OCIDENTAL
grupo ageas

FORTE
Seguro de Vida para Doenças Graves

FORTE Life Insurance

General and Special Conditions of the Policy

Customer Service: 210 042 490 / 226 089 290
Cost of call to national landline
Personalised service available during business days from 8h30 to 19h00

www.ocidental.pt

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FORTE Life Insurance
General Conditions

Article 1 - DEFINITIONS

INSURER: Ocidental - Companhia Portuguesa de Seguros de Vida, S.A., legally authorised to practice insurance activity;

POLICYHOLDER: the natural or legal person who enters into the insurance contract with the Insurer;

INSURANCE PROPOSAL: document which entitles the Policyholder to sign an insurance contract under certain conditions;

INSURABLE GROUP: the set of persons who, at any time, maintain with the Policyholder the relationship or common interest defined as an eligibility requirement in the Special Conditions, Particular Conditions or Individual Certificate;

INSURED PERSON: the person, a member of the Insurable Group who has applied to enrol and has been accepted by the Insurer for the purposes of guaranteeing the risks covered under the terms set forth in this contract;

APPLICATION FOR ENROLMENT: document which entitles the Insured Person to sign an insurance contract under certain conditions;

POLICY: the set of documents that make up the insurance contract, the integral elements of which are the Insurance Proposal, Application for Enrolment and Health Questionnaires, General Conditions, Special Conditions, Particular Conditions, Individual Certificates and any additional documents issued in order to complete or alter it;

INSURED CAPITAL: value entered in the Individual Certificate as being due to the Beneficiary in the event a risk occurs that is deemed to be covered by the insurance contract;

ACTUARIAL AGE: the age on the Insured Person's birthday closest to the start or renewal date of the insurance contract;

INDIVIDUAL CERTIFICATE: the document issued by the Insurer proving the enrolment of each Insured Person in the insurance contract, mentioning, in particular, the insured capital and Policyholder, Insured Person and Beneficiaries' identifications;

BENEFICIARY: natural or legal person in whose favour the insured capital reverts in the event of a risk occurring that is covered by the policy;

CONTRIBUTORY GROUP INSURANCE: Group insurance is said to be contributory when, according to the contract, payment of the amount corresponding to the premium due from the Policyholder is borne fully or partially by the Insured Persons;

NON-CONTRIBUTORY GROUP INSURANCE: Group insurance is said to be non-contributory when the premium payment is borne by the Policyholder.

Article 2 - RISK STATEMENT

1 - The statements made by the Policyholder and the Insured Person, provided in the Insurance Proposal and the Application for Enrolment, as well as in the Health Questionnaires, if any, serve as a basis for this contract.

2 - Non-compliance by the Policyholder or the Insured Person with the duty to accurately declare all circumstances of which they are aware and should reasonably deem to be significant to the risk assessment shall determine the contract or enrolment's voidableness, alteration or termination, according to the circumstances and terms provided for by law.

ARTICLE 3 - OBJECT OF THE CONTRACT

1 - The object of this contract is coverage of the risk of death, designated as the principal coverage, as well as supplemental coverages contracted and included in the respective Special Conditions, when mentioned in the Particular Conditions and Individual Certificates, obliging the Insurer to pay the insured capital in the event any of the covered risks takes place.

2 - This contract does not confer any right to redemption, transfer or advance.

3 - Unless otherwise agreed in the Special Conditions, Particular Conditions or Individual Certificate and without prejudice to the applicable legal and contractual exclusions, this contract contains restrictions in its territorial scope for travel taking place outside the European Union, with the exception of the following countries: United Kingdom, Switzerland, Norway, USA, Canada, Australia, New Zealand and Japan.

4 - Whenever the Insured Person or, in the case of non-contributory group insurance, the Policyholder wishes to extend coverage to locations other than those referred to in the previous paragraph, they must, prior to the travel start date, communicate this fact to the Insurer, who may accept the extension under such conditions as may be established for the purpose and through payment of the respective premium surcharge.

5 - The Insurer shall not be responsible for guaranteeing any coverage, making any payment or providing any other benefit subject to this insurance contract inasmuch as such coverage, payment, claim settlement or benefit provision exposes the Insurer to any sanction, prohibition or restriction imposed by a United Nations resolution or by European Union sanctions, laws or commercial or economic regulations, to the extent that they are applicable under Portuguese law.

ARTICLE 4 - CONTRACT START AND TERM

1 - The contract shall start at midnight on the day immediately following the Insurer's risk acceptance, unless another start date is agreed.

2 - This contract is entered into for a period of one year, unless another initial period is agreed in the Special or Particular Conditions, renewing successively, at the end of the stipulated time period, for further one-year periods, without prejudice to the possibility of its termination under the terms set forth in this contract.

3 - Enrolments that do not begin on the contract's anniversary date shall be valid for the time period up to that date, after which they shall be renewed under the terms set forth in the previous paragraph.

ARTICLE 5 - INCONTESTABILITY

With the exception of supplemental accident and disability coverages, the Insurer cannot act on negligent omissions or inaccuracies in the initial risk statement once two years have elapsed since the contract's signing.

ARTICLE 6 - ENROLMENT CONDITIONS

1.- Any person may apply to enrol in this contract who is part of the Insurable Group defined in the Special Conditions, Particular Conditions or Individual Certificate.

2 - The Application for Enrolment, duly completed and signed by the candidate for Insured Person, as well as the Health Questionnaire, when existing, shall serve as a basis for the risk assessment and acceptance, the Insurer reserving the right to require, on its own account, other information concerning the health status of the candidate for Insured Person.

3 - The Insured Person may require, at any time, access to medical data from examinations performed.

4 - In addition to the information referred to in the preceding paragraph, the Insurer may require other information needed for the risk assessment.

5 - Until such time as the information requested under the terms of the preceding paragraphs has been assessed and until the end of the time period legally established for such purpose, the Application for Enrolment shall not be deemed accepted, and the Insurer may postpone the decision one or more times, by means of a reasoned communication addressed to the candidate for Insured Person.

6 - The Insurer's overall risk assessment may result in acceptance or rejection of enrolment in the contract or acceptance through payment of a premium surcharge, capital reduction or exclusion, total or partial, of coverages.

7 - Rejection or acceptance of insurance with a premium surcharge, capital reduction or exclusion of coverages shall be communicated in writing to the Insured Person within 30 days of completion of the respective individual risk analysis.

8 - At the initiative of the Policyholder or the Insurer, the effects following from the contract may be limited to those arising from the Individual Certificates already issued and in force on a given date.

9 - For the purposes of exercising the option set forth in the preceding paragraph, the interested party shall notify the other of its intention, by means of recorded letter sent at least 30 days before the date on which it is intended to take effect.

ARTICLE 7 – EXCLUSIONS

1 - Under the main coverage of Death, claims resulting from the following are not considered to be covered:

a) **pre-existing illness, considering such to be any involuntary change in the Insured Person's health, liable to objective medical confirmation, and which may have been subject to a diagnosis or which, with a sufficient degree of evidence, may have been disclosed on a date prior to that of enrolment in this contract, of acceptance of new coverage or of increase in the coverage's insured capital, in this latter case concerning only the exclusion of additional coverage, except when such has been formally communicated to the Insurer and accepted by the latter, under such conditions as may have been established for the purpose. If there is any change in the health status of the Insured Person between the underwriting date and the enrolment date of this contract, this change must be communicated to the Insurer so that the risk can be reassessed accordingly;**
b) **suicide of the Insured Person, if it occurred up to two years after the enrolment start date or the increase of the insured capital for death, in this latter case concerning only the exclusion of additional coverage;**
c) **criminal or administrative offence committed by the Insured Person, Policyholder or Beneficiary, stated as such in a final judgment, even without an actual conviction;**
d) **state of war (whether or not the Insured Person is mobilised), terrorism or disturbances to public order in the country of residence or another country, even during temporary travel;**
e) **natural disasters;**
f) **nuclear reactions and radioactive contamination;**
g) **intentional act or voluntary mutilation, drunkenness or use of drugs outside of medical prescription, deeming a person to be drunk whose blood alcohol level has been detected as higher than 0.5 grams/litre;**
h) **temporary or permanent travel to countries or regions where health authorities have declared an epidemic;**

The coverage guaranteed by the policy may be extended to the cases provided for in sub-paragraph h) of the preceding paragraph, under such conditions as may be established for this purpose with the Insurer and by prior payment of the respective premium surcharge.

ARTICLE 8 - BENEFICIARIES

1 - Unless otherwise stipulated in the Special or Specific Conditions, the Insured Person or, in the case of non-contributory group insurance, the Policyholder, shall designate the respective Beneficiary, and may at any time alter the beneficiary clause, with such alteration taking effect as of the date on which the Insurer received the corresponding written communication, which must be included as an additional record in the policy.

2 - The option to alter the beneficiary clause shall cease at the moment the Beneficiary acquires the right to the insured capital.

3 - The beneficiary clause shall be irrevocable whenever there has been express acceptance of the benefit by the Beneficiary or express waiver from the Insured Person or Policyholder, when such has been agreed, in altering it.

4 - The waiver from the Insured Person or the Policyholder to alter the beneficiary clause, as well as the Beneficiary's acceptance, depends on the effective written communication received by the Insurer.

5 - The beneficiary clause being irrevocable, the Beneficiary's prior written agreement will be required for the exercise of any right arising from the contract or from the option to modify the contractual conditions.

ARTICLE 9 - TERMINATION OF COVERAGE FOR EACH INSURED PERSON

1 - Unless otherwise set forth in the Special Conditions, Specific Conditions or Individual Certificate, the coverages guaranteed under this contract shall cease for each Insured Person:

a) in the event of termination of the contract or relationship resulting from enrolment, on the policy's anniversary date, provided that it is communicated 30 days in advance;
b) on the date of resolution of the contract;
c) on the date on which the Insured Person reaches the age limit established in Special Conditions or Individual Certificate;
d) on the date on which the Insured Person is excluded from group insurance in the event of termination of the relationship with the Policyholder;
e) when, depending on what has been agreed, the Policyholder or the Insured Person does not pay the premium to the Insurer on the date stipulated for this purpose;
f) when the Insured Person, or Beneficiary with the former's knowledge, commits fraudulent acts to the detriment of the Insurer or Policyholder;
g) in the event of payment of the insured capital due to attainment of the contract object.

2 - The Policyholder and the Insured Person undertake to notify the Insurer, within eight days, of the termination of the relationship or common interest defined in the contract as an eligibility requirement.

ARTICLE 10 - RISK INCREASE

1 - With respect to the coverage contracted, the Policyholder or the Insured Person undertakes to notify the Insurer in writing, within 14 days of their taking place, of the occurrence of any circumstances or the practice of any activities that may constitute a risk increase, which do not result from a worsening of the Insured Person' state of health, under penalty of resolution of the contract or termination of the guarantees conferred in relation to one or more Insured Persons, under the terms provided for by law.

2 - After receiving the notification referred to in the previous paragraph, the Insurer may choose, within 30 days, to maintain the coverage by applying the respective premium surcharge, or to terminate coverage, demonstrating that in any case, it does not enter into contracts that cover risks with the characteristics resulting from such risk increase.

ARTICLE 11 - AGE ADJUSTMENT

1 - In the event of divergence, upwards or downwards, between the stated age and the true age of the Insured Person, the Insurer's provision shall be reduced in proportion to the premium paid or the Insurer shall reimburse the premium excess, depending on the case. In the case of a fixed premium, the Insured Capital shall be reviewed according to the age of the Insured Person.

2 - The Insurer may terminate the contract if the true age diverges from the minimum and maximum limits established by the Insurer for entering into this type of insurance contract.

ARTICLE 12 - PREMIUM CALCULATION

The premium is fixed throughout the term of the contract and depending on the option selected, complying with the terms set forth in the Special Conditions or the Individual Certificate.

Article 13 - PREMIUM PAYMENT

1 - The obligation to pay the premium on the dates and under the conditions stipulated in the policy belongs to the Insured Person or, in the case of non-contributory group insurance, to the Policyholder.

2 - During the contract term, the Insurer must notify the Insured Person or, in the case of non-contributory group insurance, the Policyholder, in writing as to the amount to be paid, as well as the payment method and location, at least 30 days before the date the premium or instalments thereof fall due.

3 - The premium or fraction includes the costs of risk coverage, acquisition, management and collection and fractionation fees, in addition to the tax and parafiscal charges due.

4 - The charges related to issue of the policy or additional records, provided for in the Proposal or Individual Certificate, are included in the initial premium, or the first instalment thereof, or in the premiums corresponding to contract changes.

5 - Premium payment shall take place at the Insurer's headquarters or offices, unless otherwise agreed by the parties, however, the Insurer has the option to collect payment at a different location, or to use other methods appropriate for facilitating payment.

ARTICLE 14 - NON-PAYMENT OF PREMIUM

1 - Non-payment of the premium on the due date gives the Insurer the right to terminate coverage related to the Insured Person or terminate the contract, as appropriate.

2 - If the premium is not paid on the due date, if the contract provides for an irrevocable benefit in favour of a third party, the Insurer must, within 30 days, request replacement of the Insured Person or the Policyholder, in the case of non-contributory group insurance, in order to make said payment.

3 - By means of payment of late premiums, plus default interest calculated at the rate applicable to commercial operations, the Insured Person may exercise the option to reinstate in force, under the original conditions and by means of a health declaration and subject to acceptance by the Insurer, the coverages within a maximum period of three months as of the effective date of their termination. Risk coverages come back into force upon expiration of the last premium payment.

ARTICLE 15 - CLAIM VERIFICATION AND PAYMENT OF INSURED AMOUNTS

1 - Claim verification shall be communicated to the Insurer by the Policyholder, the Insured Person or the Beneficiary within eight days of its occurrence.

2 - Whenever the claim verification is reported to the Insurer after the deadline provided for in the preceding paragraph, the value of the Insurer's payment shall correspond to the insured capital at the date of the report, and no premium shall be reimbursed.

3 - In addition to the claim communication, the following supporting documents must be provided:

a) risk verification: death certificate and medical certificate stating the circumstances, causes, onset and evolution of the disease or injury that caused the death;
b) designated Beneficiary: supporting document for designated heir or Beneficiary, fiscal card, identity card or, alternatively, citizen's card or any other documents that may legally replace them, and, if the Beneficiary is a legal person, updated commercial registration certificate, access code for permanent certificate or legally equivalent document issued by the competent authority; and
c) when applicable, compliance with the Insured Person's decisions as to allocation of the insured capital.

4 - Submission of all documents referred to in the preceding paragraph shall take place within 60 days following the claim verification.

5 - Payment of the insured capital under the principal coverage and any supplemental coverages that have been contracted shall take place at the Insurer's offices or via the method agreed upon.

6 - The Insurer undertakes to pay the contractual payment to whomsoever it is due, 30 days after confirmation of the claim and its causes, circumstances and consequences.

7 - Unless otherwise stipulated:

a) if the designation is made in favour of several Beneficiaries, the Insurer shall effect payment in equal portions;
b) in the event of predecease of the Beneficiary, or of any of them when there are several Beneficiaries, the insured capital or the Beneficiary's share in said capital shall go to the respective heirs according to the legal rules of succession;
c) if the Beneficiary is a minor, the Insurer shall pay the insured capital or the portion due to them whoever unequivocally demonstrates being their legal representative and upon presentation of the minor's birth certificate.

8 - With respect to the principal coverage, if no Beneficiary has been designated, the Insurer shall effect payment to the Insured Person's heirs upon proof of their heirship, under the terms and according to the legal rules of succession.

9 - The costs of obtaining the necessary supporting documents shall always be borne by the Beneficiary.

10 In cases where the Insurer pays the insured capital and then demonstrates that no covered risk occurred or proves the existence of an applicable exclusion, the Insurer is entitled to reimbursement of the respective amount.

ARTICLE 16 - CONTRACT TERMINATION

1 - Unless otherwise provided for by law, the contract may be terminated by the Policyholder or the Insurer on the policy's anniversary date, provided that the proper written communication is conveyed at least 30 days in advance by recorded letter or another means that produces a permanent record.

2 - After contract termination, the Individual Certificates and additional documents shall be without effect, and their reinstatement in force is not allowed.

3 - The contract may be terminated pursuant to paragraph 1 of article 14, or if, on the anniversary date, the number of Insured Persons is below the minimum that has been stipulated for the purpose in the Special or Particular Conditions or in the Individual Certificate, as well as in other cases provided for by law.

ARTICLE 17 - PROFIT SHARING

Unless otherwise stipulated in the Special or Particular Conditions, this contract does not allow for profit sharing.

ARTICLE 18 - AUTONOMOUS INVESTMENT

This contract does not allow for autonomous investment of the assets representing the mathematical provisions.

ARTICLE 19 - TRANSFERABILITY

The option to transfer the Policyholder's contractual position does not apply in this contract.

Article 20 - COMMUNICATIONS AND DOMICILES

1 - Communications from the Policyholder, Insured Person and Beneficiary or Insurer for the purposes of this contract shall be deemed to be valid and fully effective if they are effected in the Portuguese language, in writing or by another means which produces a permanent record,

and conveyed respectively to the Insurer's head office or to the last address of the Policyholder, Insured Person or Beneficiary contained in the contract.

2 - When, due to its very nature or origin, the documentation referred to in the previous paragraph is produced in a foreign language, it shall be accompanied by a duly certified translation, pursuant to article 440 of the Code of Civil Procedure.

3 - The Insured Person or, in the case of non-contributory group insurance, the Policyholder who temporarily takes up residence outside Portugal must designate a domicile in Portuguese territory for the purposes of this contract.

ARTICLE 21 – FREE RESOLUTION

1 - The Policyholder, or, when a Contributory Group, the Insured Person, has a period of 30 days, counting from the date of receipt of the policy, to withdraw from the effects of the contract.

2 - The withdrawal must, under penalty of ineffectiveness, be notified to the Insurer by recorded letter sent to the address of its head office.

3 - The exercise of the right of withdrawal shall determine termination of the contract's effects, extinguishing all the obligations arising therefrom, and shall entail in particular the return of the premiums paid to the Insurer, without prejudice to the Insurer being entitled to the premium calculated *pro-rata temporis* and to the cost of the policy.

4 - The exercise of the right of withdrawal shall not give rise to any compensation other than that stipulated in the preceding paragraphs.

ARTICLE 22 - TAX REGIME

The tax regime applicable to this contract shall be the one in force on the date of the taxable event deemed relevant, and the Insurer shall not incur any burden, charge or liability as a consequence of legislative change.

ARTICLE 23 - APPLICABLE LAW, COMPLAINTS AND ARBITRATION

1 - The law governing this contract is Portuguese law.

2 - Complaints from the Policyholder/Insured Person or other interested parties may be submitted to the department responsible for the management of the Insurer's complaints, in the Complaints Book, to the Customer Ombudsman or to the Autoridade de Supervisão de Seguros e Fundos de Pensões [Insurance and Pension Funds Supervisory Authority] (www.asf.com.pt). In the event of a dispute, the parties may have additional recourse to the following Alternative Dispute Resolution Entity: CIMPAS – Centro de Informação, Mediação e Arbitragem de Seguros [Insurance Information, Mediation and Arbitration Centre] - (www.cimpas.pt) - or the courts.

3 -In disputes arising under this contract, there may be recourse to arbitration, according to the terms of the law.

ARTICLE 24 - COMPETENT JURISDICTION

The competent jurisdiction to settle any disputes arising from this contract is that established by civil law.

ARTICLE 25 - SOLVENCY AND FINANCIAL SITUATION REPORT

The report on the Insurer's solvency and financial situation is published annually, in accordance with legislation in force, and is available at www.ocidental.pt.

Special Conditions
Special Conditions - FORTE

ARTICLE 1 - INSURABLE GROUP

1 - The Insurable Group consists of the set of persons who are customers of the Policyholder or a directly or indirectly affiliated entity, and who, in compliance with the provisions of Article 6 of the General Conditions of Annual Renewable Temporary Insurance (Group Life Insurance), have an actuarial age between 50 and 75 years of age upon underwriting.

2 - Unless otherwise stipulated, this contract cannot be associated and/or be given as a guarantee to any loan agreement entered into with the Policyholder or with any other Banking Institution.

ARTICLE 2 - INSURED PERSONS

1 - Insured Persons are those who belong to the Insurable Group and whose risk has been accepted by the Insurer, upon receipt of the respective Applications for Enrolment and clinical elements deemed necessary for the analysis of such risk.

2 - Risk acceptance may concern one or two Insured Persons, as stipulated in the Particular Conditions or Individual Certificates.

ARTICLE 3 - BEGINNING OF COVERAGE

For each Insured Person, the contract shall come into effect at midnight on the day following the Insurer's individual risk acceptance.

ARTICLE 4 - GUARANTEES

1 - By means of this contract, the Insurer guarantees, pursuant to the applicable General and Special Conditions, payment to the designated beneficiaries of the Insured Capital stipulated in the respective Individual Certificate or Additional Record, according to the option selected by the Insured Person.

2 - In addition to the main coverage, this contract includes the supplemental coverage of Serious Illnesses, subject to acceptance by the Insurer. The insured capital of this coverage is decreasing and calculated according to the actuarial age of the Insured Person, being updated annually on the renewal date of the contract and communicated in advance to the Insured Person. The insured capital for the first 10 years of the contract corresponds to that presented in the Simulation, provided that the actuarial age does not change by the time of issuance of the respective contract.

3 - The Insured Person may subscribe to one of three fixed premium options, and may change this option to another with a higher amount, once during the contract term, subject to acceptance by the Insurer.

4 - The Insured Person can only subscribe to one certificate from this product.

5 - Payment of the Insured Capital shall become due at the moment one of the risks covered with respect to the Insured Person is confirmed.

ARTICLE 5 - TERMINATION OF GUARANTEES

1 - In addition to what is stipulated in the General and Special Conditions, the contract guarantees shall cease under the following conditions:

a) when the Insured Person reaches, on the contract renewal date, 100 years of actuarial age, unless otherwise indicated in the Particular Conditions or Individual Certificate of Insurance;
b) in the event of payment of the Insured Capital upon Death or under the supplemental coverage.

ARTICLE 6 – CONTRACT TERM

Without prejudice to the provisions of articles 10 and 16 of the General Conditions, the contract shall be entered into for a period of one year, and automatically renewed for successive periods of one year.

ARTICLE 7 - PREMIUM PAYMENT

1 - The obligation to pay the premium on the dates and under the conditions stipulated in the Policy belongs to the Insured Person.

2 - The premium is paid monthly and depends on the option in force.

3 - Pursuant to paragraph 4 of Article 13 of the General Conditions, the charge for issuing the policy or additional riders is €5.00. Legal fees shall be added to this amount.

ARTICLE 8 – RISK INCREASE

1 - With respect to the coverage contracted, the Policyholder or the Insured Person undertakes to notify the Insurer in writing, within 14 days of their taking place, of the occurrence of any circumstances or the practice of any activities that may constitute a risk increase, which do not result from a worsening of the Insured Person' state of health, under penalty of resolution of the contract or termination of the guarantees conferred in relation to one or more Insured Persons, under the terms provided for by law.

2 - After receiving the notification referred to in the previous paragraph, the Insurer may choose, within 30 days, to maintain the coverage by applying the respective premium surcharge, or to terminate coverage, demonstrating that in any case, it does not enter into contracts that cover risks with the characteristics resulting from such risk increase.

Special Conditions - FORTE
Supplemental Coverage – Serious Illnesses

ARTICLE 1 - DEFINITIONS

For the purposes of this supplemental coverage, the following definitions apply:

SERIOUS ILLNESSES: The illnesses identified in article 3 of these Special Conditions.

PRE-EXISTING ILLNESS: An illness that has been the object of an unequivocal diagnosis or that, with a sufficient degree of evidence, has manifested itself on a date prior to the conclusion of this contract.

GRACE PERIOD: interim period between the coverage start date and the date on which said coverage takes effect, with illnesses that manifested during the waiting period also deemed as pre-existing.

PHYSICIAN: Licensed by a Faculty of Medicine, authorised to practice their profession in their respective country of residence. All specialities not recognised by the Portuguese Medical Association are excluded.

ARTICLE 2 - OBJECT OF COVERAGE

1 - Under this coverage, the Insurer guarantees payment to the Beneficiary of the insured capital specified in the Particular Conditions or Individual Certificate, in the event of manifesting one of the Serious Illnesses mentioned in the following article during the duration of this coverage.

2 - The guarantees provided by this coverage are subject to a grace period of 3 months for diseases such as Myocardial Infarction, Cerebrovascular Accident, Paralysis and Blindness, 6 months for Cancer and 12 months for Alzheimer's or Severe Dementia and Parkinson's. In such a case, the premiums paid for this coverage will be refunded and it will be cancelled with reference to the starting date of the same.

3 - With the payment of the capital under this coverage, all coverage of the policy ceases.

ARTICLE 3 - SERIOUS ILLNESSES

1 - For the purposes of this supplemental coverage, the following are considered to be Serious Illnesses:

a) <u>Cancer or Malignant Tumours - of specific gravity</u>

Cancer or tumour is defined by there having been growth and dissemination of malignant cells and tissue invasion, including leukaemia, sarcoma and lymphoma, confirmed in definitive diagnosis and by means of a pathological report.

The definitive diagnosis must be confirmed by an Oncologist registered with the Portuguese Medical Association. The following are excluded from coverage:

i) All tumours that are histologically described as benign, pre-malignant, suspect or borderline, of low malignancy potential, all grades of dysplasia, all grades of squamous intraepithelial lesions (LEIAG or HSIL and LEIBG or LSIL), and all degrees of intraepithelial neoplasia;
ii) Any tumour classified as carcinoma *in situ* (Cis or Tis) or Ta by the latest edition of the Cancer Staging Manual of the *American Joint Committee on Cancer,* hereinafter referred to as AJCC;
iii) All non-melanoma skin cancers, cutaneous lymphomas, and dermatofibrosarcomas that have not spread to the lymph nodes or distant areas;
iv) Stage 1 cutaneous melanomas according to the last edition of the AJCC Cancer Staging Manual; neuroendocrine tumours (carcinoids);
v) Gastrointestinal stromal tumours;
vi) Thyroid cancer classified as T1N0M0 that is smaller than 2 cm;
vii) Prostate cancer with the exception of those that are histologically classified at a grade greater than or equal to 7 according to the Gleason scale or have progressed to at least stage T2N0M0 according to the latest edition of the AJCC Cancer Staging Manual;
viii) All bone marrow malignancies (including, but not limited to leukaemia, myeloproliferative neoplasms, essential thrombocythaemia, primary myelofibrosis, polycythaemia vera, and myelodysplastic syndrome), with the exception of those requiring treatment with recurrent blood transfusions, therapeutic phlebotomies, chemotherapy, bone marrow transplantation or hematopoietic progenitor cell transplantation.
ix) All cancers identified exclusively by tumour cells, DNA fragments or any other biomarker, some of which may be present in blood, saliva, urine, or other body fluids, including but not limited to tests known as "liquid biopsies".

b) <u>Myocardial infarction (Heart attack) – of specific gravity</u>

An acute myocardial infarction is one in which part of the heart muscle has died as a result of inadequate blood supply to the heart and which meets the following three (3) cumulative criteria and which must be consistent with the diagnosis of an acute myocardial infarction:
i) Clinical symptoms;
ii) Characteristic electrocardiographic (ECG) changes; and
iii) Characteristic increase above the amounts considered normal for specific cardiac biochemical markers.

The definitive diagnosis must be confirmed by a Cardiologist registered with the Portuguese Medical Association.

The following are excluded from coverage:

i) Angina pectoris, myocarditis, heart failure, and all forms of acute coronary syndromes;
ii) Takotsubo cardiomyopathy; and
iii) Acute myocardial injury due to arrhythmias, trauma, pulmonary embolism, or septicaemia.

c) <u>Stroke – of specific gravity</u>

Acute stroke is considered to be one that is supported by the results in brain imaging tests. There must be irreversible death of brain tissue due to inadequate blood supply or bleeding within the brain matter, or bleeding within the subarachnoid space. The stroke must cause a permanent and objective neurological deficit that is evident on physical examination and that persists for a continuous period of at least 30 days after the stroke has occurred. The definitive diagnosis must be confirmed by a Neurologist registered with the Portuguese Medical Association. The following are excluded from coverage:

i) Transient Ischemic Attack (TIA);
ii) Stroke due to an accident or injury;
iii) Blood vessel disorders affecting the eye, including optic nerve or retinal infarction;
iv) Vascular events affecting the spinal cord; or
v) Asymptomatic silent stroke found on imaging tests.

d) <u>Alzheimer's dementia and other Major Neurocognitive Disorders (Dementia) – of specific gravity</u>

A Major Neurocognitive Disorder (Dementia) or Alzheimer's disease is considered to be one that is confirmed by clinical history, neurocognitive tests and brain imaging tests. There should be a progressive deterioration of memory and intellectual capacity with severe cognitive dysfunction evidenced by a Mini-Mental State Examination (MMSE) with a score below 10 of a maximum of 30, or equivalent to this score using another standardised and clinically-accepted cognitive function test. There must also be a permanent reduction in mental and social function so that the insured person requires ongoing supervision in assisting with activities of daily living.
Dementia due to psychiatric illness <u>is excluded</u>.
The definitive diagnosis must be confirmed by a Neurologist registered with the Portuguese Medical Association.

e) **Parkinson's Disease and other Specific Parkinsonian Disorders - of specific gravity**

A definitive diagnosis of idiopathic Parkinson's disease or one of the following atypical parkinsonian disorders - Progressive Supranuclear Palsy, Corticobasal Degeneration, or Multiple System Atrophy - is considered to be one in which the Insured Person shows objective signs of progressive deterioration for which the neurologist has recommended dopaminergic medication or other equivalent clinically-accepted treatment for Parkinson's Disease.

In the definition described above, any other type of parkinsonism is excluded.

The definitive diagnosis must be confirmed by a Neurologist registered with the Portuguese Medical Association.

f) **Blindness - of specific gravity**

A definitive diagnosis of blindness is considered to be one in which there is a permanent and irreversible loss of vision in both eyes. Vision tests must present one (1) of the following criteria:

i) **Vision in the better eye should be reduced to an improved, corrected visual acuity of less than 20/200 (<0.1); or**

ii) **Visual field limitation of 20 degrees or less in both eyes.**

Blindness should not be amenable to correction by surgical means or procedures.

The definitive diagnosis must be confirmed by an Ophthalmologist registered with the Portuguese Medical Association.

g) **Limb paralysis – total and irreversible – of specific gravity**

A definitive diagnosis of paralysis is considered to be one in which there is a total and irreversible loss in the use of two or more limbs due to injury or disease of the nerve reactivity in the muscle. This definition also includes quadriplegia, hemiplegia and paraplegia. Complete paralysis of the arm(s) and/or leg(s) must be evident upon physical examination and supported by adequate neurological evidence. A Neurologist registered with the Portuguese Medical Association must be of the opinion that the paralysis is permanent and must be present for more than 90 days.

In the definition described above, paralysis due to psychological disorders is excluded.

The definitive diagnosis must be confirmed by a Neurologist registered with the Portuguese Medical Association.

ARTICLE 4 - JUSTIFICATION AND RECOGNITION OF THE RIGHT TO GUARANTEES

1 - Reporting of the claim must be made in writing and within the 180 days immediately following the observation/diagnosis of the disease, sending to the Insurer, in addition to the information provided for in article 3 of these Special Conditions, the following documents:

i) **a clinical report, accurate and detailed, prepared by the specialist doctor monitoring the Insured Person, which includes the diagnosis of the Serious Illness and its date, a reference to the entire clinical history of the Insured Person and the date on which the first symptoms of Serious Illness appeared, along with the treatments, hospitalisations, surgeries and respective dates;**
ii) **histological report, when applicable;**
iii) **reports of the complementary means of diagnosis and therapy that show the diagnosis and respective clinical follow-up.**

2 - Whenever the claim verification is reported to the Insurer after the deadline provided for in the preceding paragraph, the value of the Insurer's payment shall correspond to the insured capital at the date of the report, and no premium shall be reimbursed.

3 - The Insured Person must authorise their attending physician to provide, in a confidential manner, the physician representing the Insurer with all medical information related to the declared claim.

4 - The Insurer reserves the right to demand, at its own expense, any supplemental justification and to investigate as it deems appropriate in order to determine the Insured Person's state of health, namely sending the latter to be examined by its doctors, terminating its liability if the Policyholder, Insured Person or Beneficiaries prejudice or impede the regular exercise of such option.

5 - Without prejudice to the provisions of the previous paragraph, the costs of obtaining the necessary supporting documents shall always be borne by the Insured Person or Beneficiaries.

6 - Differences of a clinical nature shall be settled by a medical committee, which must be convened on Portuguese territory, consisting of three medical experts, one designated by the Insurer, another by the Insured Person and the third by agreement between the former and latter, with the respective decisions taken by majority vote and unappealable, with each of the parties bearing their doctor's expenses and fees, as well as 50 % of the costs related to the committee's third doctor.

7 - The right to the guarantees, under the terms of this supplemental coverage, shall take effect as of the date of the Insurer's confirmation of the Serious Illness.

8 - The Insurer shall inform interested parties in writing of its position concerning the serious illness of the Insured Person within 30 days of receiving the documents described in 1.

ARTICLE 5 – EXCLUSIONS

Under this complementary coverage for Serious Illnesses, claims arising from pre-existing pathologies that have not been declared by the Insured Person are not covered.

Pre-existing illness means any pathology, disease or injury in which, prior to the date of policy effectiveness, the Insured Person has been diagnosed with said illness, or has shown signs or symptoms of the illness, or has consulted a doctor, or has been prescribed any treatment, or has performed medical tests or investigations, or was aware of its existence.

ARTICLE 6 - BENEFICIARIES

In the absence of a designated beneficiary under this supplemental coverage, the Beneficiary shall be the **Insured Person**.

ARTICLE 7 - TERMINATION OF GUARANTEES

1 - For each Insured Person, the guarantees of this supplemental coverage shall cease to be effective:

a) in the event of termination, annulment, declaration of invalidity, resolution or expiry of the main coverage to which this coverage is supplemental;
b) when the Insured Person reaches, on the contract renewal date, 100 years of actuarial age, unless otherwise indicated in the Particular Conditions or Individual Certificate of Insurance;
c) in the event of payment of the Insured Capital due under this supplemental coverage;
d) in the event of payment of Insured Capital due under the main coverage.

2 - If the death of the Insured Person occurs before fourteen (14) days elapse from the date of the pathological diagnosis, the capital due will be the insured capital from the death coverage, thereby immediately terminating the contract.

ARTICLE 8 - PREMIUM PAYMENT

Payment of the premium related to this supplemental coverage shall be made along with and under the same conditions as the main coverage premium.

ARTICLE 9 - FINAL PROVISION

The policy's General and Special Conditions shall apply to anything not expressly provided for under this supplemental coverage.

Special Conditions - FORTE
Supplemental Coverage – Support Services

Article 1 - DEFINITIONS

For the purposes of this supplemental coverage, the following definitions apply:

DOMICILE: - Place where the Insured Person is residing during the claim.

SUPPORT SERVICE: - 24-hour care service, through which Ocidental guarantees the provision of services under these conditions.

ILLNESS: –All involuntary changes in health, not caused by accident, and diagnosed by a physician.

ARTICLE 2 - OBJECT OF COVERAGE

Within the scope of this supplemental coverage, the following support services are guaranteed, regardless of whether the other contracted coverages are triggered:

(a) Home Doctor

In case of sudden illness and after pre-assessment by the Support Service, a Doctor will be sent to the Insured Person's home.

The Insured Person shall be responsible for a copayment of €10.00 per visit, as well as the amount of consumables used in the acts to be provided.
This service is available every day, 24 hours a day.

(b) Home Nursing

The Support Service arranges for the sending of a nursing professional to the Insured Person's home to perform prescribed nursing acts individually. The Insured Person shall be responsible for the costs of consumables used in the act to be provided.

The following nursing acts are included:

- **Treatment of wounds, pressure ulcers and/or scars;**
- **Injections;**
- **Catheterisation;**
- **Nasogastric intubations;**
- **Saline administration and monitoring;**
- **Removing stitches and staples;**
- **Hygiene and comfort care services;**
- **Vaccination;**
- **Aerosols;**

- **Oxygen therapy;**
- **Nursing care for colostomies, ileostomies, tracheostomies and urostomies.**
- **Food Services**

The Support Service shall organise and bear the costs of sending a specialist to deliver food to the Insured Person's home, with the cost of food borne by the Insured Person.

The costs associated with the organisation of the service shall be borne by the Support Service up to the limit of allotted requests. Once the limit is exceeded, the Support Service can make all services available, the costs being borne by the Insured Person, with the Support Service handling only their availability and organisation.

(c) Physical Therapy Services at Home

In the event of having a medical prescription, the Support Service shall arrange for a physiotherapy professional to perform the prescribed treatments that can be done at the Insured Person's home.
The costs associated with the organisation of the service shall be borne by the Support Service up to the limit of allotted requests.
Once this limit is exceeded, the Insured Person may enjoy all the services, with the costs borne by the Insured Person, and the Support Service handling only their availability and organisation.

(d) At-home Analysis

If there is a medical prescription, the Support Service shall arrange for a health technician to travel and collect the liquid samples necessary to perform clinical tests.
The costs associated with the organisation of the service shall be borne by the Support Service up to the limit of allotted requests. Once this limit is exceeded, the Insured Person may enjoy all the services, with the costs borne by the Insured Person, and the Support Service handling only their availability and organisation.

(e) Non-Urgent Transport

The Support Service shall organise the Insured Person's travel to Health Units, by taxi, for Complementary Diagnostic Examinations, Consultations, Hospitalisations and Hospital Discharges.
The costs associated with the organisation of the service shall be borne by the Support Service up to the limit of allotted requests. Once this limit is exceeded, the Insured Person may enjoy all the services, with the costs borne by the Insured Person, and the Support Service handling only their availability and organisation.

ARTICLE 3 - LIMITATIONS

The services and/or benefits to the Insured Person are limited to those described in the table of services below.

Summary of Services	Requests and Limits
Home Doctor	Unlimited Copayment €10 / per visit
Home Nursing	5 x / annually
Physical Therapy Services at Home	5 x / annually
At-home Analysis	1 x / annually
Non-Urgent Transport	2 x / annually

ARTICLE 4 - HELPLINE

Support Services can be triggered by the Insured Person through the customer support number indicated on the Individual Certificate.

ARTICLE 5 – EXCLUSIONS

Under this supplementary cover for Support Services, benefits are excluded if they have not been previously requested from the Support Services through the means of contact indicated on the Individual Insurance Certificate, or if they have been requested outside the period of validity of the contract.