May 2018 version

TEAM®

Team Existenz Absicherungs Modell

Team Existence Assurance Model – Group Life and Disability coverage in Germany

Contract information

Legal note: This is an unofficial translation of the original, German language Policy Terms and Conditions document and is for illustrative purposes only.
The original policy document in German language prevails in any case.

Policy number <PolicyNumber>
Quote reference number CAS03206-001

This contract information apply together with the policy schedule starting at the 01.06.2015.
They replace previous versions of this document.

TEAM®

Dear Sir or Madam,

In the terms and conditions we address the employer who requested the insurance coverage as the "insured" and as such our contractual partner.

The following documents constitute the entire contract between the insured and Zurich:

- This document contains the general aspects of the contract.
- The attached policy schedule details the premium and benefits of this contract as well as special terms.
- The signed application form specifies your requirements.

Individual agreements are in the special terms of the policy schedule. Such agreements take precedence over the arrangements of the terms and conditions.

This contract between you and us has priority over all previous arrangements. The employees (group members) are not contractual partners and therefore have no rights of this contract. Any other agreements between you and the group members are not binding for Zurich.

Please pay particular attention to the information about your right regarding withdrawal.

General information

Dear Sir or Madam,

Insurance companies are required by law to provide policy-holders with the below information concerning their contracts:

1. Identity of insurer, including name, address, legal form, domicile, branch (if any) where the contract was entered into, company registration details and number.

   Zurich Eurolife S.A.
   Building Elise, 21 rue Léon Laval
   L-3372 Leudelange
   Luxembourg

   Domicile: Luxembourg
   Legal form: Société Anonyme (S.A.)
   Registered in Luxembourg,
   Registre de Commerce et des Sociétés
   Company code B-51753

2. The identity of a representative of the insurer in the European Union member state where the policyholder is resident, if such a representative exists, or of another person acting commercially for the insurer, other than the person offering the insurance cover, if the policyholder deals with the latter, and the capacity in which this person acts in dealings with the policyholder.

   Zurich Eurolife S.A. operates in Germany in accordance with the principle of freedom to provide of services, and therefore does not have an authorised representative in that country. You can contact us either via your intermediary, or at the address below.

3. The insurer's physical address, and any other address relevant to business dealings between the insurer, its representative or other commercially active person as specified in paragraph 2, and the policyholder and, in the case of legal persons, corporations or groups of individuals, the name of a person authorised to represent them.

   Zurich Eurolife S.A.
   Building Elise, 21 rue Léon Laval
   L-3372 Leudelange
   Luxembourg

   Represented by Mr Xavier Nevez,
   Chief Executive Officer.

4. The insurer's principal business.

   Zurich Eurolife S.A.'s principal business is life insurance.

5. The existence of a guarantee fund or of other compensation schemes not covered by directive 94/19/EC of the European Parliament and of the Council of 30 May 1994 on deposit-guarantee schemes (Official Journal of the European Community no. L 135, page 5), and directive 97/9/EC of the European Parliament and of the Council of 3 March 1997 on investor-compensation schemes (Official Journal of the European Community no. L 84, page 22). The guarantee fund's name and address must be given.

   No guarantee fund exists.

6. The main characteristics of the insurance cover, including

   a) The general terms of insurance cover, including premiums, and the law applying to the contract

   b) The nature, scope, duration and other details of the service provided by the insurer.

   All this information is set out further below in this document.

7. The total price of the insurance cover, including all taxes and other price components, with the premiums being shown separately if the cover includes more than one independent insurance contract or, if the exact price cannot be specified, details of how it is calculated so that the policyholder can check it.

   This information is given in your quotation.

8. Any additional costs, including the total amount payable, any additional taxes, fees or costs that will not be paid or billed via the insurer, and any costs payable by the policyholder for the use of long-distance communication facilities, if these additional costs are billed.

   This information is given in your quotation.

9. Details of how premiums and other sums are to be paid.

   All this information is set out further below in this document.

10. The validity period of information provided, such as prices and other offerings.

    Your quotation will cease to apply when there is a change in the information used to calculate premiums.

11. The fact that the cover is based on financial instruments which involve special risks because of their specific characteristics or the way in which they operate, or which are subject to price fluctuations on the financial markets which are beyond the insurer's control, and that past results are no indicator of future performance. Details must be provided of these circumstances and the risks involved.

    This does not apply to pure risk insurance, e.g. life and disability insurance.

12. How the contract will come into force, when the policy and the cover begin, and for how long the application is binding on the policyholder.

    The contract comes into force when the policy schedule is sent, and the cover begins on the date specified on the policy schedule. There is no binding period for applications.

13. Whether the policyholder has a right to withdraw from the contract and, if so, details of how to exercise it, the name and address of the person to notify, the legal implications of withdrawal, and the amounts payable in such circumstances.

    This information is given further below in this document.

14. The term of the contract, and any applicable minimum period.

    Please see your quotation and below in this document.

15. How the contract is terminated, and any contractual penalties and other terms that apply.

    Please see further below in this document.

16. The European Union member state whose law applies to the insurer's dealings with the policyholder before the contract is signed.

    The contract is governed by German law.

17. A contractual clause stating which law applies to the contract, or which court has jurisdiction.

    Please see further below in this document.

18. The languages in which the contract and this preliminary information are written, and the insurer, with the policyholder's agreement, undertakes to communicate in this language during the term of the contract.

    Your contract and related documents will be in German.

19. Whether the policyholder has access to extrajudicial complaint and legal assistance procedures other than through the courts and, if so, how to access these. It should be specifically stated that these do not affect the policyholder's right to take legal action.

    There is no extrajudicial body dealing with complaints, and Zurich Eurolife S.A. is not a member of the German insurance ombudsman scheme. However, you may take court action at any time.

20. The option to submit a complaint to the regulatory authority specified in paragraph 4.

    The address of the regulatory body is:

    Commissariat aux Assurances (CAA)
    7, boulevard Joseph II
    L-1840 Luxembourg

    Alternatively, you can complain to the German financial services regulator:

    Bundesanstalt für
    Finanzdienstleistungsaufsicht (BaFin)
    Graurheindorfer Straße 108
    D-53117 Bonn

    This does not affect your right to take legal action.

We are also required by the Verordnung über Infomationspflichten bei Versicherungsverträgen (Regulation concerning the Provision of Information on Insurance Contracts) to inform you of the following:

1. Any costs relating to the intermediation and signing of this contract that are not billed separately.

   Please see your quotation.

2. Other costs included in the premium.

   Please see your quotation.

3. How your share of any surpluses will be notified and paid to you.

   There are no funds invested under this contract and consequently no surpluses exist.

4. The surrender value.

   This contract has no surrender value.

5. The minimum insurance cover for conversion into a paid-up or reduced-premium contract, and the benefits payable under such a contract.

   This contract cannot be made paid-up.

6. Whether the benefits specified in paragraphs 3 and 4 are guaranteed.

   The contract does not provide for surpluses or surrender values, so no guarantees apply.

7. The funds underlying the insurance cover, and the nature of the assets they contain (in the case of unit-linked insurance).

   This contract has no underlying funds.

8. The tax rules applying to this type of insurance

   Please see the tax information included in the contract details.

Note on the definition of disability

The definition of disability used in this insurance product is not the same as that of disability or loss of income as defined in employment law, or of disability as defined in the law on health insurance. For this reason, for example, receiving recognised illness benefit does not automatically entitle you to benefits under this group life coverage. The differences in definitions may result in gaps in illness benefit cover.

Withdrawing from the policy

Right of withdrawal

You may withdraw from a life insurance contract in writing (for example by mail, fax or email), without giving reasons, at any time during the 30-day period after you receive the policy schedule, general and specific terms and conditions of contract, the other information specified in §§7.1 and 7.2 of the Versicherungsvertragsgesetz (Insurance Contracts Act) and § 1 to § 4 of the VVG Infor-mationspflichtenverordnung (Regulation on the Provision of Information Concerning Insurance Contracts) and this document, all in written form. Notice of withdrawal will be deemed to have been served if you send it by the specified date.

You should send it to:

Zurich Eurolife S.A.
Building Elise, 21 rue Léon Laval
L-3372 Leudelange
Luxembourg

quoting your policy number.

Please address a withdrawal via e-mail at:
zigrs.zel@zurich.com.

Effects of withdrawal

If you submit valid notice of withdrawal, coverage will cease to apply and we will reimburse that part of the premium applying to the period after you withdraw, if you have consented to coverage starting before the end of the withdrawal period. We will retain that part of the premium relating to the period before you withdraw from the contract, pro rata for the number of days, with one day's premium being one 365th of the annual premium. We will refund the premium within 30 days of receiving your notice of withdrawal.

If coverage has not begun before the end of the withdrawal period, and you give valid notice of withdrawal, we will return all premiums, interest and other payments received.

Please note

Your right to withdraw from the contract no longer applies if, at your express request, we fulfil the contract before you exercise the right of withdrawal.

Terms and conditions

of insurance coverage for group life insurance with disability benefit

Contents

1. What is the scope of coverage?

(1) What is covered?

This group life policy provides coverage for employees, hereafter referred to as group members. The insured risk is the death of a group member during the policy period. Coverage may also include disability as an additional insured risk. If all group members are covered on compulsory basis, we may waive the requirement for medical underwriting under certain circumstances. See §3.1 for more details.

We may also agree to increase coverage for one or more group members, in which case we will carry out medical underwriting; see §3.2 for more details.

Details of coverage are given in the policy schedule which, among other items, includes the following:

- The insurance benefits (death, or death and disability)
- The sum insured
- Any additional contractual agreements

The policy period is one year, but you may enter into a new contract for coverage to continue. Further details are given in §6.

(2) Death benefit

We will pay the agreed benefit if a group member dies during the policy period.

Group members who leave employment due to disability during the policy period maintain their death coverage, provided that the employer continues to pay the respective insurance premium for these group members (see §8.2).

(3) Disability benefit

If coverage has been extended to include disability, we will pay the agreed disability benefit (annuity or lump sum) if a group member reaches or exceeds the agreed minimum degree of disability. Furthermore the disability has to occur during the policy period and persist throughout the waiting period and has to be prognosticated permanently from a physician. The claim arises after the agreed waiting period (see paragraph 5).

The benefit amount is determined in each case by the minimum degree of disability specified in your policy schedule.

Annuity

The benefit will be paid quarterly in advance.

Lump sum

In case disability occurs during the reduction period the sum insured is reduced. The reduction period is specified in your policy schedule. In this case the benefit is determined by the multiplication of the sum insured with the period from start of disability to the term age divided by the reduction period. Example:

Term age	65 years
Sum insured	EUR 250.000
Reduction period	5 years (60 months)
Duration from start of disability to the term age	2.5 years (30 months)
Benefit payable	EUR 250,000 x 30 / 60 = EUR 125,000

(4) Indexation

If the contract provides for annual indexation of annuity disability benefits, those will be increased by the relevant percentage from the start of the second year of payments.

(5) Waiting period

Disability benefit is payable after the agreed waiting period, which starts at the end of the month in which the group member becomes disabled, and whose duration is specified in the policy schedule. If they cease to be disabled, and then become disabled again within 24 months as a result of the same cause, previous waiting periods will be taken into account.

(6) Waiver of medical evidence for group members

No medical evidence will be required if the following conditions are met:

- Each group of group members is clearly defined on the basis of age, length of service, or length of employment (eligibility criteria).

- The type and amount of benefit is clearly defined for each group, based on specific criteria.
- The sum insured does not exceed the automatic acceptance limit specified in your policy schedule.
- The number of group members meets the current minimum group size for automatic acceptance limits (at least 20 group members).
- All of the group members are actively at work (see paragraph 7).
- All employees who meet the eligibility criteria are covered at policy start date, and coverage is compulsory.
- If an employee meets the eligibility criteria after policy start date, their coverage will start on the first day of the month after they meet the criteria. If they meet the criteria on the first of the month (for example, if they join the company), they will be covered from that date.

Any individuals who are not actively at work at policy start date will not be covered at this time, but at the time shown in the last bullet point above.

All employees who meet the eligibility criteria and are actively at work are covered under this policy.

We will investigate during the claims assessment whether these conditions were fulfilled.

In some cases, an individual may be covered even if they are not actively employed or do not meet the eligibility criteria, provided we confirm this in writing.

We may adjust the automatic acceptance limit without notice if we become aware of significant changes as defined in §12.1. Any such change will not affect group members who are already covered.

If the sum insured for a group member exceeds the automatic acceptance limit at policy start date, or their requested coverage falls outside the above mentioned criteria, they are subject to medical underwriting in accordance with §3. If individuals join the insured group during the insurance period with a sum insured that exceeds the automatic acceptance limit, they are immediately covered up to the automatic acceptance limit. If these individuals shall be covered up to their full sum insured which exceeds the automatic acceptance limit as soon as possible, these individuals have to be reported to us immediately after they join the group. In this case standard rules for medical underwriting in accordance with §3 apply. If these individuals are not reported to us immediately after they join the group, they will remain covered up to the automatic acceptance limit until the anniversary date of the policy (see §6).

(7) What does "actively at work" mean?

An individual is actively at work if they are receiving their full contractual remuneration and carrying out the work specified in their contract of employment. If an individual is unable to work at the policy start date for health related reasons and this situation continues such that they are defined as disabled in accordance with this insurance policy, they are not covered. This means, disability that occurred before the policy came into force, is not insured. Employees are not actively at work if, for example, they are no longer receiving sick pay due to a long-term illness.

If an individual is temporarily not working after coverage starts, due to a reason agreed before policy start date, excluding illness (for instance if they are on sabbatical or on parental leave) they are considered being actively at work for that period, up to 12 months.

Before paying benefits to a group member, we will, among other things, check that they met the "actively at work" criteria at policy start date. If they did not, we are not required to pay benefits unless, after policy start date, they worked normally for a continuous period of at least 30 working days.

Insured persons who are not actively at work anymore at the renewal date of the policy (see §6), maintain their existing insurance coverage on unchanged terms. If the sums insured for an entire insured group shall be increased at renewal date, the higher sums insured only apply to persons who are actively at work at this date. Insured persons who are not actively at work at

renewal date only become covered up to the higher sums after they return to work in full capacity and have worked at least 30 consecutive working days.

2. What does disability mean for the purpose of this policy?

(1) Occupation definitions

The following three occupation definitions are available:

- Group member is unable to do their own occupation
- Group member is unable to do their own and/or any similar occupation
- Group member is unable to do any occupation.

The selected occupation definition is shown on the policy schedule.

For the purposes of this insurance policy, a group member's occupation is defined as their last paid employment.

(2) What does disability mean for the purpose of this policy?

A group member is disabled if, at for least the duration of the agreed waiting period, they continuously

- Are unable to carry out their occupation as a whole, or significant aspects of it, due to illness, injury or non-age-related infirmity, and provide medical evidence of this
- Receive regular medical treatment from a physician for this reason, and
- Do not work in any other paid employment

The group member's degree of disability will be determined at the end of the waiting period. They will be considered totally disabled if they are completely unable to carry out the occupation definition due to illness, injury or non-age-related infirmity, and provide medical evidence of this. If they meet this requirement only to a certain extent, they will be defined as partially disabled. The benefit amount is determined in each case by the minimum degree of disability specified in your policy schedule.

Whether we carry out an assessment of the group member's employment situation depends on the selected degree of disability.

Group member is unable to do their own occupation

A group member's degree of disability is measured solely on the basis of their last occupation, as though they were not suffering from any health problems. If they are performing another occupation that corresponds to their education, experience and previous life situation, their degree of disability may be measured on the basis of this occupation.

An occupation will be defined as financially and socially corresponding to the group member's education, experience and previous life situation only if it does not require significantly less knowledge and skills, or enjoy significantly lower remuneration and status than that of their previous occupation. We will treat each case on its own merits and in accordance with the relevant case law. When we review an ongoing claim, other occupations are considered, if they were performed after disability.

Group member is unable to do their own and/or a similar occupation

The group member's degree of disability will be measured on the basis of their last occupation, as though they were not suffering from any health problems, or of another occupation corresponding to their education, experience, and existing life situation.

An occupation is defined as financially and socially corresponding to the group member's education, experience and previous life situation only if it does not require significantly less knowledge and skills, or enjoy significantly lower remuneration and status than that of their previous occupation. We will treat each case on its own merits and in accordance with the relevant case law.

Group member is completely disabled

The group member's degree of disability will be measured by comparing it to an occupation on the general employment market, including self-employment. These do not include occupations that are, or have to be, tailored to the group member's specific health limitations.

Their ability to do an occupation is based solely on their health, and does not take account of their last occupation, existing skills, knowledge, life situation, income, or situation on the employment market.

(3) Offsetting of benefits from a statutory income or health insurance provider against annuity benefits from this policy

If a group member receives disability benefit from a statutory income or health insurance or equivalent provider or other statutory assistant provider (e.g. an industry assistance scheme), these will be offset against the annuity benefit for disability from this group policy as follows. If the sum of the benefit under this insurance and the disability benefit from a statutory income or health insurance or equivalent provider, or other statutory assistant provider (e.g. an industry assistance scheme) exceeds 60% of the income before disability, the disability annuity benefit under this insurance is reduced by 100% of the excess.

(4) Offsetting of income from employment against annuity benefits from this policy

If a group member engages in employment despite being wholly or partially disabled, we will offset their income from this pro rata against the annuity benefit for disability under the group policy. If the total disability benefit and income exceeds 60% of income before disability, we will reduce the disability benefit by 50% of the excess income. If a group member receives apart from the income after disability benefit from a statutory income or health insurance or equivalent provider, or other statutory assistant provider (e.g. an industry assistance scheme) we will reduce the disability benefit first of all as described in §3.3. Afterwards the income after disability will be added to the remaining value. If the sum exceeds 60% of the income before disability, the disability benefit will be offset by 50% of the excess.

The total of the reduced benefit and the income also may not exceed the group member's income before disability.

3. What is medical underwriting?

(1)

A group member is not subject to medical underwriting if their current sum insured is less or equal than the automatic acceptance limit. A group member is subject to medical underwriting though, if their current sum insured exceeds the automatic acceptance limit. The amount of the automatic acceptance limit is stated in your policy schedule.

The actual amount underwritten is the amount exceeding the automatic acceptance limit or the previously accepted sum insured, if higher.

Any new underwriting decisions, including special terms and premium loadings, do not affect coverage for the sum insured up to the automatic acceptance limit or the previously accepted sum insured, if higher.

(2) Adjustment of the automatic acceptance limit

We may adjust the automatic acceptance limit of your policy at each renewal date (see § 6). We reserve the right to adjust the automatic acceptance limit immediately in case of a significant change in accordance with § 12.

In situations where we increase the automatic acceptance limit, the revised automatic acceptance limit is applicable to new group members and existing group members who have not previously been declined or have a medical underwriting decision postponed. For group members who have been declined or have a medical underwriting decision postponed, coverage is limited to the automatic acceptance limit which was applicable at the time of the decision.

In situations where we decrease the automatic acceptance limit, the revised automatic acceptance limit will apply to new group members only. We will maintain the previously accepted sum insured for existing group members and all previous medical underwriting decisions will continue to apply.

(3) When do underwritten group members need to go through the process again?

An increase in a group member's sum insured above the automatic acceptance limit may be subject to medical underwriting again. There is no need for medical underwriting if the increase of the sum insured results from a change of the underlying remuneration and if the group member was underwritten on standard terms before.

Whether medical underwriting is necessary again if the sum insured reaches or exceeds the medical underwriting bar or also if it increases for more than 15% within 12 months, is stated in your policy schedule.

In any other situation, group members will be required to undergo further medical underwriting for any increase to their sum insured.

Again, the actual amount underwritten is the amount exceeding the automatic acceptance limit or the previously accepted sum insured, if higher.

(4) Coverage during the medical underwriting process

While a group member undergoes medical underwriting, their coverage is limited to the automatic acceptance limit or their previously accepted sum insured, if higher.

We will confirm our underwriting decision in writing. If our decision involves special terms or premium loadings, the coverage and terms will only be effective when we receive your written acceptance of such terms. Should you decline the revised terms, or if you do not provide written acceptance of the terms the automatic acceptance limit or the previously accepted sum insured, if higher, will continue to apply.

(5) Medical examination costs

Where we have asked for medical evidence or examination, we will pay reasonable costs for the specific evidence we requested upon receipt of satisfactory invoices. You must obtain our approval before incurring any such expenditure.

4. When does coverage start?

Coverage starts when the contract is concluded, but not before the agreed policy start date as specified in the policy schedule. However, we will not be obliged to pay any benefits if your premiums are paid late (see § 9). Disability starting before coverage comes into force and cases of death occurring before coverage starts are not covered (see also §1.7).

5. When does coverage end?

A group member's coverage ends when any of the following events occur:

- They reach term age;
- They die;
- They retire;
- At policy anniversary date, unless the contract is extended in accordance with §6;
- At policy anniversary date if they leave the employer.

6. When does the policy terminate and how do you renew it?

(1) The contract is valid for one year, and will then end.

(2) Continuation of insurance coverage

The insurance policy may be extended. If you have simplified administration (see §10), we will notify you whether the policy can be extended, and if so, under what conditions, within 30 days of receiving updated details of the group members at the end of the policy period. Unless you decline this offer in writing within 30 days of receiving it, you will be deemed to have accepted the new insurance policy including the previously notified premiums, agreed terms, and all other conditions of the original policy.

(3) If a new policy is not accepted, our mutual contractual obligations will end, with the following exceptions:

- Current benefit payments
- Insured events that have occurred, but have not yet been reported
- Premiums not yet paid by the termination date

7. What is excluded from coverage?

(1) We normally offer worldwide coverage, and claims benefits are payable regardless of the cause of the insured event.

(2) ## Disability exclusions

However, we will not pay benefits if the disability is caused by:

a) The direct or indirect effects of war, except where the disability is caused by war-related events affecting the group member while they were outside Germany, and in which they were not actively involved;

b) Civil unrest in which the group member takes part on the side of the instigators;

c) The group member deliberately committing or attempting to commit a crime;

d) Illness or non-age-related infirmity that are deliberately caused, or deliberate self-injury or attempted suicide, unless we receive evidence that these actions were the result of mental disturbance and, as such, beyond the group member's control.

e) Nuclear radiation, endangering or otherwise adversely affecting the lives or health of large numbers of people and requiring measures by a disaster protection authority or similar bodies.

f) Caused directly or indirectly by the deliberate use of nuclear, biological or chemical weapons, or by the deliberate use or deliberate release of radioactive, biological or chemical substances, where the use or release are intended to endanger the lives or health of a large number of people, and resulting in an unforeseeable change in the total benefit calculated according to actuarial principles, so that the benefit can no longer be paid. This must be confirmed by an independent trustee.

(3) ## Time limitations of benefits for specific disorders

Annuity payments are time-limited for the following disorders:

- Disability caused by mental illness diagnosed as category F using the criteria laid down in the current version of the International Statistical Classification of Diseases (ICD-10). These include psychosomatic illnesses (such as burnout) even when not expressly covered by ICD-10 category F.
- Disability caused by drug or alcohol abuse.

In these cases, we will pay benefits for a maximum of 24 months. This limit applies for the entire policy period and subsequent policies. If, during the duration of illness, the group member temporarily returns to active employment and then becomes disabled again, the accumulated payment periods will be deducted from the 24-month limit.

If mental illness is only one part of an overall disorder, the group member's degree of disability will be assessed at the end of the 24-month period, ignoring the mental illness, and the benefit will be paid in accordance with the resulting percentage.

However, we will continue to pay benefit after the 24-month limit if either of the following requirements is met:

1. The group member is receiving inpatient treatment after the 24-month period in a hospital or psychiatric clinic and as a result of the illness. If they are still disabled after being discharged from inpatient treatment, we will continue paying benefit for a further 180 days for rehabilitation purposes, regardless of the 24-month limit.

   If the group member returns to inpatient treatment in a hospital or psychiatric clinic during the rehabilitation period, and this treatment lasts for more than 14 days at a time, we will pay benefits for the duration of the additional inpatient treatment.

At the end of the inpatient treatment, we will pay rehabilitation benefit for a further 180 days regardless of the 24-month limit.

2. If our liability for benefits as a result of the 24-month limit, and any extensions and rehabilitation periods, ends as defined in the previous bullet point, we will pay benefit for the duration of any necessary follow-up inpatient treatment for this illness in a hospital or psychiatric clinic, if this lasts for 14 days or more at a time.

We will stop paying benefits on the benefit end date agreed in the policy, regardless of whether the 24-month limit applies or extensions are agreed in accordance with the above two bullet points.

The benefit payment time limit for mental illness does not apply if this is due to any of the following causes:

- Stroke causing lasting neurological deficit and lasting clinical symptoms;
- Severe post-traumatic stress disorder with a proven ICD-10 diagnosis of F 43.1;
- Viral infection resulting in lasting neurological deficit and lasting clinical symptoms;
- Alzheimer's disease with a proven ICD-10 diagnosis of G30.0;
- Anxiety and panic attacks with significant vegetative symptoms and a proven ICD-10 diagnosis of F 41.0;
- Parkinson's disease with a proven ICD-10 diagnosis of G 20.1 or G 20.2;
- Huntington's chorea with a proven ICD-10 diagnosis of G 10;
- Borderline personality disorder with a proven ICD-10 diagnosis of F 60.31.

We define lasting neurological deficit with lasting clinical symptoms as symptoms resulting from one or more functional disorders of the nervous system which are incurable based on the current medical state of the art. They must be clearly diagnosed by an up-to-date clinical examination. The symptoms covered include numbness, paralysis, dysarthria (speech difficulty), aphasia (inability to speak) dysphagia (swallowing problems), visual impairment, inability to walk without assistance, lack of coordination, tremor, cramp, dementia, delirium and coma.

(4) If a lump sum disability benefit is agreed

The benefit period limit for mental illness does not apply, as the benefit is paid out in a single lump sum.

The waiting period for mental illness is equal to the standard waiting period stated in the policy schedule. For psychosomatic illness stated in § 7.3 the waiting period is equal to the standard waiting period, however in no circumstance less than 12 months.

(5) Death benefit exclusions

We will not pay benefits if the group member's death was caused by

a) The direct or indirect effects of war, except where the death is caused by war-related events affecting the group member while they were outside Germany, and in which they were not actively involved;

b) Civil unrest in which the group member takes part on the side of the instigators;

c) Directly or indirectly, the deliberate use of nuclear, biological or chemical weapons, or by the deliberate use or deliberate release of radioactive, biological or chemical substances, where the use or release are intended to endanger the lives or health of a large number of people, and resulting in an unforeseeable change in the total benefit calculated according to actuarial principles, so that the benefit can no longer be paid. This must be confirmed by an independent trustee.

(6) Event limits

If the policy schedule states, the total benefit for any one event may be subject to a maximum limit as specified in the policy schedule. The following event limits may apply:

(7) Business travel limit

This limit applies if the insured event affects group members while travelling together on business.

8. How do you pay premium?

(1) Premiums are payable annually, six-monthly, quarterly or monthly as stated in your policy schedule, and are due at each policy start date.

(2) The initial premium is payable immediately after the insurance contract is concluded, but not before the policy start date agreed with you and specified in the policy schedule. All subsequent premiums are payable on the relevant due dates.

The premium for the disability coverage of a group member is waived when such members are on disability claim. If the cover for the mortality risk shall be maintained after disability occurs (see §1.2), the premium for the mortality risk is still due. The premium liability for the disability and mortality risk of a group member ends when the group member dies.

(3) We will deduct any premium arrears from benefit payments that we make.

(4) Premium payments are made at your risk and expense.

(5) Premium rates are expressed as unit rates. That means, a single premium rate is calculated for all group members.

(6) Premium rates may be adjusted at the end of the rate guarantee period (see §11).

(7) The premium payable for each insured biometric risk (death/disability) is calculated from the sum of defined contributions for the respective biometric risk as stated in the benefit promise. The premium also corresponds to the sum insured multiplied by the premium rate in each case. The premium and its components are disclosed in your policy schedule.

9. What happens if you pay a premium late?

(1) Initial premium

If you pay the initial premium late, we may withdraw from the contract at any time until you pay it, unless you provide evidence that the late payment was not your fault. If we withdraw, we may require you to pay the costs of any medical examinations carried out as part of a medical underwriting as specified in §3.

(2) If the initial premium has not been paid and an insured event takes place, we are not required to pay claims benefits. This is also clearly noted on the policy schedule. However, we will pay the claims benefits if you provide evidence that the non-payment is not your fault.

(3) Subsequent premiums

If you are late in paying a subsequent premium or other amount due under the contract, we will send you a written reminder, at your expense, requiring you to make the payment within a specified period of not less than two weeks. If you do not pay the arrears by that time, your coverage will be reduced or cancelled. The reminder will include specific details of the legal implications of such action.

(4) Please contact us if you have difficulties making payments. We will be happy to advise you on ways of maintaining your coverage.

10. How is the premium adjusted after a significant change?

The agreed premium rate is based on the number of group members in the group as notified at time of quotation, and on the agreed benefits and sums insured. If the number of group members changes, it affects the premium as follows:

Simplified administration

If you have simplified administration, we will charge a fixed single premium based on a minimum number of 20 group members. You must provide us with the information about the group that we require to calculate the sums insured at the policy inception and on each anniversary date, in other words the day on which the next policy starts. You must notify us in writing by noon on the anniversary date.

The premium rate is calculated for each policy period, and will not change during that duration. We will calculate the premium adjustment for the past period at the end of each policy period, based on the information which you provide

us with at that time. For simplicity, the adjustment assumes that all changes occurred in the middle of the policy period on average; in other words the adjustment is based on the sum insured of those group members who join the insured group during the insurance period. Fifty percent of this sum insured multiplied by the unit premium rate, is the adjustment for the past policy period. The premium adjustment will be debited to your premium account or, if you extend the policy, offset against the next premium.

If you extend the policy in accordance with §6, you must give due notice of any changes. Any changes reported late will not become effective until the policy period following that in which the delay occurred.

If the number of group members falls below the minimum limit of 20 group members, we will investigate whether the policy can be extended for the next policy period and if so, under what conditions. The procedure described in §8.6 will apply accordingly.

11. Are the premium rates guaranteed?

We may agree not to change the premium rate for a specific period if you extend coverage (see §6).

The end of the rate guarantee period is shown in the policy schedule. We will then notify you of the new premium rates and guarantee period, and issue a new policy schedule.

12. What information do you need to provide?

(1) Notification of significant changes

You must notify us immediately of any significant change concerning the provision of coverage. A change is considered significant if

- The number of group members deviates by more than 30%;
- There is a change in the benefit configuration, for example in the eligibility criteria or the type or amount of benefits;
- More than 25% of the group members change occupations, or more than 25% relocate abroad;
- The average age of the group members changes by more than two years.

(2) If you fail to notify us in accordance with paragraph 1, we may terminate the policy with immediate effect.

(3) We may recalculate the premium rates including the guarantee, if applicable (see §11), or the automatic acceptance limit or charge an immediate premium adjustment in the event of a significant change. The new premium amount will apply for the rest of the policy period, and any premiums already paid for this period will be offset against this amount. In this case, you may terminate the policy in writing within 30 days of receiving details of the new premium.

If you are unsure whether a significant change has occurred, please contact us. If we detect a significant change, we provide you with modified terms and conditions. Afterwards, you can decide within 30 days whether the policy is to be continued with the changed terms and conditions or shall be terminated instead. If 30 days elapse without any response from you, the changed terms and conditions are deemed accepted by you.

(4) Death claims

If a group member dies, you must inform us within two years and send us the following documents:

- An official death certificate, including the group member's age and place of birth,
- A copy of their identity card or passport,
- Full details from a physician or official body concerning the cause of death and the start and progression of the illness that caused it,
- Evidence of employment, and the group member's last payslip,
- Any other documents we may require to make a decision concerning the claim.

(5) We may require additional evidence, and carry out our own investigations, in order to assess your claim.

(6) As the policyholder, you will be responsible for the costs of obtaining this evidence.

(7) Disability claims

If you make a claim under this contract, you must provide us with evidence of the disability in accordance with §2. We may also require you to provide any additional information that we need to establish the circumstances of the insured event and the extent of our liability. This is known as your information obligation. We may also require you to provide any additional information that we need to clarify the circumstances of the insured event and the extent of our liability. This is known as your clarification obligation. If you or any of the group members fail to meet either of these obligations, we will not be obliged to pay benefits.

(8) We may also require group members to be examined by doctors of our choice, at our expense, in Germany or abroad.

(9) If a group member declines to undergo a surgery prescribed by the examining or treating physician in order to cure or reduce their disability, then this fact will not deter the insurer's admission of liability under this policy. However the group member is also subject to a general legal duty to minimize damage by following reasonable instructions given by physicians and intended to improve their health.

Instructions are defined as reasonable if they do not involve danger or excessive pain and have a reliable prospect of at least improving the patient's condition to the point where benefits are no longer payable. These include, for example, dieting, the use of orthopaedic or other medical aids (e.g. prostheses and optical and hearing aids), speech therapy, and wearing support hose.

(10) The cost of obtaining evidence of disability is at your expense as policyholder.

13. When will we notify you of our claims decision?

(1) Once we have all the information we require to make a claims decision, we will inform you within four weeks of whether and to what extent we accept your claim. If the claim is for disability benefit, we will also tell you for how long the benefit will be paid.

(2) We will keep you informed of the progress of the assessment, and any additional documents we require.

(3) In certain circumstances, we may agree to pay benefits for a one-off, limited period of up to 18 months, in which case we will state our reasons for doing so. If it is in your interest, we may also agree a longer period. This agreement is binding on us until the end of the specified period.

14. Do we carry out reviews to check whether group members are still disabled?

(1) Once we have accepted a disability claim, or liability has been otherwise established, we may carry out regular reviews to ensure that the group member is still disabled, and whether they could carry out a different occupation or acquire new skills as defined in §2. We will not carry out a review if we agree to pay benefit for a limited period as defined in §13.

(2) We may require additional information or a medical examination by our doctors, in order to carry out such a review. We will pay the medical expenses, and §12.7 and 12.8 will apply.

(3) You must notify us immediately if a group member experiences a reduction in disability, resumes their employment or changes to the occupation.

(4) If a group member experiences a complete or partial reduction in disability, we may reduce or stop their benefit payments and notify you and them in writing accordingly. The change will take effect at the end of the third month after you receive this notice. If the insured meets the eligibility criteria

for compulsory coverage after this time, their premiums will become payable again. If they die, we may stop paying benefits at the end of the month in which they die.

(5) If disability occurred a long time ago and at time of notification the group member has recovered again, we may stop benefit payments at the end of the month of recovery.

15. Under what circumstances can you increase coverage?

(1) You may subsequently request to increase the sum insured if the group member meets the "actively at work" criteria (see § 1.7) at the time of the increase. If they do not, the following applies:

The existing level of coverage will remain in force until the group member meets the actively at work criteria again. If a medical examination is required in order to increase coverage, the sum insured will be restricted to the automatic acceptance limit or the previous sum insured, whichever is higher, until the group member again meets the actively at work criteria, and depending on the result of the medical underwriting carried out in accordance with § 3.

(2) Before paying a benefit, we will assess, among other things, whether the group member meets the "actively at work" criteria. If they did not meet these at the time of the increase, we will not be required to pay the increased benefit, but will pay the originally agreed sum insured unless the group member has, after the increase date, worked normally and continuously for at least 30 days.

16. Who receives benefit payments?

(1) Death and disability benefits are payable to the employer. It may not be assigned to the group members, their relatives, or other third parties. This requirement is irrevocable.

(2) Entitlements under this policy may not be assigned or used as collateral.

17. How is notice served?

(1) Notice concerning the policy must be served on us by letter, unless we have agreed that it may be served electronically, and will take effect as soon as we receive it.

Our address is:

Zurich Eurolife S.A.
Building Elise, 21 rue Léon Laval
L-3372 Leudelange
Luxembourg

(2) You must notify us immediately of any change in your mailing address, as we serve all notices to the last address known to us, and you may be adversely affected if this is out of date. We serve notice by registered mail, and it will be deemed to have been served three days after we send it. This also applies if the address on the policy is that of your business premises.

(3) Paragraphs 1 and 2 also apply if you change your entity name.

18. Which country's law applies to your policy?

Your insurance policy is subject to German law.

19. What is the legal status of the parties to this contract?

This contract is between Zurich Eurolife S.A. and you as policyholder, and is subject to the conditions and benefits applying when it was signed. Group members have no direct legal recourse against Zurich Eurolife S.A., and we will not be bound by any oral or written agreement between you and the group members outside the terms of this contract.

20. What happens if a clause under this policy is deemed invalid?

If any clause is invalid, it will become nil and void, and will not affect the validity of any other clauses.

21. Where is the place of jurisdiction?

(1) Any claims against us concerning this contract will be referred to the courts having jurisdiction over our head office or the branch responsible for the contract. If you are an individual, the courts of your place of residence or ordinary residence will also have jurisdiction.

(2) If you are an individual, any claims against you in relation to the contract will be dealt with by the courts having jurisdiction in your place of residence or ordinary residence. If you are a legal person, the courts of your head office or branch will have jurisdiction.

(3) If you move to a state outside the European Union, Iceland, Norway or Switzerland, the courts of our domicile will have jurisdiction.

22. How do international sanctions impact the contract?

Despite any other agreed terms regarding this contract, we will not provide you or a third party with either insurance coverage or benefit payments from this contract if this might violate applicable trade or economic sanctions. We reserve the right to terminate the contract at any time if you, your employees or executives are subject to trade or economic sanctions that we consider to be relevant.

23. Data protection

In accordance with the applicable Luxembourg data protection law and, as of 25 May 2018, with the European Regulation no. 2016/679 of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (the **'Data Protection Law'**), Zurich Eurolife S.A. as data controller collects, stores and processes, by electronic or other means, the personal data of the members of the policy and of the policyholder's contact persons, including but not limited to: title, family name, forename(s), country and place of birth, nationality, date of birth, date of starting or ending employment, residential address, country/countries of residence, health information if applicable, tax identification number if applicable, email address, telephone number, gender, marital status and employment and financial details (the **'Personal Data'**). In accordance with the Data Protection Law, the policyholder must duly inform its contact persons of the processing undertaken by Zurich Eurolife S.A..

The lawful basis for the Personal Data processing are (i) the performance and the provision of our insurance services to the policyholder of the Policy, (ii) the consent of the policy members for the processing of their health information (where applicable), (iii) the legitimate interests of Zurich Eurolife S.A. and the legitimate interests of the parties benefiting from the Policy and (iv) compliance with applicable legal and regulatory obligations relating e.g. to fraud prevention and detection, anti-money laundering rules, tax reporting requirements, economic or financial sanctions laws and the legal and regulatory requirements applicable to insurance companies. In this regard, Personal Data is processed in particular for purposes of:

- The subscription, performance, servicing and administration of the Policy (including but not limited to provide insurance cover or to pay for a claim, to manage the risk associated to the insurance coverage through reinsurance);
- The provision of related assistance services, advice and support;
- Underwriting and claim management purposes;
- IT servicing, IT security and data analytics, including but not limited to administration of our website(s), troubleshooting, data analysis, testing, research, statistical and survey purposes; and
- Complying with all applicable legal and regulatory obligation (e.g. to prevent and detect fraud or money laundering, to comply with tax reporting requirements and economic or financial sanctions laws

and to comply with the legal and regulatory requirements applicable to insurance companies).

The provision of Personal Data, including health data where applicable, by the Policy members and the policyholder's contact persons is required for the performance of the Policy. Failure to provide sufficient, accurate and up-to-date information as well as failure by the members of the Policy to provide consent regarding the processing of their health data, where applicable, may prevent Zurich Eurolife S.A. from providing cover.

The Personal Data may be disclosed or transferred to third parties for the above-mentioned purposes. This may, depending on circumstances, include the parties listed below (the 'Recipients'):

- Zurich Insurance Group Ltd. or any of its affiliated companies, as listed in the most recent annual accounts. Companies in the Zurich Group share information with each other where it is relevant and appropriate; this includes health information for underwriting and claims purposes. If you apply for insurance with more than one company in the Zurich Group, they may share your details;
- Involved financial advisers, brokers, agents or distribution intermediaries;
- Contractors or service providers who may supply services to us such as administration, information technology, telecommunication, actuarial, data entry, data storage, data recovery, data security, mail distribution, claim assessment, adjudication, payment, investment, cheque printing, fiscal representation, marketing, emergency assistance services, due diligence screening, auditors, lawyers, medical and professional services, survey and research services;
- Credit reference agencies, reinsurers, other insurers and financial institutions;
- On the sale, transfer or reorganisation of our or our Group's business (or any part of it) to the acquirer or new organisational unit; and
- Governmental/Legal/Tax/Regulatory authorities, courts, dispute resolution forums (which have jurisdiction over us or our Group companies), investigators or legal process participants and their advisors.

The Recipients are located within and outside the European Union and, in particular, in the Isle of Man and Switzerland. Where we transfer Personal Data outside the European Union, we will ensure that the transfer relies on one of the legitimacy basis set out by the Data Protection Law. We will do this by ensuring that there is either an adequacy decision of the EU Commission regarding the transfer of Personal Data or that the Personal Data is given adequate safeguards by using 'standard contractual clauses' which have been adopted by the EU Commission or, as the case may be, any other legitimacy basis provided for by the Data Protection Law. The Isle of Man and Switzerland benefit from an adequacy decision of the EU Commission. The members of the Policy and the policyholder's contact persons have a right to request a copy of the 'standard contractual clauses' by writing to the Data Protection Officer of Zurich Eurolife S.A.

Personal Data may also be disclosed to the Luxembourg tax authorities, which in turn may disclose the same to foreign tax authorities (including for compliance with automatic exchange of information standards as the Foreign Account Tax Compliance Act (FATCA) and Common Reporting Standard (CRS)).

The Personal Data shall not be kept by Zurich Eurolife S.A. for any period longer than necessary, with respect to the purposes of the data processing, including compliance with applicable statutory retention periods or limitations.

In accordance with the conditions laid down by the Data Protection Law, the members of the policy and the policyholder's contact persons have the right to:

- Access their Personal Data;
- Correct their Personal Data where it is inaccurate or incomplete;
- Object to the processing of their Personal Data;

- Ask for erasure of their Personal Data;
- Ask for the restriction of processing of my Personal Data; and
- Ask for Personal Data portability – to obtain personal information in a digital format.

They also acknowledge the existence of their right to lodge a complaint with the Luxembourg National Commission for Data Protection ('CNPD').

They may exercise their above rights by writing to the Data Protection Officer of Zurich Eurolife S.A. at the following address:

Data Protection Officer
Zurich Eurolife S.A.
Building Elise
21 rue Léon Laval
L-3372 Leudelange
Luxembourg
E-mail: ZELprivacy@zurich.com

The policyholder undertakes to provide to each member a copy of the Member Data Protection Statement made available to the policyholder by Zurich Eurolife S.A.

24. Specific notes concerning the re-insurance of employers' benefit commitments

Valid in the Federal Republic of Germany (last updated January 2015). The following information does not reflect any changes in the law since that date, and makes only general reference to the tax law applying at the time of printing. We may not be held liable for any inaccuracies or omissions, and you should obtain advice from the tax authorities or an accountant as required by § 3 of the Steuerberatungsgesetz [Tax Advice Act].

A. General tax information on business insurance

Profits tax

Group life insurance premiums are deductible as business expenses.

Premiums due should be shown as operating income, and any claims should be shown as a write-down or write-off of assets.

Income tax

Payments by an employer to a group member as a result of a commitment to pay benefit are subject to income tax.

Insurance premium tax

Premiums for term life insurance contracts and disability insurance contracts are not subject to insurance premium tax.

B. General information concerning employment law

Compulsory adjustment reviews

Employers are required by § 16 of the Gesetz zur Verbesserung der betrieblichen Altersversorgung (Company Pensions Improvement Act, BetrAVG) to review current benefits every three years with a view to adjusting them. However, § 16.3 of the act states that such reviews are not required if the employer agrees to adjust current benefits by at least 1% each year.

Statutory illness and healthcare insurance for pensioners

All benefits from a company pension scheme are subject to compulsory illness and healthcare premiums if the beneficiary is covered by voluntary or compulsory statutory illness insurance.

Zurich Eurolife S.A. is a life insurance company incorporated under the laws of Luxembourg and registered with the Luxembourg register of commerce and companies under no. B51753.

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VAT no. LU 1660 2944.

Zurich Eurolife S.A. is subject to the applicable Luxembourg legislation and falls under the exclusive supervision of the Luxembourg insurance regulator, the Commissariat aux Assurances (7, boulevard Joseph II, L-1840 Luxembourg, Luxembourg).

Calls may be recorded or monitored in order to offer additional security, resolve complaints and for training, administrative and quality purposes.

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