OCIDENTAL
grupo ageas

Expenses Protection Plan

General and Special Conditions of the Policy

Customer Support: 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

www.ocidental.pt

CONTENTS

PERSONAL ACCIDENTS

GENERAL CONDITIONS

Article 1 - Coverages

1. This contract guarantees the following coverages, contained in the respective Special Conditions, provided they are identified in the Particular Conditions: Temporary Total Incapacity to Work due to Accident or Illness (TTI), Involuntary Unemployment (IU) and Hospitalization (H).

2. It is only possible to activate one of the coverages referred to in the previous paragraph for each incident.

3. Personal Accidents: Death or Permanent Disability.

4. The coverage of Death or Permanent Disability can be activated simultaneously with the other coverages of the policy (TTI, IU, H).

Article 2 - Definitions

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

INSURER: Ageas Portugal – Companhia de Seguros, S.A., entity legally authorized 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 Particular Conditions of the Policy, on behalf of whom the contract is concluded and that holds a current account in which the payment of the domestic expenses indicated in the policy are domiciled, whose life, health or physical integrity is insured.

EMPLOYEE: the exercise, in return for a remuneration, of a professional activity, as a dependent worker, for an employer, under the authority and direction of the latter, through the establishment of an individual employment contract, being registered with Social Security.

SELF-EMPLOYED PERSON: the exercise of a professional activity, as a self-employed person, or a commercial, industrial or agricultural activity as an entrepreneur trading under his/her own name, either individually or associated to other people, provided he/she is registered in the National Register of Legal Persons as an entrepreneur trading under his/her own name or as a self-employed person in the respective Finance Office and pays social security contributions or is registered under an equivalent contributory scheme.

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.

FRAUD: unlawful conduct by the Insurance Policyholder, Insured Person, Beneficiary or third party, aimed at obtaining from the Insurer, for him/herself or another, an illegitimate benefit or an illegitimate increase of the benefit.

BENEFICIARY: the natural or legal person receiving the Insurer's payment by effect of the coverage established in this insurance contract in the case of the Insured Person's death under circumstances covered by the 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.

EXPENSES PROTECTION PLAN: understood to be an insurance policy connected to the "Payment Domiciliation" service that guarantees the monthly payment of the domestic expenses (exclusively television, internet and telephone, electricity, water, gas and condominium services) domiciled in the bank account identified in the contract and that ensures the payment of a monthly sum according to the contracted option, which is identified in the Insurance Proposal or in the Particular Conditions of the Policy.

REFUND: is the sum returned to the Insurance Policyholder of a part of the insurance premium already paid.

DOCTOR: graduate of a Medical Faculty, legally authorised to carry out the profession in the respective country, and whose speciality and registration are recognised by the Portuguese Medical Association.

SUM INSURED: the maximum sum payable by the Insurer per Claim or insurance annuity or another time limit, according to what is established.

ACCIDENT: a fortuitous, sudden and unexpected event, due to an external cause, violent and against the wishes of the Insured Person, which results in clinically and objectively confirmed bodily injuries to the Insured Person;

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 ACCIDENT OR ILLNESS: 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.

HOSPITALIZATION: clinical situation requiring the hospitalization 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.

TOTAL UNEMPLOYMENT: situation arising from the total and involuntary lack of employment of the Insured Person, who is registered at the Employment Centre, not including the situations of partial unemployment or employment that allow maintaining the right to payment of unemployment benefit.

INVOLUNTARY UNEMPLOYMENT: situation of Total Unemployment due to:
(i) Collective dismissal, i.e. termination of the employment contract by the employer,

which covers (simultaneously or successively over a period of three months) at least two or five workers (depending on whether it is, respectively, a micro company or small company, on the one hand, or a medium-sized or large company, on the other), whenever it is based on the closure of one or various sections (or equivalent structures) or on the reduction of workers due to market, structural or technological reasons;
(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;

(iv) Unilateral termination of employment by the employee for justified reasons, i.e. indication of the reason for termination given by the employee, based namely on the breach of obligations by the employer, on the need by the worker to fulfil a legal obligation that is incompatible with the continuation of the contract or on important and permanent changes to the working conditions made by the employer.
For the purposes of this definition of Involuntary Unemployment, market reasons means the reduction of the company's activity resulting from the foreseeable decrease in demand for goods or services or from the practical or legal impossibility of placing those goods or services on the market; structural reasons means economic and financial imbalance, change in activity, restructuring of the productive organization or substitution of dominant products; and technological reasons means changes in manufacturing techniques or processes, automation of production, control or cargo handling tools, as well as computerisation of services or automation of communication means.

DEDUCTIVE ITEM: the value of the settlement of the incident claim which, under the terms of the insurance contract, is not payable by the Insurer, and whose amount or form of calculation is stipulated in the contract;

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 acceptance of the Insured Person, there is no entitlement to the sum payable by the Insurer.

REQUALIFICATION PERIOD: time period after the payment of the sum payable by the Insurer under this policy during which there is no entitlement to the payment of the sum payable by the Insurer in the event of another incident. The requalification period only applies between two incidents of the same coverage.

Article 3 - Obligations of the Parties

Without prejudice to other duties foreseen in this contract and in the law:

1. The Insurance Policyholder or Insured Person are obliged to:

a) provide the Insurer with all the documents deemed reasonably necessary by the latter for assessment of compliance with the conditions of acceptance or verification of the circumstances of an Incident;
b) carry out any medical examinations that may be requested by the Insurer, when the insurance contract is signed or in the event of a Claim, without prejudice to the Insured

Person's right to, upon request, access the results of the medical examinations undertaken;

c) inform the Insurer of the occurrence of any Incident covered by the Policy within a maximum period of eight days;

d) inform the Insurer, within the period of 14 days counted as of becoming aware of the fact, of all the circumstances that increase the risk;

e) contribute to the non-deterioration of any situation that may worsen the consequences of an Incident that may have occurred and make use of the means at his/her disposal to prevent or limit the damages;

f) inform the Insurer of other insurance contracts with the same object of this contract.

2. The Insurer is obliged to:

a) provide, at the request of the Insurance Policyholder or Insured Person, all the information necessary for the effective understanding of this contract;

b) pay the compensations he/she is obliged to under this Policy, following confirmation that each Incident falls within the scope of the guarantees of said policy;

c) provide, in accordance with applicable legislation, access to the results of any medical examinations undertaken;

d) maintain confidential, in accordance with the law, all the information that is provided by the Insurance Policyholder or Insured Person, namely with reference to the state of health.

e) Within 30 days of becoming aware of the increased risk, the Insurer may:

- present the Insurance Policyholder with a proposal to modify the contract, which the latter should accept or refuse during an equal period of time, after which it is understood that the proposed modification has been approved;
- terminate the contract, demonstrating that under no circumstances shall the Insurer conclude contracts covering risks with the characteristics resulting from this increased risk.
- the termination of the contract under the terms established above takes effect at 24 hours of the 14th day following the Insurer's dispatch of the communication stating the cancellation.

Article 4 - Omissions or Inaccuracies

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.

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

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 annulment 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. 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.

5. In the event 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.

6. In the event of negligent breach of the duty referred to in paragraph 1, the Insurer can:

a) within the period of 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 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 days as from the date of reception of the proposed amendment, with the subscription terminating if 20 days after reception of the amendment proposal the Insured Person does not reply or rejects the proposal.

7. Upon termination of the contract foreseen in the foregoing paragraph, the premium paid, in proportion to the period of time that has elapsed until the end of the annuity underway, is returned.

8. If an Incident occurs prior to the termination or amendment of the contract under the terms foreseen in paragraph 6 of this article 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 celebration of the contract, 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.

Article 5 - Start and Duration of Coverage

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 zero hours of the day indicated in the policy, except in relation to the guarantee of Personal Accidents whose coverage of the risks begins on the day following the acceptance of the insurance proposal or of

the adherence bulletins of the Insured Persons.

2. The guarantees cease automatically relative to each Insured Person on the earlier of the following dates:
a) in the event of termination of the contract by the Insurance Policyholder and the Insured Person;
b) on the date on which the Insured Person reaches 65 years of age;
c) on the date on which the Insured Person ceases to have the "Domiciled Expenses" service associated to the Current Account indicated in the policy;
d) on the date on which the Current Account is closed;
e)on the date of retirement or pre-retirement of the Insured Person (pre-retirement means the occurrence of a situation of reduction or suspension of work, by agreement between the employer and a worker aged 55 or over, during which the worker is entitled to receive from the employer a monthly cash benefit, known as pre-retirement), for the coverages of TTI, IU and H.
f) On the date of payment of compensation related to Death or Permanent Disability.

3. Without prejudice to the provisions in the foregoing paragraph, the Insurance Policyholder may terminate this contract by registered letter posted 30 days prior to the date intended for the purposes of termination;

4. Except in cases of early payment of the premium, the early termination of the subscription results in the rebate to the Insurance Policyholder of the premium paid in proportion to the period of the contract that has not elapsed, provided there has not yet been a payment of any sum payable by the Insurer arising from a Claim.

5. The contract ceases effect at 24 hours of the last day of its term.

6. When the contract is signed for a year to be continued for following years, it is considered successively renewed for annual periods, unless one of the parties issues notice of termination of the contract in writing or other means leaving a durable record at least 30 days in advance of the end of the annuity.

Article 6 - Period of Relative Deductible and Requalification

The guarantees object of this contract are subject to:
a) a Relative Deductible Period of 30 days for the coverages of Temporary Total Incapacity to Work due to Accident or Illness and Involuntary Unemployment and of seven days for the coverage of Hospitalisation;
b) a Grace Period of 90 days;
c) a Requalification Period: Between the last payment of a compensation relative to a claim and a new claim, a minimum period of 6 months of active work must elapse. The requalification period only applies between two incidents of the same coverage.

Article 7 - Beneficiary Designation

The sole beneficiary of this contract is the Insured Person, who is irrevocably designated.

Article 8 - Conditions of Eligibility of the Insured Person

In order to be eligible for this contract, a person must:

a) be between 18 and 64 years of age;
b) have been working professionally, at least 16 hours a week, during the last 12 months, and is not aware of impending unemployment;
c) hold a current account in which domestic payments and expenses are domiciled.
d) have signed a health statement, confirming awareness that all pre- existing pathologies on the date of subscription and any future pathology directly or indirectly related to the latter are excluded.

Article 9 - Premiums

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

2. The premium, with the fractioning foreseen in the Particular Conditions, is paid directly by the Insurance Policyholder to the Insurer, via debit of the Insurance Policyholder's bank account.

3. Unless agreed otherwise, the initial premium or its first instalment falls due on the date of the signing of the contract.

4. During the enforcement of the contract, the Insurer must notify the Insurance Policyholder in writing of the amount payable, as well as the form and place of payment, at least 30 days in advance of the date when the premium or its instalments fall due.

5. The notice must present, in a legible manner, the consequences of non-payment of the premium or its instalment.

6. For insurance contracts where it is agreed that the premium should be paid in instalments every three months or less and whose contractual documentation indicates the due dates of the successive instalments of the premium and the corresponding amounts payable, as well as the consequences of their non-payment, the Insurer can decide not to send the notice referred to in number 1. In this case, the Insurer is responsible for proving the issue, acceptance and sending to the Insurance Policyholder of the contractual documentation referred to in this number.

7. Non-payment of the initial premium or its first instalment, on the due date, determines the automatic cancellation of the contract as of the date of its conclusion.

8. Failure to pay the premium of subsequent annuities or its first instalment, on the due date, will prevent the extension of the contract.

9. Non-payment determines the automatic cancellation of the contract on the due date of:

a) an instalment of the premium in the course of an annuity;
b) an adjustment premium or part of a premium of a variable amount;

c) an additional premium arising from an amendment to the contract based on a supervening increase of risk.

10. Non-payment, by the due date, of an additional premium arising from a contractual amendment shall make the amendment void, with the contract remaining with the scope and under the conditions that were enforced before the intended amendment, unless the contract proves impossible to remain in effect, in which case it shall be deemed to have been cancelled on the unpaid premium due date.

11. The termination of the contract due to non-payment of the premium, or part or an instalment of the premium, does not exonerate the Insurance Policyholder from the obligation to pay the premium corresponding to the period when the contract was in force, plus any late payment interest payable.

12. If there is no alteration to the risk, any alteration to the premium applicable to the contract can only take effect on the following annual due date.

Article 10 - Claim Procedures

1. In the event of an Incident, the Insurance Policyholder, Insured person or whomsoever has a legitimate interest in activating the insurance must report the incident to the Insurer within eight days immediately following the date on which the Policyholder, Insured person or other become aware of the Incident, under penalty of a reduction of the sum payable by the Insurer given the damage that non-compliance with this duty causes the latter. The Insured Person must, namely, report the Accident or Illness to the Insurer as soon as he/she has indication that the Relative Deductible Period indicated in this contract will be exceeded.

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 his/her entitlement to coverage.

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.

4. Once the Insurer has been notified of the Incident, without prejudice to the provisions in the preceding paragraphs, the Insurance Policyholder or the Insured Person 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.

5. Fraud or attempted fraud committed by the 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 or exclude the Insured Person from the same, without prejudice to the applicable criminal provisions and compensation for losses and damages.

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 Insurance Policyholder or the Insured Person.

7. 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.

8. The settlement of each Incident claim approved for payment is carried out following the reception, by the Insurer, of the documentation necessary for the analysis of each process.

9. The Insurance Policyholder or Insured Person also undertakes to, under penalty of being accountable for losses and damage:

a) notify the Insurer, up to 15 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 attending doctor to provide all the information requested by the Insurer.

10. In the event of the confirmed impossibility of the Insurance Policyholder or Insured Person complying with the obligations established in this article, these obligations are transferred to whosoever is able to comply with them.

Article 11 - General Exclusions

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 or persons for whom the former are civilly liable;

The Insurer is not be liable for guaranteeing any coverage, make any payment of a claim or provide any other benefit object of this insurance contract to the extent that the guarantee of that coverage, that payment, the settlement of that claim or the provision of that benefit expose the Insurer to any sanction, prohibition or restriction imposed by a United Nations resolution or by commercial sanctions, laws or regulations of the European Union, provided the latter are applicable according to Portuguese law.

Article 12 - Coexistence of Contracts

In the case of multiple insurances, this contract shall only operate in the case of the non-existence, nullity, ineffectiveness or insufficiency of previous insurance policies, except in relation to the coverage of Death or Permanent Disability.

Article 13 - Profit Sharing

This contract does not provide entitlement to profit sharing.

Article 14 - Transfer of Contract

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

Article 15 - Free Termination

1. **The Insured Person can, by notifying the Insurer, in writing or by any other means which provides a durable record, terminate the contract without invoking just cause within the 30 days immediately after the date of reception of the policy. The period begins from the conclusion of the contract, provided the Insurance Policyholder has, on that date, on paper or any other durable medium, all the relevant information about the insurance.**

2. **Termination of the insurance contract, foreseen in the foregoing paragraph, implies the refund of the premium paid in proportion to the period of time that has not yet elapsed.**

3. **The contract may be cancelled by the parties at any time, when there is just cause, by written communication or other means leaving a durable record.**

4. **The Insurer may invoke the occurrence of a succession of incidents in the annuity, as a relevant cause for the effect established in the previous number.**
5. **The cancellation of the contract takes effect at 24 hours of the 14th day following receipt of the communication of cancellation.**

Article 16 - Complaints

Any complaints from the Insurance Policyholder/ Insured Person or other interested parties can be presented to the Insurer's services, in the Complaints Book, Ombudsman, Insurance and Pension Fund Supervision Authority (www.asf.com.pt). In the event of a dispute, the parties can also resort to the following Alternative Dispute Settlement Entity: CIMPAS – Centro de Informação, Mediação, Provedoria e Arbitragem de Seguros www.cimpas.pt or courts.

Article 17 - Applicable Law and Jurisdiction

1. When the parties have not chosen, within the limits of the law, another law by which they are bound, this contract shall be governed by the provisions of Portuguese law.

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

SPECIAL CONDITION

TEMPORARY TOTAL INCAPACITY TO WORK DUE TO ACCIDENT OR ILLNESS (TTI)

Article 1 - Scope / Coverages (what is covered)

1. In the event of Temporary Total Incapacity to work due to Illness or Accident of the Insured Person occurred during this contract period and that extends beyond 30 consecutive days, the Insurer shall pay the Beneficiary the sum corresponding to the expenses domiciled in the bank account indicated in the policy and due that month, up to the maximum value of the insured capital, according to the monthly limit of the Option contracted under the terms foreseen in the Particular Conditions. The payment shall continue until the Insured Person is able to return to work or until the maximum limit of 12 months per Incident is reached.
In the compensation, relative to the last period, which has a duration of less than 30 days, the amount to be reimbursed is calculated based on 1/30 of the monthly sum of the cash benefit and multiplied by the number of days of duration of that same period. For all due purposes, the last period means the number of days between the last paid period (payment of the claim) and the date on which the condition that gave rise to the activation of the coverage, e.g. returning to work, ceases.

2. Without prejudice to the Relative Deductible period, the Temporary Total Incapacity to work due to Accident or Illness period begins on the day immediately after the date on which the start of incapacity for work through a certificate of incapacity is attested.

3. This contract applies to Incidents occurred both at home and abroad.

Article 2 - Exclusions (what is not covered)

Without prejudice to the Exclusions established in the General Conditions of the Contract, the situations excluded from the guarantees of this Special Condition include 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 arising from alcoholism, both in acute and chronic processes, drug addiction or consumption of 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 or goods;
e) diseases caused intentionally by the Insured Person or arising from 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 similarly dangerous sports;
j) aesthetic and cosmetic treatments, unless they are directly associated with any Illness or Accident.
k) back pain or lumbago.

Article 3 - Claim Obligations

In the event of Temporary Total Incapacity to work due to Accident or Illness, the Insured Person shall submit copies of all the Certificates of Temporary Incapacity issued by the doctor of the Health Centre or by the Insurance Company in the event of a road or work accident, statement issued by the employer and report from the family doctor or assistant doctor about the Insured Person.

SPECIAL CONDITION - INVOLUNTARY UNEMPLOYMENT (IU) - FOR EMPLOYEES

Article 1 - Scope / Coverages (what is covered)

1. In the event of occurrence of a situation of Involuntary Unemployment during the contract period and that extends beyond 30 consecutive days, the Insurer shall pay the Beneficiary the sum corresponding to the expenses domiciled at the bank account indicated in the policy and due that month, up to the maximum value of the insured capital, according to the monthly limit of the Option contracted under the terms foreseen in the Particular Conditions. The payment shall continue until the Insured Person is able to return to work or until the maximum limit of six months per Incident is reached.
In the compensation, relative to the last period, which has a duration of less than 30 days, the amount to be reimbursed is calculated based on 1/30 of the monthly sum of the cash benefit and multiplied by the number of days of duration of that same period. For all due purposes, the last period means the number of days between the last paid period (payment of the claim) and the date on which the condition that gave rise to the activation of the coverage, e.g. returning to work, ceases.

2. The Involuntary Unemployment coverage only applies to employees. If the Insured Person is self-employed, the IU coverage shall be substituted by the H coverage.

3. This contract applies to Incidents occurred both at home and abroad.

4. In those cases where the legality of dismissal on fair grounds is being decided in Court, the Insurer can undertake the reimbursement when the judicial decision where the involuntary unemployment is recognised is rendered.

Article 2 - Exclusions (what is not covered)

Without prejudice to the Exclusions established in the General Conditions of the Contract, the situations excluded from the guarantees of this Special Condition include those that result from:

a) Termination of the employment contract due to retirement or pre- retirement of the Insured Person, i.e. termination of the employment contract due to retirement of the worker or due to the occurrence of a situation of reduction or suspension of work, by agreement between the employer and a worker aged 55 or over, during which the worker is entitled to receive from the employer a monthly cash benefit, known as pre-retirement;

b) Termination of the employment contract by agreement between the worker and the employer;

c) termination of the employment contract by the employee without justified reasons, i.e. with no indication for dismissal given by the worker, based namely on the breach of obligations by the employer, on the need by the worker to fulfil a legal obligation that is incompatible with the continuation of the contract or on important and permanent changes to the working conditions made by the employer.

d) Termination of the employment contract during the experimental period by the worker or employer;

e) workers abroad with employment contracts not bound by Portuguese legislation;

f) dismissal for justified reasons, i.e. following wrongful conduct of the worker which, due to its gravity and consequences, makes the continuation of the work relationship immediately and practically impossible;

g) termination of the employment contract for a fixed or uncertain term, commonly called "fixed-term contract", i.e. termination of the employment contract due to the fact that the period of time set for its duration ended or due to the fact that the situation that led to its conclusion terminated;

h) unemployment resulting from seasonal activity, i.e. from activity that only arises in a specific period of the year, necessarily limited, subsequently losing its utility;

i) pre-existing unemployment situations at the date of contract subscription.

Article 3 - Claim Obligations

Specifically regarding the coverage of Involuntary Unemployment and without prejudice to the provisions of article 10 of the General Conditions of the Policy, the Insured Person is obliged to, under penalty of liability for losses and damages, report in writing to the Insurer the IU situation, as soon as he/she has indication that the Relative Deductible period will be exceeded and within a maximum period of 30 days from the date of the event, indicating its start date and causes by completing the "Incident Report" form 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 days after the start date of the unemployment situation and must be renewed every month).

SPECIAL CONDITION - HOSPITALIZATION (H) - FOR SELF-EMPLOYED PERSONS

Article 1 - Scope / Coverages (what is covered)

1. If the Insured Person is self-employed and his/her Hospitalisation exceeds a period of seven consecutive days, the Insurer shall pay the Beneficiary the sum corresponding to the expenses domiciled at the bank account indicated in the policy and due that month, up to the maximum value of the insured capital, according to the monthly limit of the Option contracted under the terms foreseen in the Particular Conditions.

2. If the Hospitalisation situation referred to in the previous paragraph exceeds more than 30 consecutive days, the payment of the amount corresponding to the expenses domiciled at the bank account indicated in the policy and due that month shall be carried out under the guarantee of Temporary Total Incapacity to work due to Accident or Illness, until the Insured Person is able to return to work or until the maximum limit of five months per incident is reached.

3. In the compensation relative to the last period, which has a duration of less than 30 days, the amount to be reimbursed is calculated based on 1/30 of the monthly sum of the cash benefit and multiplied by the number of days of duration of that same period. For all due purposes, the last period means the number of days between the last paid period (payment of the claim) and the date on which the condition that gave rise to the activation of the coverage, e.g. returning to work, ceases.

4. The Hospitalisation coverage only applies to self-employed persons.

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

Article 2 - Exclusions (what is not covered)

Without prejudice to the Exclusions established in the General Conditions of the Policy, the situations referred to in article 2 of the Special Conditions of coverage of Temporary Total Incapacity to work due to Accident or Illness are excluded from this coverage.

Article 3 - Claim Obligations

Specifically regarding the coverage of Hospitalisation and without prejudice to the provisions of article 10 of the General Conditions of the Policy, the Insured Person is obliged to, under penalty of liability for losses and damages, send the Insurer, within the deadlines referred to in article 10 of the General Conditions, the respective hospitalisation statement and subsequent monthly statements supporting continued hospitalisation.

SPECIAL CONDITION PERSONAL ACCIDENTS

Article 1 - Scope / Coverages (what is covered)

1. By this contract, the Insurer, as a consequence of an accident incurred by the Insured Person, provided it is included in the coverage of Death or Permanent Invalidity, guarantees the payment up to the limits established therein of the corresponding indemnity.

2. By explicit agreement in the Individual Certificate, Particular Conditions, Special Conditions or Endorsement, the Insurance Policyholder, Insured Person or Beneficiaries may be charged the deductive items mentioned therein.

3. Unless explicitly provided for otherwise in the Individual Certificates or Specific Conditions, accidents occurred in any part of the world derived from the following are covered:

a) Professional and Extra-Professional risk, with risk coverage 24 hours a day;
b) Extra-Professional risk is defined as that derived from all activity not related to the performance of the Insured Person's profession, whether performed as a self-employed person or employee;
c) Professional risk is defined as that inherent to the performance of the professional activity of the Insured Person, explicitly referred to in the Individual Certificate, Particular Conditions, Special Conditions or Endorsement
d) Unless established otherwise in the Particular Conditions, Individual Certificate or Endorsement, the Personal Accidents guarantees of this contract are exclusively valid for Insured Persons resident in Portugal, with the guarantees expiring on the date when the Insured Person moves his/her

residence to abroad. Without prejudice to prior communication of the Insured Person/Insurance Policyholder, travel abroad for a period above 90 days is considered, in the context of this contract, change of residence, with all the guarantees ceasing at this time.

4. Coverages:

a) Death: In the case of Death of the Insured Person, occurred as a consequence of an accident covered by this contract and when the causal link with the accident is clinically confirmed, the Insurer shall pay the indemnities to the Beneficiaries named in the Particular Conditions, Special Conditions, Individual Certificate or Endorsement.

b) Permanent Disability: In the case of Permanent Disability of the Insured Person, occurred as a consequence of an accident covered by this contract, immediately or during two years counted from the date of the accident and, unless explicitly stated otherwise in the Particular Conditions, Special Conditions, Individual Certificate or Endorsement, the Insurer shall pay the Insured Person the indemnity amount corresponding to the sum insured and clinically confirmed degree of devaluation, determined pursuant to the National Table for Assessment of Permanent Incapacity in Civil Law.
For the purposes of the guarantee of the risks mentioned above, the following definitions are applicable:

PERMANENT DISABILITY: situation of subsequent permanent functional limitation as a consequence of after-effects produced by an accident;

Unless agreed otherwise in the Insurance Proposal, Particular Conditions, Special Conditions or Endorsement, the degree of devaluation of Total or Partial Permanent Disability is always attributed in accordance with the National Table for Assessment of Permanent Incapacity in Civil Law, with the Insurer not recognizing, for the effects of indemnity concerning professional risk, any other degree of devaluation which may have been attributed to the Insured Person, based on another table, namely the Portuguese National Table on Incapacity Related to Work Accidents.

Injuries not listed in the devaluation table, even of minor importance, shall be indemnified in proportion to their severity compared to that of the listed cases, without taking into account the profession practised.

Any physical defects related to limbs or organs which the Person already had shall be taken into consideration when establishing the degree of devaluation derived from the accident, which shall correspond to the difference between the already existing disability and that henceforth.

The partial or total functional incapacity of a limb or organ is assimilated to the corresponding partial or total loss.

Regarding the same limb or organ, the accumulated devaluation cannot exceed that which would correspond to the total loss of this same limb or organ.

Whenever an accident results in injuries to more than one limb or organ, the total

indemnity is obtained by adding the value of the indemnities relative to each one of the injuries, provided that the total does not exceed the sum insured.

5. When Death or Permanent Disability coverage is contracted, this coverage is not cumulative, therefore, if the Insured Person dies as a consequence of an accident occurred during two years counting as of the date of the accident, the Death indemnity shall be abated by the value of any indemnity due to Permanent Disability which may have been attributed or paid relative to the same accident.

Article 2 - Exclusions (what is not covered)

Without prejudice to the Exclusions established in the General Conditions of the Policy, the following are always excluded from the coverages of the Special Condition of Personal Accidents:

1. injuries or consequences derived from crimes or other intentional acts of the Insured Person;
2. accidents imputable to the Insured Person and occurred when under the effect of psychotropic substances, narcotics or any drugs or toxic products without medical prescription or when the Insured Person shows a blood alcohol level equal to or above 0.5g/l;
3. accidents occurred at a time when the Insured Person, due to a psychic anomaly or other cause, shows incapacity to control his/her acts;
4. hernias, whatever their nature, varicose veins and their complications and lumbago (resulting from planned efforts carried out in a constant manner).
5. action carried out by the Beneficiary of the Policy, Insurance Policyholder or anyone for whom they are civilly liable, on the Insured Person;
6. heart attack and cerebrovascular accidents (stroke);
7. exacerbation of an accident, as a consequence of a pre-existing illness or infirmity on the date of conclusion of the insurance contract, in which case the Insurer's liability cannot exceed that which would result if the accident had occurred to a person not bearing this illness;
8. any other illnesses, when not confirmed through unequivocal and indisputable medical diagnosis that they are a direct consequence of the accident;
9. accidents resulting from lack of observance of preventive or punitive legal or regulatory provisions, applicable in general or especially, to the practice of different sports, cultural or recreational activities in the context in which they occur;
10. notoriously dangerous acts which are not justified by the performance of the Insured Person's profession;
11. negligent acts or omissions, when the negligence can be classified as gross;
12. suicide or attempted suicide and voluntary or attempted self- mutilation, as well as self-inflicted bodily injuries or inflicted by others under the consent of the Insured Person, even if these acts are committed unconsciously;
13. all treatments, namely rehabilitation, when not carried out by duly qualified health professionals or without the required clinical diagnosis, medical supervision or guidance;
14. explosions or any other phenomena directly or indirectly related to nuclear fission or fusion, as well as the effects of radioactive contamination, or from the use or transport of radioactive material;

15. accidents derived from the practice of professional sports or competitions, even if amateur, integrated in championships and respective training;
16. accidents arising from natural disasters, acts of war, terrorism, disturbances to public order and the use or transport of radioactive material;
17. accidents derived from the practice of big game hunting, equestrian sports, power boating, diving, winter sports, parachute jumping, bull- fighting, hang-gliding, motor-free flying, boxing, martial arts and other similarly dangerous sports;
18. use of any type of aircraft, except as passengers of commercial airlines;
19. muscular ruptures or distensions and back pain, whenever this does not result from an external, involuntary and spontaneous cause not controlled by the Insured Person;
20. strikes, labour disturbances, riots or alteration in public order, acts of terrorism and sabotage, insurrection, revolution, civil war, invasion and war against foreign countries, declared or not, and hostility between foreign nations, whether or not war is declared, or warlike acts directly or indirectly derived from these hostilities;
21. participation in any type of speed competition;
22. accidents occurred in mines or during mining activity;
23. professional risks of divers and ship personnel and crews;
24. activities of the Air Force, Navy, Army or Military Forces, where extra-professional risks are only accepted in individual insurance policies.

The Insured Person, or the Beneficiary, if different, lose the right to indemnity if:
a) they voluntarily or intentionally exacerbate the consequences of the incident;
b) use fraud, simulation or any other deceitful means as well as false documents to justify their claim.

The present contract does not guarantee, under any circumstances whatsoever, the risk of death to persons under the age of 14 years old.

Article 3 - Claim Obligations

1. Take measures to prevent exacerbation of the consequences of the accident;

2. Provide written notification of the accident during the immediately following eight days, indicating the place, day, time, causes, witnesses and consequences;

3. Send, up to eight days after the Insured Person has been clinically assisted, a medical statement indicating the nature of the injuries, their diagnosis, any expected days of Temporary Incapacity, as well as indication of possible Permanent Disability;

4. Communicate, up to eight days after its occurrence, the cure of the injuries, by sending a medical statement indicating the percentage of Permanent Disability which may have been confirmed, based on the National Table for Assessment of Permanent Incapacity in Civil Law, unless stipulated otherwise in the Particular Conditions, Special Conditions or Endorsement;

5. Comply with the medical prescriptions or else the Insurer shall only be liable for the consequences of the accident which would presumably have occurred if

these prescriptions had been followed;

6. Take the medical examination designated by the Insurer;

7. Authorise the doctors to provide all of the information requested by the Insurer, otherwise the Insurer's liability shall cease;

8. If the accident results in the death of the Insured Person, the Insurer should be sent, supplementary to the notification of the accident, a death certificate indicating the cause of death and, when considered necessary, other elucidative documents on the accident and its consequences.

9. In the case of the confirmed impossibility of the Insurance Policyholder or insured Person to meet any of the obligations established in this article, this obligation is transferred to whosoever – Insurance Policyholder, Insured Person or Beneficiary – can comply with them;

10. Lack of truth in the communications and information to the Insurer implies liability for any consequent losses and damage.

Article 4 - Beneficiaries

The Beneficiary in the case of Permanent Disability is the Insured Person. In the case of Death, the Beneficiary or Beneficiaries are the Legal Heirs of the Insured Person.

Article 5 - Settlement of the insured amounts

1. Unless explicitly agreed otherwise, the payments to be made by the Insurer under this insurance contract will always be carried out by credit to the bank account used for the payment of the premiums.
In situations which have not been explicitly foreseen, the payments due will be made at the offices of the Insurer, at the place of issue of this contract.

2. The values of the guaranteed indemnities are explicitly indicated in the Particular Conditions of the Policy or Individual Certificates.

3. If the Beneficiary is a minor, the Insurer shall make a deposit in his/her name, at the Banking Institution indicated by the Insurance Policyholder or Insured Person or legal representatives of the Beneficiary, of the amount corresponding to the insured amounts.

4. In the case of Death, the Insurer shall pay the corresponding sum insured to the Beneficiary explicitly named in the Policy.

5. In the case of Permanent Disability, the payment of the indemnity, unless explicitly stated otherwise in the Particular Conditions, shall be made to the Insured Person.

6. If the consequences of an accident are exacerbated by a pre-existing illness, illness or infirmity prior to the date of its occurrence, in this case the Insurer's liability cannot exceed that which it would incur if the accident had occurred to a person not bearing this illness or infirmity, unless explicitly stated otherwise in the Particular Conditions or Individual Certificate.

Article 6 - Medical Advisory Board

If the parties fail to reach an agreement regarding the occurrence of a situation of permanent disability or temporary incapacity, the Insurance Policyholder and Insured Person undertake to accept that the decision shall be obtained through a medical advisory board composed of three experts - one indicated by the Insurer, another indicated by the Insurance Policyholder or Insured Person and a third indicated by agreement of the first two experts, with the respective decisions taken by absolute majority which cannot be subject to appeal. Each party shall pay the expenses and fees of his/her expert doctor, as well as 50% of the charges related to the third expert doctor of this board.

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