. For this purpose, the third parties are released from their obligation to secrecy.

The total premium must be paid in advance in accordance with the chosen payment period. I hereby give permission for the premiums to be debited from my account or credit card (see above). Note: the premium is due after confirmation of insurance cover has been received and no later than the beginning of the insurance. I / we am / are aware that the policy holder will not register the listed persons as insured persons with the insurer or will terminate their registration if the premium or other charges have not been paid in full due to the actions of the person eligible to be insured. I / we am / are also aware that we do not have insurance cover in this case.

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

Insurer: HanseMerkur Reiseversicherung AGMondial Assistance International AG
Policy holder: BDAE Dienstleistungsgesellschaft mbH

Stand: 01.08.2010

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info@bdae.de • www.bdae.com

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TERMS AND CONDITIONS FOR LIMITED HEALTH INSURANCE AND SICKNESS DAILY ALLOWANCE COVER OF THE EXPAT®-SERIES FOR LONG-TERM JOURNEYS PART I

**PART A - GENERAL PROVISIONS
VALID FOR ALL THE INSURANCE POLICIES AND THE
RESPECTIV TARIFFS LISTED IN PART B**

§ 1 INSURABLE PERSONS AND INSURABILITY

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

1. The application of insured persons in the framework insurance agreement can only be submitted by the party entitled to insurance. Parties entitled to insurance are juridical and natural persons according to the respective underlying tariff conditions.
2. Natural persons may be insured.
3. Not insurable and despite premium payment not insured are
 - a) Persons who are in need of constant care. A person is in need of care if he/she for the most parts needs external help in order to manage the tasks of daily life.
 - b) Persons who are constantly excluded from participating in daily life. For this classification, in particular the mental state and the objectiv life circumstances of the person must be considered.
4. No insurance cover is granted for insured persons, who have their main place of residence in the Federal Republic of Germany.
5. Natural persons with a limited residence permit for the Federal Republic of Germany may not be insured, if at the time of applying for registration in the framework insurance agreement the entire insurance duration of all health insurance agreements concluded during the visit exceed a period of 5 years.

§ 2 CONCLUSION AND DURATION OF THE INSURANCE CONTRACT

1. The framework insurance contract will be concluded between the insurance company and the policy holder for the duration of a year. The framework insurance contract will be extended by one year if notice of termination is not given with a term of notice of three months to the expiry date.
2. The legal regulations on the extraordinary right to give notice of termination remain unaffected.
3. At termination of the framework insurance agreement, the insurance company will offer the insured persons continuation of the insurance cover.

§ 3 PREMIUM, BENEFIT ADJUSTMENT, INSURANCE YEAR

1. The policyholder is entitled to deregister individual insured persons from the framework insurance agreement because of non-payment of the premium.
2. Insurance company shall be entitled to make changes in the premium level or the extent of the benefits at the beginning of a new insurance year, provided that it notifies the policyholder of this with a term of notice of three months to the end of the agreed tariff insurance year.

3. The insurance year will be defined in the conditions of insurance for health insurance and sickness daily allowance cover of the EXPAT® -series for long-term journeys conditions of insurance part II.
4. The policyholder shall be obliged to give the party entitled to insurance and the insured person written notice of an adjustment of the premium level or of the level of benefits paid within a term of two months to the end of the agreed tariff insurance year.

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

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

1. The insurance cover starts for the insured person after binding registration into the framework insurance agreement at the time (start of insurance) specified in the insurance confirmation document,
 - a) however not before start of the stay of the insured person in the agreed tariff area;
 - b) not before effectiveness of the insurability of the insured person according to tariff;
 - c) not before payment of the premium;
 - d) not before expiration of waiting periods agreed according to tariff.
2. No insurance cover is granted for claims occasioned before or at start of insurance.
3. No benefits will be paid for claims occasioned during the waiting period as agreed in the tariff.
4. The maximum duration of insurance cover for the insured person is defined in terms of the relevant tariff.
5. Insurance cover for individual persons insured comes to an end, even in connection with pending claims, with
 - a) end of the insurance relationship of the insured person, at the latest however upon expiration of the maximum duration of insurance of the select ed tariff;
 - b) deregistration from the group of persons insured by the party entitled to insurance, taking into account the terms of notice and conditions defined in the tariff;
 - c) death of the person insured;
 - d) with the ending of the insurability of an insured person according to conditions of insurance part I, A, §1;

- e) at the end of the month following termination of the temporary visit of the insured person in the agreed tariff area or final return of the insured person to their native country;
- f) as soon as the tariff terms on the insurability of an insured person are inapplicable;
- g) with termination of the framework insurance agreement between the insurance company and the policy holder.

§ 5 OBJECT OF INSURANCE COVER AND SCOPE OF INSURANCE BENEFITS

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

1. The insurance company shall offer insurance cover for urgent and unexpected insured events occurring during the stay in the agreed tariff area.
2. The insurance cover results from the insurance confirmation, these conditions of insurance, the selected tariffs, statutory regulations of the Federal Republic of Germany.

§ 6 GENERAL LIMITATIONS OF THE OBLIGATION TO PAY BENEFIT

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

1. Insurance cover is not granted for damage occasioned by active participation in strikes, war, war-like events, civil disturbance, damages by nuclear energy, as well as for such events, resulting from intentional activities of the policyholder, the party entitled to insurance or the insured person.
2. There is no obligation to pay benefit:
 - a) On account of illnesses and complaints including their consequences existing and known at start of the insurance cover. Furthermore, there is no insurance cover for the consequences of such illnesses and accidents, which have been treated in the last six months before start of insurance.
 - b) For spa and sanatorium treatments as well as rehabilitation measures organised by party legally responsible for rehabilitation;
 - c) For treatments during a stay in a spa or a health resort, even if this involves a stay in hospital. This limitation shall no longer apply if the person insured has his/her constant place of residence there or if he/she becomes unable to work as a result of a sickness independent of the purpose of his/her visit or as a result of an accident that has occurred there, so long as this results, on medical testimony, in his/her being unable to journey home. This limitation also shall no longer apply if and to the extent that the insurance company has given written consent to benefit being paid before the start of residence abroad.
 - d) In consequence of an accommodation occasioned by the need of lingering illness, care or custody;
 - e) For the treatment of mental or emotional disturbances, or for hypnosis, psychoanalysis or psychotherapy;
 - f) For immunisation measures;
 - g) For medical aids;
 - h) For treatment of sterility, including in vitro fertilisation well as pertinent preliminary examinations and subsequent treatments;
 - i) For preventive medical examinations;
 - j) For treatments by spouses, parents, children or persons living together in the immediate domestic circle or persons living together with the insured person within his/her own or guest family. Costs of materials will be reimbursed in keeping with the given tariff.

- k) For treatment on account of such illnesses, including their consequences, or consequences of such accidents as are occasioned through professional participation in sporting competitions organised by sporting federations and associations or prenotory measures related to these, or such as are recognised as war injuries and are not explicitly included in the insurance cover.
- l) On account of withdrawal measures including courses of withdrawal treatment;
- m) On account of such illnesses, including their consequences, which arise as a result of the person's having neglected to obtain the protective inoculations recommended by the World Health Organisation or prescribed by statute, unless there should be medical reasons why protective inoculation cannot be carried out. In this case, the medical reasons are to be proved to the insurance company by the submission of a doctor's certificate.
- n) For treatment of a dependency syndrome and its consequences;
- o) For attempted suicides and their consequences;
- p) For organ donations and their consequences;
- q) For tooth replacement (such as e.g. pivot teeth, insert fillings, crowns, implants) and orthodontic treatment, occlusive overlay aids and gnathologic measures.

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

§ 7 OBLIGATIONS AND CONSEQUENCES OF FAILURE TO OBSERVE TO OBLIGATIONS

1. Policyholder, parties entitled to insurance and insured person are obligated, after occurrence of the insured event
 - a) To avoid everything that could lead to an unnecessary increase in costs;
 - b) To immediately notify the insurance company or its agent of all damages that could presumably exceed a sum of EUR 1,000.00,
 - c) To permit the insurance company or its agent to make all reasonable examinations regarding the cause and amount of its duty to pay benefits, provide all relevant information in this connection, to submit original documents, and submit a death certificate in the case of death.
2. If required by the insurance company, the insured person is obligated to be examined by a doctor assigned by the insurance company.
3. Start and end, as well as an interruption of a stay in the area according to tariff, as well as the presence of the tariff terms concerning insurability must be proved by the insured person on request of the insured company in the case of benefit.
4. If the policy holder, the party entitled to insurance or the person insured willfully infringes one of the contractually agreed obligations, the insurance company shall be released from its obligation to pay benefits. In the case of a grossly negligent infringement of the obligation, the insurance company is entitled to reduce the benefits by an amount commensurate with the seriousness of the fault of the policyholder, the party entitled to insurance or the person insured. The onus of proving that there has been no gross negligence rests with the policyholder, the party entitled to insurance or the person insured.
5. The party entitled to insurance and the person insured are obligated to immediately communicate changes of address to the policyholder.

§ 8 PAYMENT OF INSURANCE BENEFITS

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

1. The insurance company shall be obliged to pay out benefits only if the follow-

ing documentary proof is supplied, which then become the property of the insurance company:

- a) Paid original receipts, which must carry the first name, surname and date of birth of the person treated, name and address of the doctor treating the patient, the description of the illness, nature of the services provided by the treating doctor according to type, place and treatment period. If compensation may be claimed under another insurance contract in connection with an insured event and if the claim has first been asserted for the other contract, then duplicates of the invoices will be considered sufficient, provided that the other insurance company has made a note on the document of the benefit paid.
 - b) Prescriptions must be presented together with the doctor's bill, the bill for pharmaceuticals and medical aids together with the prescription.
 - c) Proof of the amount of costs, which would have ensued in the case of a regular return journey, if benefits are asserted for a medically necessitated return transport. Furthermore, a doctor's certificate, which should clearly demonstrate the medical necessity of return transport, must be submitted.
 - d) For the assertion of claims in connection with conveyance of the body or funeral costs an official death certificate and medical certificate giving the cause of death must additionally be submitted.
2. Costs that have been incurred in a foreign currency will be converted into the currency valid in Germany at the exchange rate of the day on which the receipts are received by the insurance company, unless the foreign currency required for payment of the invoice was acquired at a less favourable rate and that this was caused by a change in the currency valuation.
 3. Costs incurred for the payment of insurance benefit by banker's draft to a foreign country, or for special forms of fund transfer which have been agreed on, will be deducted from the benefit paid.
 4. Claims to insurance benefit can neither be assigned nor given in pledge.
 5. In connection with examining the benefits to be provided, it may be necessitated for the insurance company to obtain personal-related health data within the legally permitted scope. If the party entitled to insurance or insured person fail to consent to this and if the insurance company as a result, is unable finally to determine the amount and scope of its obligation to provide benefits, the due date of payment shall be suspended. The same applies if the institutions or persons who are requested to provide information are not released from their duty of secrecy vis-à-vis the insurance company.
 6. One month after notification of a claim, the minimum amount which is payable as matters then stand may be claimed as a payment on account. The said period stops running as long as the insurance company's examination of the claim is hindered by fault on the part of the policyholder, the party entitled to insurance, the insured person.
 7. Claims under this framework insurance agreement shall become time-barred after three years. The limitation period begins at the end of the year in which the benefit may be demanded.

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

1. If compensation may be claimed under another insurance contract in an insured case, the other contract shall take precedence over this contract. This applies likewise, even if a subordinate liability has also been agreed upon in one of these insurance contracts, irrespective of when the other insurance contract was concluded. If the insured event was first communicated to the insurance company via this framework insurance agreement, the insurance company will pay in advance and will contact the other insurance company directly concerning distribution of costs.
2. Claims of the policyholder, the party entitled to insurance or the insured person against third parties pass to the insurance company to the statutory extent,

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

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

§ 10 OFFSET

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

§ 11 DECLARATIONS OF INTENTION AND NOTIFICATIONS

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

§ 12 APPLICABLE LAW / LANGUAGE OF THE CONTRACT

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

§ 13 SURPLUS SHARING

The insurance specified here is not entitled to surplus.

§ 14 SUPERVISORY AUTHORITY AND OMBUDSMAN

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

If you should not be satisfied with a benefit or a decision of the insurance company, please contact the insurance company directly. The insurance companies are members of the Verein Versicherungsombudsmann e.V. This gives you the possibility as a special service to address the independent and neutral Ombudsmann, if you should not agree to a decision. The procedure is free of charge.

The address of the Versicherungsombudsmann e.V. for foreign travel HI is:

Ombudsmann
Private Kranken- und Pflegeversicherung
Postfach 060222,
10052 Berlin
Tel.: 0180 / 255 04 44
Fax: 030 / 20 45 27 85
E-mail: ombudsmann@pkv.de
www.pkv-ombudsmann.de

Complaints can however also be addressed to the above-mentioned supervisory authority responsible for the insurance company.

PART B – SPECIAL PROVISIONS FOR INDIVIDUAL INSURANCES

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

SECTION I HEALTH INSURANCE FOR LONG-TERM JOURNEYS (ONLY VALID, IF CONTAINED IN THE SELECTED TARIFF)

§ 1 OBJECT OF INSURANCE

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

1. Grounds of a claim shall be the medically necessitated treatment of a person insured on account of illness or in consequence of an accident. The claim shall be considered to begin with the treatment, and shall end when medical findings indicate that there is no further need of treatment. If the medical treatment must be extended to an illness or consequence of an accident, with no causal connection to the previously treated condition, then this is considered a new claim.
2. In so far as the tariff defines the relevant benefits, further grounds for a claim shall also be:
 - a) Medically necessitated treatment including pregnancy examinations, pregnancy treatments, in as far the pregnancy had not yet commenced at the beginning of the insurance relationship of the insured persons as well as treatment for miscarriage;
 - b) Medically necessitated pregnancy treatment due to acute complaints caused by and treatment due to miscarriage as well as medically necessitated abortions and deliveries up to the end of the 36th week of pregnancy (premature birth), even if the pregnancy had already commenced at the start of the insurance relationship of the insured person, if the necessity for treatment was not yet obvious at this time;
 - c) Deliveries after expiry of the waiting period according to the agreed tariff;
 - d) Outpatient examinations for early diagnosis of illnesses according to programmes and introduced to the Federal Republic of Germany and prescribed by statute (purposeful preventive medical checkups);
 - e) Death.
3. The nature and amount of the insurance benefits shall be derived from these conditions of insurance of the respectively selected tariff.
4. In the area of cover the insured person may choose from those medical doctors, dentists, licensed general practitioners specialised on alternative medicine and midwives who are practising on a legally approved basis in the insured's country of residence and who invoice on a locally customary basis or - if applicable - according to the official scale of charges for their profession.
5. Pharmaceuticals, bandages, medicines and medical aids must be prescribed by the qualified practitioners mentioned in conditions of insurance section I, B, I, §1, para. 4. Pharmaceuticals may also be obtained from a pharmacy. Nutriment, tonics, mineral water, disinfectants and cosmetics, mineral water, dietary, and baby food and the like are not considered pharmaceuticals even if they have been prescribed.
6. In case of medically necessitated hospital treatment, the person insured has free choice from among those public and private hospitals that are under constant medical supervision, possess sufficient diagnostic and therapeutic equipment and conduct case histories and do not provide health resort respectively sanatorium treatments or accept convalescent patients. Insurance protection is granted for the general class (multiple bedrooms) without coverage options (private treatment by doctor).
7. In case of medically necessitated hospital treatment in licensed hospitals, which also carry out health resort or sanatorium or convalescent treatments but which in other respects conform to the conditions of section I, B, I, § 1, para. 6, benefits at the agreed rate will only be paid if the insurance company has given written consent to this before the start of the treatment. In case of a TB condition, benefit will be paid to the extent defined by the contract for hospital treatment in TB treatment centres and sanatoria as well.
8. The insurance company will pay benefit to the extent defined by the contract for examination and treatment methods and pharmaceuticals that are generally recognised by school medicine. It will in addition pay benefit for methods and pharmaceuticals, which have proved themselves in practice to be equally likely to achieve success; the insurance company may however reduce the level of benefit to the amount that would have been paid if existing school medicine methods or pharmaceuticals had been used.
9. The insurance company will pay to the extent defined in the tariff the conveyance and funeral costs, if the death of an insured person is the consequence of an insured event.
10. The insurance company carries additional costs to the extent defined in the tariff for a medically necessitated return transport prescribed by a doctor to the nearest suitable hospital in the native country or to the permanent place of residence of the insured person. Medical necessity for a return journey is given, if it is proven that in the agreed tariff area sufficient medical treatment is not ensured and the return journey is recommended by the doctor of the insurance company. The costs of an also insured accompanying person are assumed, in as far the accompaniment is medically necessitated, officially ordered or required by the accomplishing transport company.

§ 2 SPECIAL EXCLUSIONS

1. So far as has not been agreed to the contrary, there is no obligation to provide benefits for treatments by doctors, dentists, licensed general practitioner specialised on alternative medicine, hospitals or midwives whose invoices the insurance company has excluded from reimbursement on good grounds. Precondition for this is that the insurance company has notified the party entitled to insurance and the insured person before occurrence of the insured event and of the practitioner who will not be reimbursed. In so far as at the time of notification a claim should be pending, no obligation to pay benefit for the practitioner concerned shall exist for expenses incurred after the expiry of three months from the time of notification being given.
2. If the medical treatment or other measure for which benefit has been agreed upon should exceed the medically necessitated limits, or if the remuneration claimed is out of proportion, the insurance company may reduce benefit to an acceptable level.

§ 3 SPECIAL OBLIGATIONS AFTER OCCURRENCE OF THE INSURED EVENT

1. The insurance company is to be notified of any hospital treatment within ten days from its starting.
2. The person insured must submit the relevant documentary evidence to the insurance company within three months from the time of each individual course of treatment.
3. If a person insured has concluded a contract for the insurance of medical expenses with another insurance company, if such exists or a person insured avails himself/herself of the entitlement to insurance in connection with statutory health insurance cover, the party entitled to insurance or the person insured shall be obliged to notify the insurance company without delay of the other insurance cover arranged.
4. The insurance company is to be informed of a case of pregnancy within four weeks after the existence of a pregnancy has been established, unless defined otherwise in terms of the relevant tariff.
5. The insurance company is to be informed of medically necessitated return transports before being carried out.
6. The legal consequences of a breach of one of these obligations are set out in conditions of insurance part I, A § 7, para. 4.

SECTION II SICKNESS DAILY ALLOWANCE INSURANCE COVER (ONLY VALID, IF CONTAINED IN THE SELECTED TARIFF)

§ 1 OBJECT OF THE INSURANCE

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

1. The insurance company offers insurance cover against loss of income in consequence of illness or accidents either within Germany or abroad. In case of a claim arising based on inability to work, it will provide a daily sickness benefit allowance.
2. A claim shall exist in case of a proven inability to work in the course of medically necessitated treatment by a doctor. The claim shall be considered to

begin with the treatment, and shall end when medical findings indicate that the patient is no longer incapable of working.

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

§ 2 SCOPE OF INSURANCE BENEFITS

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

1. The insurance company's obligation to pay benefit shall begin with the first day of inability to work, with the addition of any days without benefit that form part of the terms of the agreement (period of restriction). The obligation to pay benefit ends when the person insured is able to resume work or with the end of the insurance cover according to conditions of insurance part I, A, § 4, para. 5 conditions of insurance part I, B, II, § 4, but at latest with the end of the duration of benefit as defined in the given tariff.
2. The insurance company hereby undertakes to adjust the insurance cover with effect from the first of the following month after application has been made by the party entitled to insurance and the person insured, if and to the extent that,
 - a) through a change in the regular net income derived from professional activity an increase in the sickness daily allowance agreed upon is necessary, so as to maintain the previous percentage ratio between sickness daily allowance and net income. This obligation is also incumbent on the insurance company in case of a reduction in the level of a sickness benefit claim on a statutory benefit provider.
 - b) through a change in the duration of continued payment of salary, in case of inability to work, a switch to a different tariff level with a different waiting period should be called for.

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

3. If it should come to the knowledge of the insurance company that the net income of insured person has sunk below the level of the income on which the insurance agreement is based, it shall be entitled, without distinction as to whether an insurance claim has already occurred or not, to reduce the sickness daily allowance and the premium correspondingly, with retrospective effect from the onset of the reduction, or call for the reimbursement of benefit paid in excess.
4. The payment of sickness daily allowance is based on the assumption that the person insured will be treated by a doctor or in hospital for the duration of the period that he/she is unable to work.
5. In case of medically necessitated hospital treatment, the person insured has free choice from among those public and private hospitals that are under constant medical supervision, possess sufficient diagnostic equipment and conduct case histories.
6. In case of medically necessitated hospital treatment in licensed hospitals which also carry out health resort or sanatorium or convalescent treatments but which in other respects conform to the conditions of insurance part I, B, II, § 2, para. 5, benefits in terms of the given tariff will only be paid if the insurance

company has given written consent to this before the start of the treatment. In case of a TB condition, benefit will be paid to the extent defined by the contract for hospital treatment in TB treatment centres and sanatoria as well.

§ 3 SPECIAL EXCLUSIONS

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

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

§ 4 ADDITIONAL STIPULATIONS ON THE END OF INSURANCE COVER

1. The insurance cover comes to an end, in addition to the circumstances mentioned in conditions of insurance part I, A, § 4, para. 5 with the person insured's giving up gainful employment, with the onset of occupational disability or earning incapacity or a partial reduction of earning ability or when the person insured starts to draw an old age pension or pension for occupational disability or earning incapacity or for reduced earning capacity.
2. The insurance company will decide on the question whether, to what degree and starting from what time occupational disability or earning incapacity or reduced earning capacity has set in, on the basis of the documentary evidence submitted to or obtained by the company, and will communicate its decision on the matter in writing.

§ 5 SPECIAL OBLIGATIONS

1. The insurance company should be notified immediately of a medically attested inability to work, through presentation of the appropriate documents. The doctor's certificate may be sent in advance by fax. The originals must be sent by post without delay. Certification by spouses or life partners, parents or children are not sufficient as a proof of inability to work. If notification is received late, the sickness daily allowance will be paid only from the day of receipt, not however before expiry of the period of restriction. Documentary proof of continuing inability to work should be regularly supplied to the insurance company, in so far as the insurance company does not request it on a different basis, at two-weekly intervals at most.
2. If a sickness daily allowance policy is concluded for a person insured with another insurance company, or if a person insured has recourse to the insurance entitlement included in statutory health insurance, the party entitled to insurance and the person insured shall be obliged to inform the insurance company forthwith of the other insurance policy.
3. The insurance company is to be notified without delay of any change of career by the person insured.
4. The party entitled to insurance and the insured person must immediately notify the insurance company of the termination of the employment contract between the party entitled to insurance and the insured person.
5. A new insurance policy with a third party insurer that includes a claim to sickness daily allowance may be taken out, or an existing one increased, only with the consent of the insurance company.
6. Persons insured are obliged to notify the insurance company immediately of a reduction in their net income derived from professional activity, if this is not just a temporary condition, or of a change in the duration of continued salary payment by their employer.