

GENERAL CONDITIONS OF INSURANCE FOR SUPPLEMENTARY GROUP INCOME PROTECTION COVER WITH DAILY ALLOWANCES FOLLOWING A NON-OCCUPATIONAL ILLNESS OR NON-OCCUPATIONAL ACCIDENT SUFFERED BY CERN STAFF MEMBERS

PREAMBLE

UNIQA Assurances S.A. offers CERN staff members the option of taking out private income protection cover for a non-occupational illness or accident. Although all staff members are covered by basic social security provision, the part of the risk of loss of earnings that is not guaranteed by CERN may be covered by an insurance contract that is based on these General Conditions of Insurance.

Article 1: GENERAL BASES

The bases of the supplementary income protection cover with daily allowances following a non-occupational illness or non-occupational accident are comprised of:

- a) these General Conditions of Insurance (G.C.I.);
- b) the Swiss Federal Law on Insurance Contracts of 2 April 1908 for issues that are not governed by the G.C.I. under a) above;
- c) the written statements made by the proposer in the proposal and in any other documents;
- d) the articles in the CERN Staff Rules and Regulations and the relevant administrative circulars issued by CERN, as well as any amendments that are made thereto, provided they specify:
 - the existence of a non-occupational illness or non-occupational accident;
 - the period of reduced earnings for the non-occupational illness or non-occupational accident that corresponds to the period for receipt of benefits from the insurer.

Article 2: PURPOSE OF THE INSURANCE

The insurance covers, within the scope of the contractual provisions, a loss of earnings that is the consequence of a non-occupational illness or a non-occupational accident certified by a doctor.

Article 3: AFFILIATION

The insurance is non-transferable. Acceptance of the risks to be insured is specified in Articles 7 and 12.

Article 4: DEFINITIONS

4.1 Illness

Any changes in health (including mental disorders) diagnosed by a competent medical authority.

4.2 Accident

Any impairment of physical health caused by the sudden impact of an external force, including radiation that originates from particle acceleration and/or radioisotopes, whereby individual physical exertion that results in an injury of a physical or mental nature is deemed to be tantamount to an accident

4.3 Unfitness for work

The insured person is unfit for work when he/she is diagnosed as totally or partially incapable of exercising his/her profession or engaging in any other gainful employment that is compatible with his/her social status, experience and skills, following an illness or an accident that is covered by the insurance policy.

4.4 Doctor

Any medical practitioner who has a degree from a Swiss university and is entitled to practice or any medical practitioner who has a degree from a foreign university that is deemed to be of an equivalent standard.

4.5 Hospital

Any establishment that provides medical treatment, surgery or rehabilitation prescribed by or under the continuous supervision of a medical practitioner, has full-time nursing staff, and

- a) primarily provides inpatient treatment to the sick and injured;
- b) has the equipment and facilities that are required for treatment;
- c) keeps an up-to-date medical file on each patient.

Article 5: TERRITORIAL VALIDITY

5.1

The insurance is valid in Switzerland and in the two adjacent French departments in the Canton of Geneva (Ain and Haute-Savoie), hereinafter "border region".

5.2

Provided the employment contract with CERN is not terminated, an insured person who goes abroad will retain worldwide cover for 180 days. At the end of this period the insurance ceases, unless otherwise agreed.

5.3

The insurer must be notified of a change of address and a change of the place of residence (abroad).

Article 6: PREMIUM

6.1 Calculation of the premium

The premium is payable for a calendar year. The premium is calculated on the basis of the minimum annual salary amounting to twelve times the monthly salary, as shown in Annex RA 5 of the CERN Staff Rules and Regulations. The level of premium payable is stated in the insurance policy.

6.2 Provisional premium and final statement

6.2.a

The insured person is required to pay a premium that is provisionally set at the beginning of each calendar year (provisional premium) and that corresponds as closely as possible to the estimated level of the premium. Payment is due one month in arrears.

6.2.b

The final premium statement is prepared at the end of each calendar year or upon termination of the contract. The insurer will provide the insured person with a form for this purpose, asking him/her to supply all the information that is required to prepare the final statement. The resultant additional premium shall be paid within one month from the date on which the insured person receives notification from the insurer of the amount that is payable. The insurer will reimburse the insured person any excess premium paid, within the same deadline commencing from the date of issue of the final premium statement.

If the insured person fails to return the form that is required to determine the final premium statement within one month from receipt thereof, the insurer is

entitled to set the final premium on the basis of its own assessments.

6.2.c

The insurer is entitled to verify the data supplied by the insured person, who must accordingly allow the insurer to inspect all the relevant items (payslip, etc.). If the declarations made by the insured person regarding the bases for the calculation of the premiums have no bearing on reality, the insurer will send the insured person, at the latter's expense, a formal demand to amend his/her statement within 30 days commencing from the date of dispatch of the aforementioned formal demand. If the formal demand does not have the desired effect, the obligations on the part of the insurer will be suspended upon expiry of the 30-day deadline. Once the declaration has been amended, the insurer will send the insured person an amended premium statement, with retroactive effect, which the insured person will be required to pay within 30 days.

6.2.d

The insurer may adjust the provisional premium (clause 6.2.1 above) at the beginning of each calendar year to the changes in the circumstances of the insured person, in particular to the actual level of salary on which the premium is based.

6.3 Consequences of non-payment of the premiums

If the premium is not paid within the stipulated deadlines, the insurer will send the insured person a reminder to pay within 14 days, setting forth the consequences of further default. The insurer will suspend the entitlement to benefits if the premium is not paid within this deadline.

If the premium and charges are paid within two months following the expiry of the deadline, the insurer will reinstate the suspended insurance cover. If the arrears are paid at a later date, the renewal of the contract will be contingent upon a new risk appraisal. Even if the premium is paid at a later date, any illnesses and/or accidents that have occurred during the period of suspension are not then covered.

6.4 Change to the premium rate

The insurer may change the premium rate. If the premium rate is changed, the insurer will inform the insured person of the new contractual provisions no later than 60 days before the end of the insurance year.

The insured person is then entitled to terminate the contract for the end of the current insurance year. The notice of termination is not valid unless it reaches the insurer by the last day of the insurance year. If the contract is not terminated, the insured person is

deemed to have accepted the contractual amendment. The new premiums are calculated in accordance with the terms and conditions approved by the Swiss Federal Office of Private Insurance.

Article 7: INSURED PERSONS

7.1

Staff members who are employed on a permanent basis by CERN and receive a regular salary are eligible for insurance cover. Someone who has an employment contract and is paid without interruption is deemed to be a person who receives a regular salary.

7.2

However, the maximum age limit for eligibility is 60.

7.3

The following persons are not eligible for insurance cover without the express agreement of the insurer: homeworkers, persons who are not permanently employed by CERN, persons who pose a high risk.

Article 8: EXTENSION OF COVER

The insurer waives the following rights in favour of the insured person:

- a) exercise of the statutory provisions governing non-disclosure, provided 5 years have passed since the conclusion of the contract;
- b) exercise of the right conferred by operation of the law to reduce the benefits payable in the event of gross negligence by the insured person;
- c) exercise of the right to terminate the contract in the event of the materialisation of a risk, barring fraud or an attempt to defraud the insurance company;
- d) application of the penalties prescribed for the insured person in the event of a breach of his/her obligations, if he/she is by no means to blame under the circumstances.

Article 9: ASSIGNMENT OF RIGHTS

The rights to the insured benefits may not be assigned or pledged before the final payment without the formal approval of the insurer.

Article 10: NOTIFICATIONS TO THE INSURER

10.1

All notifications must be sent: to the headquarters of the insurer in Geneva or to the representative nominated by the employer.

10.2

All notifications that are the responsibility of the insurer are validly sent to the last address indicated by the insurer.

Article 11: PLACE OF PERFORMANCE AND JURISDICTION

The obligations arising from this insurance contract must be performed on Swiss territory and in Swiss currency.

The common law jurisdiction applies to judgments in disputed matters. The insured person and the beneficiary have the following choice of jurisdiction: Geneva as the Swiss headquarters of the insurer, or the address in Switzerland of the insured person or the beneficiary.

Article 12: INSURANCE COVER

12.1.a

Upon receipt of the insurance proposal at the headquarters of the insurer, the latter will provide the proposer with temporary insurance cover for all illnesses and accidents. Where applicable, the insurance cover will cease to be effective three days after receipt by the proposer of a notification of refusal of cover.

In the absence of a refusal, the temporary insurance cover will remain in effect until the insured person receives the policy within 30 days at the latest.

12.1.b

The insurer decides whether the insurance is to be subject to standard conditions or whether it is to be refused. As a general rule, this decision is made on the basis of the files that are available to the insurer, but the insurer is also entitled to make this decision contingent upon the additional information to be provided by the insured person or on the basis of a medical examination, at the expense of the insurer, of those applicants for whom the insurer deems such an examination to be necessary. The insured person is obliged to answer the questions asked accurately and truthfully and not to conceal any facts about his/her state of health that might affect the decision made by the insurer. In the event of a breach of this obligation, the insurer will cease to be bound by the contract, provided he has not rescinded the contract within 4 weeks of becoming aware of the breach.

12.1.c

The insurer will not pay any benefits before the expiry of a waiting period of twelve months commencing from the date of affiliation.

12.2 End of the insurance cover:

- a) the contract ends when the insured person no longer receives a regular salary pursuant to Article 7.1;
- b) upon termination of the contract or upon suspension of the contract in consequence of non-payment of the premium;
- c) when the insured person has terminated the contract pursuant to Article 12.3;
- d) upon the death of the insured person;
- e) when a claim is excluded pursuant to Article 16;
- f) upon transfer of domicile abroad, with the exception of a transfer to the border region pursuant to Article 5.1;
- g) during a period of residence abroad of more than 180 days, unless agreed otherwise pursuant to Article 5.2;
- h) when the gainful employment ceases, but upon attainment of the age of 65 at the latest.

12.3 Termination

12.3.a

At the end of the agreed term the contract is renewed automatically each year unless it is terminated by the insured person at least 2 months before its expiry. The notification of termination is deemed to be timely if it reaches the insurer on the day that precedes the commencement of the 2-month notice period. If the contract is terminated by the insured person, the insurer will still be entitled to the premium for the current year.

12.3.b

Whenever the insurer is called on to provide a benefit, the insured person concerned may terminate his/her contract no later than 14 days of becoming aware of the payment. If the insured person terminates the contract, his/her cover will cease on the date the notification reaches the insurer. The latter will still be entitled to the premium for the current year.

Article 13: RESTRICTIONS ON THE SCOPE OF COVER

The insurance policy does not cover:

- a) unfitness for work that existed on the date of affiliation;
- b) illnesses and the consequences of accidents that were ongoing on the date on which the contract entered into force and for which additional information was obtained pursuant to Article 12.1 b) of the G.C.I and which the insurer has specifically excluded;
- c) illnesses or accidents resulting from a deliberate and intentional act by the insured person, such as self-inflicted injury;
- d) illnesses or accidents that insured persons are likely to sustain during military service or during voluntary service in wartime since insurance cover will be suspended under such conditions,
- e) the consequences of wounds or injuries resulting from active participation in car racing event and from active participation in dangerous competitive sports; the consequences of participating in other types of amateur competitive sports are usually covered;
- f) the consequences of riots or rebellions if the insured person has participated in them in breach of the applicable laws; the consequences of brawls, except in cases of legitimate self-defence, are also excluded;
- g) the consequences of surgery that is designed to correct or eradicate physical defects or imperfections, unless they are required as part of a claim;
- h) illnesses or accidents resulting from abuse, by the insured person, of alcohol or drugs that are not prescribed for an illness;
- i) illnesses or accidents that are the direct consequence of crimes or offences committed intentionally;
- j) the direct or indirect repercussions of an explosion or liberation of heat, radiation or toxic emission resulting from the use, transport or possession of critical masses of fissile materials, as referred to in the Paris Convention of 29 July 1960 and its protocols;
- k) subject to the provisions of Article 13.1.1, aviation, flying or jumping accidents (airplane, glider, hang-glider, paraglider, ULM, parachute, or other similar devices or equipment), when such flights or jumps are undertaken in breach of the official regulations or without having obtained the official licences and certificates or without having taken out insurance that covers the disability claims that are specific to this type

of risk;

l) aviation accidents are not covered unless the insured person or the beneficiary is on board an aircraft with a valid Certificate of Airworthiness and the aircraft is flown by a qualified pilot who holds a valid licence for the type of aircraft concerned, whereby the pilot may be the insured person himself.

Article 14: DETERMINATION OF INSURED BENEFITS BASED ON EARNINGS

14.1 Basis for calculation

The calculation of the daily allowance is based on the earnings that the insured person would have received throughout the period of unfitness for work if he/she had been able to work.

14.2 Insured earnings

Insured earnings are deemed to be

- the basic minimum monthly salary payable by CERN pursuant to Annex RA 5 of the CERN Staff Rules and Regulations;
- the non-residence or expatriation allowance.

14.3 Benefits

14.3.a Entitlement

The insurer will pay the agreed daily allowance throughout the period of unfitness for work certified by the doctor. The daily allowance is payable throughout the period of 36 months for as long as CERN reduces or stops paying the salary. The monthly pay statement received by the insured person is proof of the salary reduction.

Certificates of unfitness for work issued in advance are only accepted for a maximum period of one month.

The allowance is calculated on the basis of the actual loss of salary and must not exceed the effective loss of earnings. The corresponding daily allowance for insured persons who are paid monthly is apportioned to each working day and holiday and the month is calculated on a 30-day basis.

14.3.b

The entitlement to benefits is reduced if the insured person limits or ceases his gainful employment or professional activity for reasons that are unconnected with the claim.

14.3.c

The insurer is entitled to offset the benefits that are due

with the amounts that are payable by the insured person.

14.3.d Commencement and duration of benefits

The commencement and duration of benefits are determined in accordance with Article R II 4.14 of the CERN Staff Rules and Regulations. The daily allowance is payable throughout the period of 36 months for as long as CERN reduces or stops paying the salary. The monthly pay statement received by the insured person is proof of the salary reduction.

14.3.e

The daily allowance is paid for a maximum period of 180 days to insured persons who reside outside the territory mentioned in Article 5.1 above (with the exception of periods of hospitalisation). This restriction is not applicable to insured persons who reside in the border region, as long as they are live at their home address or in the vicinity of their home address.

An insured person who is ill and goes abroad without the consent of the insurer has no entitlement whatsoever to receive benefits until the date of his/her return.

The insured person who is unfit for work and goes abroad temporarily may receive benefits, provided he/she has obtained prior written consent from the insurer. However, if an insured person, who is unfit for work, leaves Switzerland or the border region for good, he/she will lose all entitlement to the benefits for the current period of unfitness for work.

If an additional insurance claim is made during an insurance claim that has already been registered, the number of days for which benefits have been paid in respect of the first claim will be taken into consideration.

14.4 Partial unfitness for work

In the event of partial unfitness for work of at least 50%, the insurer will pay a daily allowance that is proportionate to the degree of unfitness.

14.5 Third-party benefits

When the insured person reports a claim, he/she is obliged to tell the insurer if he/she receives benefits for loss of earnings or unfitness for work from other private or social insurance institutions. If the insured person is entitled to benefits from social insurance institutions, the insurer will supplement these benefits up to the amount of the effective loss of earnings of the insured person. The insurer will pay no more than the agreed daily allowance. The provisions of this paragraph also apply to social insurance institutions that are headquartered in other countries. If the insurer pays a daily allowance for loss of earnings in place of a liable third party, the insurer is subrogated, in respect of that

part of its benefits, to the rights of the insured person or the beneficiary.

When daily allowances for loss of earnings are covered by several private insurance institutions, the loss of earnings insured by this clause is only covered in proportion to the aggregate benefits guaranteed by all the insurers concerned. The allowances payable by all the insurers must not exceed the loss of earnings actually suffered.

When other insurance institutions pay their benefits retroactively or the insured person belatedly notifies the insurer that he/she is in receipt of such benefits, the insured person is obliged to repay to the insurer the part of the daily allowances that exceeds the actual loss of salary, taking the benefits from other insurance organisations into consideration.

Any reductions made by other insurance organisations will not increase the obligations of the insurer.

14.6 Payability of insurance benefits

Insurance benefits are payable within 4 weeks of the date on which the insurer has received all the information that is required to assess the claim. In the event of long-term unfitness for work, part payments may be requested for the daily allowances that are due, but once a month at most. The benefits that are owed by the insurer may be offset by the amounts that are owed by the insured person under the terms of the contract.

Article 15: REPORTING A CLAIM

15.1

When the insured person is entitled a benefit, he/she must inform the insurer without delay. A doctor must be consulted within a reasonable time limit after the onset of the illness or after the accident. If the insured person is entitled to a daily allowance, he/she must submit to an examination by a doctor every 30 days, unless agreed otherwise with the insurer. Any changes to his/her degree of unfitness for work must be reported within one week.

15.2

The insured person agrees to do his/her utmost to assist in determining the nature and causes of the illness as well as the after-effects of an accident. The insured person is required to undergo a medical examination performed by a medical officer designated by the insurer, whenever he/she is requested to do so, and a stay in a hospital or a sanatorium, if this is necessary for recovery.

If the obligation to report a claim or the requisite measures are not observed voluntarily and this affects the severity or diagnosis of the illness or accident, the insurer may accordingly reduce the benefits that are payable.

15.3 Obligation to provide information

The insured person agrees to provide the insurer with all the information that is likely to be relevant for the assessment of an insurance claim. The insurer is entitled to request information about his/her state of health from the doctors who are treating or have treated the insured person, provided these data are used to determine the degree of entitlement to benefits. The insurer may specifically request medical certificates and other documents and arrange for the medical examination of the insured person to be performed by one or more doctors of its choice. For this purpose, the insured person releases all the doctors that he/she has consulted from their obligation of professional secrecy before and after the conclusion of the insurance contract.

All the information that is provided to the insurer as well as the results of examinations and analyses that are notified to the insurer shall be treated in the strictest confidence by the insurer.

15.4

If the insured person breaches the obligations set forth in Article 15.3, he/she will lose his/her entitlement to benefits until such time as he/she complies with such obligations again. The insurer will set an additional deadline of 14 days for compliance with all such obligations. The entitlement to benefits will cease upon expiry of this deadline.

Article 16: BREACH OF CONTRACTUAL OBLIGATIONS

If the insured person breaches one of the obligations to which he/she is bound, this will release the insurer from its obligations, unless there is evidence that this breach was not the result of negligence, or that it has had no impact whatsoever on the damage or on the rights and obligations of the insurer. In the event of abuse or fraud or attempted abuse or fraud that is proven by the insurer, the latter is entitled to exclude the insured person concerned from cover with immediate effect.