OCIDENTAL
grupo ageas

Residential Mortgage Credit Protection

General and Special Conditions of the Policy

Customer information line: 210 042 490 / 226 089 290
Cost of a call to the national fixed network
Personalized customer service available every business day from 08h30 to 19h00

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CONTENTS

GENERAL CONDITIONS

1. Coverages

Temporary Total Incapacity to Work due to Accident or Illness **(TTI),**
Involuntary Unemployment **(IU)**, Hospitalisation **(H).**

Section A) COMMON CONDITIONS

2. Definitions

For the purposes of this contract, the following definitions are applicable:

INSURER: Ageas Portugal – Companhia de Seguros, S.A., entity legally authorised to exercise insurance activity and that underwrites the insurance contract with the Insurance Policyholder.

POLICYHOLDER: person that signs the insurance contract with the Insurer and is responsible for the payment of the premium.

INSURED PERSON: person indicated in the insurance proposal and in the Specific Conditions of the Policy, on behalf of whom the contract is concluded and that is a party to the Credit Contract, indicated in the policy.

INCIDENT: total or partial occurrence of the future and uncertain event beyond the wishes of the Insured Person that triggers the activation of the risk coverages established in this insurance contract.

SUM PAYABLE BY THE INSURER: sum (compensation or delivery of money) payable by the Insurer to the Beneficiary in the event of an Incident involving the Insured Person.

MORTGAGE CREDIT CONTRACT: contract identified on the first page of this document, through which the Insured Person becomes a debtor of the Insurance Policyholder and where the conditions of use and of payment of the credit granted are established.

INSURANCE GROUP: clients of the Insurance Policyholder that are intervenients in a Personal Loan Contract.

CASH BENEFITS: sums that, as established in the Personal Loan Contract and on behalf of the latter, the contract holders are obliged to pay to the Insurance Policyholder.

SUM INSURED: the maximum sum payable by the Insurer per Claim or group of Claims or insurance annuity, according to what is established in this subscription.

PERMANENT TOTAL DISABILITY (PTD): state that occurs whenever the Insured Person has the permanent need to resort to the assistance of a third person to perform the ordinary acts of everyday life, with no possibility of any improvement of the state of health according to the medical knowledge at the date of the medical confirmation of this disability by the Insurer's Attending physicians, which counts as the date of the Incident.

ACCIDENT: sudden, external and violent event, beyond the control of the Insured Person, resulting in personal injuries confirmed by a Attending physician;

ILLNESS: involuntary and abnormal change in the state of health of the Insured Person, clinically confirmed, and not caused by an Accident.

TEMPORARY TOTAL INCAPACITY TO WORK DUE TO ILLNESS OR ACCIDENT (TTI): total physical impossibility, clinically proven, of the Insured Person to temporarily exercise his/her professional activity, as a result of having suffered an Accident or having contracted an Illness.

HOSPITALISATION (H): clinical situation requiring the hospitalisation of the Insured Person for a period in excess of a specific number of days, generating a situation of Temporary Total Incapacity to work due to Accident or Illness (TTI).

TOTAL UNEMPLOYMENT: situation arising from the total and involuntary lack of employment of the Insured Person, who is registered at the Employment Centre.

INVOLUNTARY UNEMPLOYMENT (IU): situation of Total Unemployment due to: (i) collective dismissal;
(ii) dismissal as a result of the dissolution of jobs justified by economic or market, technological or structural reasons, relative to the employer; (iii) unilateral dismissal by the employer and (iv) unilateral termination of employment by the employee for justified reasons.

RELATIVE DEDUCTIBLE: predetermined period, counted immediately after the Incident, during which there is no entitlement to the sum payable by the Insurer, except when the period of incapacity exceeds the Relative Deductible period, in which case the latter shall not be applied.

GRACE PERIOD: period during which, immediately following the subscription of the Insured Person to the Insurance Group, there is no entitlement to the sum payable by the Insurer.

REQUALIFICATION PERIOD: period during which, immediately following the cessation of the effects of a Claim, there is no entitlement to the sum payable by the Insurer.

3. Obligations of the Parties

Among other duties foreseen in this contract and in the law:

a) the **Insurance Policyholder** is obliged to: (i) provide the Insurer with all the information requested by the latter and related to this contract; (ii) provide, at the request of the Insured

Person, all the information necessary for the effective understanding of this contract and (iii) maintain appropriately updated all the information and records relating to the business transacted under this contract, enabling their consultation by the Insurer whenever deemed necessary and provided the request is made during business hours, notwithstanding the sending of the originals of all the Subscription Statements to the Insurer;

b) the **Insurer** is obliged to: (i) provide, at the request of the Insured Person, all the information necessary for the effective understanding of this contract; (ii) provide access to the results of any medical examinations performed;

c) the **Insured Person is obliged to** provide the Insurer with all the information and documents that the latter requests, related to this contract, regardless of when the request is made.

4. Omissions or Inaccuracies

4.1 The Insured Person and the Insurance Policyholder are obliged to, prior to subscribing to this contract, accurately declare all the circumstances they are aware of and that are deemed to be reasonably significant for risk assessment by the Insurer, even though their mention is not requested in any questionnaire provided by the Insurer for that purpose.

4.2 In the case of fraudulent non-compliance with this duty, the Insurer may, by statement sent to the Insurance Policyholder, annul the subscription.

4.3 If the Insurer is aware of the omission or inaccuracy prior to the occurrence of any Incident:

a) it has 3 (three) months to send this statement;
b) it is not obliged to cover any Incident that occurs during this period;
c) it is entitled to receive the premium payable up to the end of this period, unless there has been deliberate fraud or gross negligence committed by the Insurer or its representative.

4.4 If the Insurer only becomes aware of the omission or inaccuracy after the occurrence of an Incident, it is not obliged to cover that Incident, and may choose to annul the contract.

4.5 In the case of deliberate fraud by the Insured Person or Insurance Policyholder for the purpose of obtaining an advantage, the premium is payable up to the end of this contract.

4.6 In the event of negligent breach of the duty referred to in paragraph 4.1, the Insurer can:

a) within the period of 3 (three) months as from the date on which the breach came to its attention and by statement sent to the Insured Person, terminate the subscription, demonstrating that under no circumstances will it accept subscriptions for the coverage of risks related to the omitted or misrepresented fact, with the subscription terminating 30 (thirty) days after the statement has been sent;

b) propose an amendment to the contract, which the Insured Person must accept or present a counterproposal within 14 (fourteen) days as from the date of reception of the proposed amendment, with the subscription terminating if 20 (twenty) days after reception of the amendment proposal the Insured Person does not reply or rejects the proposal.

4.7 Upon termination of the subscription foreseen in paragraph 4.6, the premium paid, in proportion to the contract period that has not elapsed, is returned.

4.8 If an Incident occurs prior to the termination or amendment of the contract under the terms foreseen in paragraph ??? and that Incident has been influenced by a fact regarding which there was omission or negligent inaccuracy, the Insurer:

a) shall cover the Incident in the proportion of the difference between the premium paid and the premium that would have been payable if, at the time of subscription, the Insurer had been aware of the omitted or misrepresented fact;

b) shall not cover the Incident, by demonstrating that in no case whatsoever would it have accepted the subscription if it had been aware of the omitted or misrepresented fact, and shall return the premium.

5. Start and Duration of Coverage

5.1 Without prejudice to the verification of the conditions of eligibility in the event of an Incident and of the payment of the premium, the coverage of the risks begins, relative to each Insured Person, as of 0 (zero) hours of the day following the date on which the Insured Person becomes a debtor of the Insurance Policyholder, as established in the respective Personal Loan Contract, which may not be prior to the date on which the latter was signed. In the event of distance contracting at a later date, the inclusion in the insurance contract shall occur following telephone formalisation of the subscription.

5.2 The guarantees cease automatically relative to each Insured Person on the earlier of the following dates:

a) In the event of the full duration of the Personal Loan Contract under the agreed terms, on the maturity date of the last Cash Benefit payable under the same contract, whether it is comprised of only interest, or only capital, or of interest and capital;

b) In the event of early settlement of the Personal Loan Contract or cancellation of the latter, on the date on which said settlement or cancellation occurs;

c) On the date of Death or Permanent Total Disability of the Insured Person;

d) On the date on which the Insured Person reaches 65 (sixty-five) years of age;
e) On the date of retirement or pre-retirement of the Insured Person;
f) On the date on which the Insured Person reaches the maximum compensation limits for the range of coverages.

5.3. Without prejudice to the provisions in paragraph 5.2, the Insured Person may terminate this subscription by registered letter posted 90 (ninety) days prior to the date intended for the purposes of termination, where permissible under the terms of the Mortgage Credit Contract, with this subscription terminating once the prior notice period has elapsed or, if there was an early payment of the premium, at the end of the corresponding period.

6. Period of Relative Deductible and Requalification

The guarantees object of this contract are subject to:
a) a Relative Deductible Period of 30 (thirty) days for the TTI and IU coverages and of 7 (seven) days for the H coverage;
b) a Grace Period of 60 (sixty) days;
c) a Requalification Period of 6 (six) months of active work.

7.Beneficiary Designation

The Insurance Policyholder is the irrevocable Beneficiary of this contract. The Insured Person cannot revoke or change this beneficiary designation.

8. Conditions of Eligibility of the Insured Person

Inclusion in the Insurance Group is only possible for those persons who so request through the fully completed subscription statement, and who, on that date:
a) are between 18 (eighteen) and 64 (sixty-four) years of age;
b) have a Mortgage Credit Contract from the Insurance Policyholder.

9. Subscription and Exclusion of the Insured Persons

9.1 The subscription of new Insured Persons is considered to have been effected under the terms of the subscription statement duly signed by the Insured Person, if, after 30 (thirty) days following reception of the statement by the Insured Person, the Insurer has not notified the proponent of its refusal or the need to collect essential information for risk assessment. The respective subscription is, however, conditional on receiving the premium.

9.2 The subscription is also considered to have been effected, when further information is requested, if the Insurer does not notify the proponent of its refusal within 30 (thirty) days following the provision of this information, even if through the Insurance Policyholder.

9.3 The Insured Person can be excluded from the Insurance Group if:

a) he/she does not pay the premium to the Insurance Policyholder;

b) he/she practices fraudulent acts to the detriment of the Insurer or the Insurance Policyholder;

c) he/she ceases the agreement that connects it to the Insurance Policyholder, namely the Mortgage Credit Contract.

9.4 The exclusion of an Insured Person must be communicated to the latter by the Insurance Policyholder or Insurer, as the case may be, by means of a notice sent to the address included in the subscription statement, becoming effective on the date of its reception.

10. Calculation of Premiums and Method of Payment

10.1. The value of the premium results from the application of the rate of 0.01225% to the capital financed for the first policy holder and of 0.01197% to the capital financed for the second policy holder, when applicable, at the moment of subscription. This rate already includes the legal taxes in force.

10.2. The premium is monthly and must be paid directly by the Insured Person to the Insurer every month, via direct debit.

10.3. The risk coverage depends on the prior payment of the premium.

11. Claim procedures

11.1 In the event of an Incident, the Insured Person or whomsoever has a legitimate interest in activating the insurance must report the Incident to the Insurer within 8 (eight) days immediately following the date on which the Insured person or other interested party become aware of the Incident, under penalty of a reduction of the Insurer's Payment given the damage that non-compliance with this duty causes the latter. The Insured Person must, namely, report any incident to the Insurer with respect to the TTI, IU or H coverages, as soon as he/she has indication that the Relative Deductible Period indicated in this contract will be exceeded. In the event of an Incident, the Insured Person can contact the Insurer on 217954665 (Cost of a call to the national fixed network).

11.2 In the case of intentional breach of the duty referred to in the previous paragraph that causes significant damage to the Insurer, the Insured Person loses their entitlement to coverage.

11.3 The Insured person must, in the report, explain all the circumstances surrounding the Incident, any possible causes for its occurrence and the respective consequences.

11.4 Once the Insurer has been notified of the Incident, without prejudice to the provisions in paragraph 11.6, the Insured Person or whomsoever has a legitimate interest in activating the insurance will receive a Notification of Claim form which must be returned

to the Insurer, fully completed and accompanied by all the information and relevant documents relative to the Incident and its consequences that are requested.

11.5 Fraud or attempted fraud committed by the Insurance Policyholder, Insured Person or by any person acting under the responsibility of the latter, releases the Insurer from any liability relative to the Incident in question, entitling it to dissolve the contract and, without prejudice to the applicable criminal provisions, to compensation for losses and damages.

11.6 The onus of the proof of the veracity of the claim regarding the Incident, as well as proof of complying with the conditions of eligibility relative to the coverage in question, falls on the Insured Person or whomsoever has a legitimate interest in activating the insurance.

11.7 The occurrence of an Incident does not exempt the Insured Person from the obligation of payment of all the instalments due in connection with the Mortgage Credit Contract.

11.8 The costs of obtaining the supporting documents necessary for the settlement of incident claims are borne by the Insured Person or whosoever has a legitimate interest in activating the insurance.

11.9 The settlement of each Claim approved for payment is carried out following the reception, by the Insurer, of the documentation - from both the Insured Person and the Insurance Policyholder - necessary for the analysis of each process.

11.10 The Insured Person is also obliged to, under penalty of being accountable for losses and damage:

a) Notify the Insurer, up to 15 (fifteen) days after its occurrence, of the cure of the injuries, by sending a medical statement indicating, in addition to the date of discharge, the total TTI period;
b) Comply with the medical prescriptions;
c) Subject him/herself to medical examinations designated by the Insurer;
d) Authorise the assistant Attending physician to provide all the information requested by the Insurer.

11.11 In the event of the confirmed impossibility of the Insured Person complying with the obligations established in this clause, these obligations are transferred to whoever can comply with them.

12. Profit Sharing

This contract does not provide entitlement to profit sharing.

13. Transfer of Contract

1. The Insurance Policyholder can transfer his/her contractual position in this contract, with the agreement of the Insurer, without the need for consent from the Insured Person.

2. The Insured Person is not allowed, under any circumstances, to transmit his/her contractual position.

14. Free Termination

Only in situations of distance contracting can this contract be freely terminated by the Insured Person in the 14 days immediately after the reception of the Policy, through written communication sent to the Insurer, on paper or on another durable medium available and accessible to the Insurer.

15. Complaints

Without prejudice to the recourse to courts, any person can submit to the Insurer, Ombudsman or the Insurance and Pension Fund Supervision Authority, according to the instructions set out on its website (www.asf.com.pt) complaints related to this contract.

16. Applicable Law and Jurisdiction

This contract shall be governed by Portuguese law and any issues or disputes that may arise in connection with the same shall be subject to the exclusive jurisdiction of the Lisbon District Court, hereby explicitly renouncing all others. Although there is no specific means of settling disputes out of court, the parties can seek arbitration under the terms of the general arbitration law.

Section B) Total Incapacity to Work due to Illness or Accident (TTI)

17. Scope/Guarantees Covered

17.1 In the event of TTI due to Accident and/or Illness of the Insured Person occurred during the subscription period and that extends beyond 30 (thirty) consecutive days, the Insurer shall pay a monthly sum to the Beneficiary corresponding to the Cash Benefit payable under the Personal Loan Contract for every month of duration of the Incident situation, with the maximum monthly limit of € 1,700.00 (one thousand seven hundred euros), regardless of the monthly amount of the Cash Benefit. The reimbursement shall continue until the Insured Person is able to return to work or until the maximum limit of 12 (twelve) months per Incident Claim is reached. At the last payment, the sum payable as compensation shall be 1/30 of the Cash Benefit for each day of duration of the Incident situation.

17.2 Without prejudice to the Relative Deductible period, the TTI period begins on the day immediately after the date on which the start of TTI for work through a certificate of incapacity is attested.

17.3 This section applies to Incidents occurred both at home and abroad.

18. Exclusions

18.1 The situations excluded from the guarantees of this contract are those that directly or indirectly result from:

a) War, declared or not, invasion, acts by foreign enemies, hostilities or warlike operations, civil war, insurrection, rebellion or revolution, as well as those caused accidentally by explosive or incendiary devices;

b) Military uprisings or acts by legitimate or usurped military power;

c) Explosion, release of heat and radiations from nuclear or radioactive fission or fusion as well as resulting from radiation caused by the artificial acceleration of particles;

d) Strikes, riots or alterations of public order;

e) Malicious acts of terrorism, vandalism and sabotage;

f) Earthquakes, volcanic eruptions, tsunamis, as well as landslides, landslips or sinking of land and other geological phenomena and, in addition, any catastrophic event related to the inevitable forces of nature;

g) Deliberately fraudulent acts or omissions by the Insurance Policyholder or Insured Person.

18.2 In addition to the situations referred to in the previous paragraph, the situations excluded from the guarantees of this sub-section are those that directly or indirectly result from:

a) diseases existing at the start date of the Policy guarantees;

b) congenital abnormalities, physical or mental disabilities and physical defects existing at the start date of the Policy guarantees;

c) diseases that resulted directly from the consequences of alcoholism (both in acute and chronic processes), drug addiction or narcotic substances or other drugs not medically prescribed;

d) diseases resulting from the intervention of the Insured Person in wagers, challenges or duels, unless, in the latter case, the Insured Person acted in legitimate defense or in the attempt to rescue people and goods;

e) diseases caused intentionally by the Insured Person or attempted suicide;

f) childbirth, pregnancy or voluntary or involuntary interruption of pregnancy;

g) accidents caused by the driving of motor vehicles by the Insured Person, without being legally authorised to do so;

h) diseases caused by Psychopathologies of any nature, as well as illnesses without clinical proof;

i) accidents resulting from the professional practice of sports and, in addition, within the scope of amateur sport, sports competitions integrated in championships and respective training, winter sports, boxing, karate and other martial arts, parachute jumping, bull-fighting and other similary dangerous sports;

j) aesthetic and cosmetic treatments, unless they are directly associated with any Illness or Accident.

19. Claim obligations

Specifically regarding the coverage of TTI and without prejudice to the provisions in paragraph 11 above, the Insured Person is obliged to, under penalty of liability for losses and damages, send the Insurer, within the deadines referred to in paragraph 11 above, the information of the assistant Attending physician with a photocopy of the sick leave certificate with the mentioned dates.

Section C) Involuntary Unemployment (IU)

20. Scope/Guarantees Covered

20.1. In the event of an IU situation occurred during the subscription period and that extends beyond 30 (thirty) consecutive days, the Beneficiary shall receive from the Insurer the sum corresponding to the Cash Benefit payable under the Mortgage Credit Contract at the moment of the Incident, for every month of duration of the Incident situation, with the maximum monthly limit of € 1,700.00 (one thousand seven hundred euros), regardless of the monthly amount of the Cash Benefit. The reimbursement shall continue until the Insured Person is able to return to work or until the maximum limit of 6 (six) months per Incident Situation is reached. At the last payment, the sum payable as compensation shall be 1/30 of the Cash Benefit for each day of duration of the Incident situation.

20.2 If the Insured Person is self-employed, the IU guarantee shall be substituted by the H guarantee.

21. Exclusions

Without prejudice to the other exclusions stipulated in the General Policy Conditions, the following cases are excluded from the scope of IU coverages:

- **a) expiration of the employment contract since the Insured Person has reached retirement or pre-retirement age;**
- **b) termination of the employment contract by mutual agreement;**
- **c) rescission of the employment contract by the employee, for justified reasons;**
- **d) termination of the employment contract, during the trial period;**
- **e) workers abroad with employment contracts not bound by Portuguese legislation;**
- **f) dismissal for justified reasons;**
- **g) expiration of an employment contract for a fixed term;**
- **h) unemployment resulting from seasonal activity.**

22 - Special Condition of Eligibility of the Insured Person

Without prejudice to the provisions of paragraph 8 above, any subscriber shall only be considered an Insured Person for the purposes of the UI and H coverages, provided that, at the moment of subscription, he/she has been working professionally, at least 16 hours a week, during the last 12 months, and is not aware of impending unemployment.

23. Claim obligations

Specifically regarding the coverage of UI and without prejudice to the provisions of paragraph 11 above, the Insured Person is obliged to, under penalty of liability for losses and damages, report in writing to the Insurer the UI situation, as soon as he/she has indication that the Relative Deductible period will be exceeded and within a maximum period of 30 (thirty) days from the date of the event, indicating its start date and causes by completing the "Notification of Claim" form mentioned in paragraph 11.4 above, accompanied by the following documentation, as soon as it becomes available:

a) photocopy of Model RP5044 (official model, submitted and completed by the Employer);

b) photocopy of the employment contract or other document confirming the start date of his/her activity;

c) photocopy of the unemployment benefit application form issued by the Employment Centre);

d) photocopy of the notice of resignation letter or other document confirming the termination of the employment contract, indicating the respective cause;

e) statement from the Employment Centre confirming the respective registration (this document must be requested from the Employment Centre 30 (thirty) days after the start date of the unemployment situation and must be renewed every month).

Section D) Hospitalisation

24. Scope/Guarantees Covered

24.1 If the Insured Person is self-employed, the Involuntary Unemployment (IU) guarantee shall be substituted by the Hospitalisation (H) guarantee.

24.2 The extension of a hospitalisation situation for a period of more than seven consecutive days entails the payment of an amount corresponding to a Cash Benefit.

24.3 If the Insured Person continues in a hospitalisation situation beyond 30 days (inclusive), the monthly reimbursement of the Cash Benefit up to a maximum limit of 12 months per Claim shall be made, unless the Insured Person is able to return to work, in which case the scope of this coverage ceases.

24.4 The maximum monthly compensation limit of this coverage is € 1,700.00 (one thousand seven hundred euros), regardless of the monthly value of the Cash Benefit.

24.5 At the last payment, the amount to be compensated shall be 1/30 of the Cash Benefit for each day of duration of the hospitalisation situation.

24.6 If the Insured Person ceases to be in a hospitalisation situation, but remains in

a situation of Temporary Total Incapacity to work due to illness or accident, under this coverage the monthly reimbursement of the Cash Benefit up to a maximum limit of 12 months per Claim shall be made, unless the Insured Person goes back to work, in which case the scope of this coverage ceases.

24.7 The maximum compensation limit per Claim, considering the Hospitalisation and Total Incapacity to work due to illness or accident coverages, shall always correspond to 12 months of Cash Benefits.

24.8 This coverage applies to Incidents occurred both at home and abroad.

25. Exclusions

The situations referred to in paragraph 18 of these General Conditions are excluded from this sub-section.

26. Special Condition of eligibility of the Insured Person

Without prejudice to the provisions of paragraph 8 above, any subscriber shall only be considered an Insured Person for the purposes of the H coverages, provided that, at the moment of subscription, he/she has been working professionally, at least 16 (sixteen) hours a week, during the last 12 months, and is not aware of any impending H situation.

27. Claim obligations

27.1 Specifically regarding the coverage of H and without prejudice to the provisions of paragraph 11 above, the Insured Person is obliged to, under penalty of liability for losses and damages, send the Insurer, within the deadlines referred to in paragraph 11 above, the following documentation as soon as it becomes available:

- **a) Photocopy of the hospitalisation statement;**
- **b) Last personal income tax (IRS) declaration and document proving deductions for Social Security or equivalent contributory scheme (for self-employed workers);**
- **c) Photocopy of medical statement which includes the diagnosis, the nature of the injuries and the estimated H time.**

27.2 The assistant Attending physician is responsible for estimating and declaring that the H period exceeds the Relative Deductible period indicated in this contract.

The present document is a translation of the Portuguese version. In case of discrepancy between the versions, the Portuguese version shall prevail.