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General Conditions

Liberty Seguros

LIBERTY**LIFE**

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Important Note

This translation is only intended as a rough guide and the company cannot accept any liability for omissions, inaccuracies or variations arising from the translation. The contract between the Insurer and the Insured is on the basis of the Spanish text which prevails in case of any differences. The English translation does not form any part of the insurance contract.

11/08

Liberty Seguros, Compañía de Seguros y Reaseguros, S.A. Domicilio Social: Obenque 2, 28042- Madrid.
R.M. de Madrid, T. 21.275, L.O, F. 83, S. 8, H. M-377.257, I. 15- C.I.F.: A-48/037642

INFORMATION STATEMENT

In accordance with that set forth in Article 60 of the revised text of the Regulation and Supervision of Private Insurance Act, approved by Royal Decree 6/2004 of 29 October, and Articles 104 and 105 of the regulations developed therein, the following is stated:

1. The member state that controls the insurance activity of the company is Spain, and the controlling authority is the Directorate General for Insurance and Pension Funds of the Ministry of Economy and Treasury.

2. Spanish legislation is applicable to the agreement, in particular, the Insurance Contracts Act 50/80 of 8 October and the revised text of the Regulation and Supervision of Private Insurance Act, approved by Royal Decree 6/2004 of 29 October, and the regulations set forth therein.

3. LIBERTY SEGUROS, COMPAÑÍA DE SEGUROS Y REASEGUROS, S.A., as part of the Liberty Insurance Group, has a Customer Service Department and an Insurance Ombudsman to deal with and resolve any complaints or claims made by customers regarding their legally recognised interests and rights.

4. Policyholders, insureds, beneficiaries, affected third parties and their entitled dependents may separately submit their complaints and claims:

– To the Liberty Group Customer Service Department by writing to Calle Obenque, Number 2, 28042, Madrid; by sending a fax to 913 017 998; or by sending an e-mail to **atencionalcliente@libertyseguros.es.**

– To the Liberty Group Insurance Ombudsman by writing to Calle Marqués de la Ensenada 2, 6ª planta, 28004, Madrid; by sending a fax to 913 084 991; or by sending an e-mail to **reclamaciones@da-defensor.org.**

5. Any complaints or claims made by customers will be dealt with and settled within a period of two months, starting from the date on which the complaint or claim is submitted to the Customer Service Department or the Insurance Ombudsman, if applicable.

6. In the event of dissatisfaction with the decision adopted by any of the aforementioned bodies or if a period of two months has elapsed without receiving any response whatsoever, the claimant may submit his/her complaint or claim in writing to the Insured Party and Pension Plan Participant Ombudsman's Commission at the following address: Pº de la Castellana, 44, 28046 Madrid.

7. In addition to the methods for placing claims listed above, disputes may be brought before the relevant judges and courts by legal means.

8. The regulations regarding customer complaints are available to customers in all offices of Liberty Group companies. These regulations cover the internal complaints and claims process, the activity and procedures of the Customer Services Department, the Insurance Ombudsman and the relationship between them. These regulations are also available on the website (www.libertyseguros.es) or from your insurance agent.

9. The insurance company LIBERTY SEGUROS, COMPAÑÍA DE SEGUROS Y REASEGUROS, S.A. has registered offices at Calle Obenque 2, 28042, Madrid, Spain.

10. The company has legal status as a joint stock company.

CONTENTS

PRELIMINARIES DEFINITIONS

For the purposes of this agreement, the following definitions shall be used:

- **Insurer:** The insurance company is Liberty Seguros, Compañía de Seguros y Reaseguros, S.A., which underwrites the policy along with the policyholder and undertakes, through collection of the relevant premium, the cover of all risks insured hereunder, whether survival, death or any other.
- **Policyholder:** The natural or legal person who signs the policy with the insurer, undertaking to pay the established premiums and to fulfil all obligations arising thereunder. The schedule will establish whether he/she acts on his or her own behalf or on behalf of another.
- **Insured:** The person on whose life or physical integrity the policy is issued.
- **Beneficiary:** The natural or legal person or persons entitled to the benefits contracted under the policy in the event of the occurrence of any of the risks subject to the cover.
- **Policy:** The document or set of documents containing the conditions governing the insurance. The general conditions, special conditions, schedule (which individualises the risk) and such endorsements or riders as may be issued to supplement or modify the terms of the policy all form an integral part thereof. None of these documents shall be valid nor have effect without the others.
- **Premium:** The price of the insurance. The bill will additionally include the legally applicable surcharges and taxes.
- **Insurance age:** The age of the insured on the birthday closest to the day on which the policy incepts and on each anniversary thereof.
- **Sum insured:** The sum of money that the insurer will pay the beneficiary should any of the risks covered under the policy occur.
- **Claim:** The occurrence of any event that, under the policy, obliges the insurer to pay the sum insured or the benefit provided for in the contract.
- **Suicide:** The death of the insured caused knowingly and intentionally by the insured.

1 PURPOSE AND COVER OF THE POLICY

A. OBJECT OF THE INSURANCE

The insurer undertakes to pay the sum insured and/or arrange for the benefits established in the policy's special conditions and schedule, if the risk or risks for which cover has been contracted, occur within the scope of the policy, and subject to the exceptions stipulated (in accordance with the indications stipulated in Section B, basic policy cover and Section C, additional insurance cover of the present Article).

Except where otherwise expressly stated in the special conditions or schedule, the policy is established on a first loss basis. That is, in the event of the occurrence of any event subject to cover, whether basic or additional, the insurer will assume the consequences provided for under the policy for said risk, and the policy will be cancelled from that time on, with the exception of the cover for serious illnesses.

B. BASIC COVER OF THE POLICY

The insurer undertakes to pay the designated beneficiary the sum insured in the schedule, in the event of the death of the insured during the policy's period of cover, regardless of the cause, subject to the exclusions set out herein. If the insured survives upon completion of this term, the insurance will be cancelled and the premiums will be paid to the account of the insurer.

If the insured and the spouse of the insured die in the same accident, the insurer guarantees, in addition, a sum equal to the sum insured in the case of the death of the insured, **only if they have children, including those adopted, under 18 years of age and/or suffering from permanent total disability.**

C. ADDITIONAL COVERS OF THE POLICY

The policy schedule will state, where applicable, any additional covers the policyholder may decide to contract. These additional covers will be governed by the terms of these special conditions, the schedule and the policy's general conditions. If the policyholder has contracted additional covers not included in these special conditions, the schedule will specify the clauses governing the same.

Each of the following additional covers will be provided only where expressly contracted as stated in the policy's schedule, and the cover will only be provided subject to payment of the corresponding premium.

1. Accidental death

In the event of the accidental death of the insured, the insurer undertakes to pay the designated beneficiary a sum insured in addition to the sum insured for death under the basic cover equal to the amount established in the schedule.

For the purposes of this cover, the following definitions shall apply:

■ **Accidental death:** Death caused by any bodily injury resulting from the action of an external, sudden and violent event, beyond the control of the insured and causing his or her death within three hundred sixty-five calendar days following the date on which the injury is sustained.

2. Death due to a road-traffic accident

In the event of the death of the insured due to a road-traffic accident, the insurer is obliged to pay the designated beneficiary, in addition to the sum insured established in the schedule of the basic cover for death, the amount stipulated for this cover in the schedule.

For the purposes of this cover, the following definitions shall apply:

■ **Road-traffic accident: Any accident suffered by the insured in his or her capacity as:**

- **A pedestrian on a public road.**
- **A land, sea or air public transport user.**
- **The driver or a passenger of a land vehicle, with or without a motor, other than public mass transport, except for motorcycles or mopeds with a cubic capacity of over 125 cc.**

The risk of death will be covered providing it occurs as a result of the road-traffic accident, **whether immediately or within a period of three hundred sixty-five days following the date of the accident.**

This cover may only be applied for in conjunction with the cover described above.

3. Permanent total disability

In the event of the permanent total disability of the insured, as defined in this Clause, the insurer undertakes to pay the designated beneficiary the sum insured established for this cover in the schedule.

For the purposes of this cover, the following definitions shall apply:

■ **Permanent total disability: Any medically-proven irreversible, physical injury that renders the insured unable to perform any type of remunerated work. This must exist continuously for at least six months beforehand.**

If the policyholder has contracted both the cover for permanent total disability and the cover defined in Clause 6 for serious illness, and the risks covered under both covers occur to the insured during the period of insurance, the insurer will only pay the sum insured for the risk occurring first.

4. Permanent total disability due to an accident

Should the permanent total disability, as defined in Section 3 above, occur as a result of an accident, understood to mean the bodily injury arising from an external, violent, sudden cause beyond the control of the insured, and providing that it is declared within six calendar months following the accident, the insurer undertakes to pay a sum insured in addition to that defined in Section 3 above equal to the amount established in the schedule.

This cover may only be applied for in conjunction with the cover described above.

5. Permanent total disability due to a road-traffic accident

Should the permanent total disability occur as a result of a road-traffic accident, in the terms and within the scope provided for in the second clause herein, the insurer undertakes to pay a sum insured in addition to the sum insured for permanent total disability as established in the schedule.

This cover may only be applied for in conjunction with the cover described above.

6. Serious illnesses

If the insured is diagnosed with any of the illnesses, or undergoes any of the surgical interventions, included under this cover, the insurer undertakes to pay the designated beneficiary the sum insured established for this cover in the schedule.

Once the risk included in this cover for serious illness occurs to the insured, any remaining additional covers that may have been contracted will be cancelled and only the basic cover for death will remain in effect, but with a sum insured reduced in the amount paid out for this cover.

For all major illnesses guaranteed under this cover, an elimination period is established from the policy's inception date, and it is understood that if the diagnosis of any of these

major illnesses occurs within this period, the potential claim will not be admitted and the coverage will be considered void. Upon completion of the elimination period, if no illness has been diagnosed, the cover will be extended until the date established for this cover in the policy's schedule.

The corresponding premium of this cover is not guaranteed in the future; it may be modified by the insurer. The insurer must inform the policyholder of any changes at least two months prior to the date of the next renewal. If the policyholder does not accept the new premiums, he/she may request the cancellation of the cover or of the entire policy.

Covered serious illnesses and operations

Only the following serious illnesses are covered:

■ **Heart Attack:** This is the death or necrosis of part of the heart muscle (myocardium) as a result of the sudden interruption of the blood flow to the myocardium, occurring for the first time. The diagnosis must be based on:

- History of typical chest pain.
- New electrocardiographic changes confirming the attack.
- Significant increase in cardiac enzymes.

Angina is specifically excluded.

Elimination period: three months.

■ **Coronary artery (by-pass) surgery:** This is open-heart surgery performed to correct the stenosis or obstruction of one or more coronary arteries with artery or vein grafts. The diagnosis must be performed by coronary angiography and the surgical indication must be considered medically necessary by a cardiologist.

Angioplasty and any other intra-arterial technique, as well as laser techniques, are specifically excluded.

Elimination period: six months.

■ **Cerebrovascular accident (STROKE):** Any cerebrovascular accident with significant functional impairment leading to a clearly significant and permanent functional and anatomical deficit.

The diagnosis must be confirmed by new changes in a CAT (computerised axial tomography) scan and/or MRI (magnetic resonance imaging). The cover for cerebrovascular accidents includes those caused by:

- Cerebral infarction.
- Intracranial haemorrhage.
- Embolism with an extracranial source.

Transient ischemic attacks (TIA) and cerebrovascular accidents resulting from external trauma are specifically excluded.

Elimination period: six months.

■ **Cancer:** Malignant tumour caused by the uncontrolled growth and rapid proliferation of cells with invasion and destruction of normal tissue. The cancer must be diagnosed and confirmed as malignant by means of a histological analysis. Leukaemia, malignant lymphoma, Hodgkin's disease, malignant bone marrow diseases and metastatic skin cancer are included.

THE FOLLOWING ARE NOT COVERED:

- In situ cancer, cervical cancer and CIN I, II and III cervical dysplasia and all pre-malignant situations or non-invasive cancers.
- T1 early prostate cancer, including T1a and T1b, according to the TNM classification.
- Skin melanomas measuring less than 1.5 mm. Breslow thickness or Clark level under 3.
- Self-inflicted wounds, attempted suicide, intoxication or use of narcotics and drugs not prescribed by a physician.

All tumours in the presence of an HIV infection and all types of skin cancer except for malignant melanoma, as per the prior definition, are likewise excluded.

Elimination period: three months.

■ **Organ transplants:** When, as a result of a medical diagnosis, it is necessary to perform a heart, heart and lung, liver, kidney, pancreas or blood marrow transplant.

Inclusion on an official waiting list for the transplant of any of the organs mentioned above is also included under the cover. The cover solely insures the recipient and not the donor.

Elimination period: six months from the policy's inception date until the onset of organ failure or certification of inclusion on the waiting list.

■ **Kidney failure:** The irreversible chronic functional failure of both kidneys, requiring regular peritoneal dialysis, haemodialysis and/or the need for a kidney transplant.

Elimination period: three months.

■ **Paralysis - paraplegia:** The total functional loss of two or more limbs or extremities due to injury or illness of the spinal chord or brain, when this functional loss is considered permanent by a neurologist. Functional losses of members or extremities classified as diplegia, hemiplegia and quadriplegia are included.

Elimination period: three months.

2 EXCLUDED RISKS

The policyholder acknowledges that the premium has been calculated based on the fact that the following events or risks are expressly excluded from the cover:

2.1. Risks excluded from all cover

The followings risks are expressly excluded from the basic cover and from any contracted additional covers of the policy.

a. Over the first year of the period of insurance, the insurer will not cover the risk of death by suicide. Upon completion of this period, it assumes said risk. In the event of reinstatement of the policy, or if the policyholder increases the sum insured for death, whether as a basic cover or as any form of additional cover, the same criteria shall be followed, such that:

   In the event of reinstatement, the insurer will not cover the risk of death by suicide for the first year following the reinstatement date.

In the event of an increase in the sum insured, the insurer will not cover the risk of death by suicide in proportion to the amount by which the sum insured is increased, for the first year following the date of said increase.

b. The risk of a plane crash will be covered providing the insured takes part in the flight as a mere passenger on a regular commercial line, charter flight or, in general, on any civilian aircraft that has a duly authorised certificate of airworthiness. In all cases, the aircraft must be piloted by persons holding a valid pilot's license for the authorised craft. Claims occurring as a result of parachute descents not required due to the status of the aircraft, as well as flights or descents with paragliders, hang gliders, ultralight aircraft or similar craft, shall likewise not be covered.

c. Claims occurring as a direct or indirect consequence of a nuclear reaction or radiation or radioactive contamination and those occurring during underwater navigation or on exploration expeditions.

d. Should the death of the insured be caused intentionally by his or her sole beneficiary, the insurer will be released from its obligations to said beneficiary, and the sum insured will be incorporated into the policyholder's estate. In the event that there is more than one beneficiary, those not involved in the death of the insured will retain their rights.

e. Claims occurring as a result of war or similar operations or derived from political or social events.

2.2. Risks excluded from additional covers

The risks and events brought about as a consequence of the following are not covered in the accidental death cover, permanent total disability cover or permanent total disability due to an accident cover, as described in Articles 1.C.1, 1.C.3 y 1.C.4:

a. Self-inflicted wounds, attempted suicide, intoxication or use of narcotics and drugs not prescribed by a physician.

b. The practice of or participation in equestrian competitions, motorcycle races, car races, mountain climbing, rock climbing, spelunking, deep-sea diving at depths of over 25 metres, hang gliding, paragliding, flights in ultralight aircraft or similar craft, parachute descents not required due to the status of an aircraft and any other type of sport or activity entailing, as a result of its dangerous nature, a risk to the physical integrity of the insured.

c. Wounds or bodily injuries caused to the insured by him or herself or by the beneficiary of the policy.

d. Illnesses or accidents occurring as a result of alcoholism or the use of narcotics and drugs not prescribed by a physician.

e. Any loss resulting from an act of recklessness or grave negligence on the part of the insured, when legally so declared, as well as any arising from his active participation in criminal acts, duels or brawling or fighting, except, in case of the latter, when acting in legitimate defence or in an effort to save persons or property.

f. Accidents caused by earthquakes, volcanic eruption, flooding and other extraordinary seismic or meteorological events.

g. Consequences of an illness that existed or of an accident that occurred prior to the effective period of the policy and was known but not declared by the insured on the health questionnaire.

h. Road-traffic accidents that the insured may suffer as driver of a motorcycle, moped or motorbike of more that 125 cc.

i. In the event of the additional sum insured for death and permanent total disability due to an accident, disability or death caused by Acquired Immunodeficiency Syndrome or any associated illness is expressly excluded from the definition of accident.

j. Risks not covered by any of the policies listed in Article 2.1.

Risks or events arising as a result of the following are not covered in the covers for death due to a road-traffic accident and permanent total disability due to a road-traffic accident as stipulated in Articles 1.C.2 and 1.C.5:

a. Accidents caused as a result of the insured's participation as a contestant in races with any type of automobile, rallies, competitions and bets, and also as a driver if he/she is not the holder of the requisite driver's license for the corresponding vehicle.

b. Accidents that may occur to the insured in his/her capacity as a personal chauffer or member of the operating personnel of a means of land, sea or air transport.

c. Risks not covered in any of the covers listed above in Articles 2.1 and 2.2

The following are not covered in the serious illnesses cover as described in Article 1.C.6:

a. Major illnesses diagnosed for the first time prior to the insurance policy's inception date or caused by a surgical intervention prior to said date.

b. Major illnesses caused by or relating to the acquired immunodeficiency syndrome (AIDS) or the presence of the human immunodeficiency virus (HIV), verified by means of testing positive in an antibody test.

c. Any illness or surgical intervention other than those expressly described in this Section 6.

d. Self–inflicted wounds, attempted suicide, intoxication or use of narcotics and drugs not prescribed by a physician.

3 POLICY BENEFIT PAYMENTS

1. Obligations in the event of a claim, claims for benefits or expiry of the policy

The policyholder, the insured where applicable, or the beneficiary should report the occurrence of a loss to the insurer within a maximum period of seven days from when they receive knowledge of it. The policyholder, the insured or, where applicable, the beneficiary, shall present the following original documents or, where necessary, certified photocopies, to the insurer:

Claims due to death

- A certified copy of the death certificate.
- A certified copy of the birth certificate (photocopy of the insured's National ID Card).
- The report of the doctor visited by the insured describing the origin, evolution and nature of the illness that caused the death, or, where applicable, a complete copy of the

testimony from the court proceedings or documents offering proof of an accident as the cause of death, such as an autopsy report.

- Original copy of the policy and the last bill paid.
- The certificate issued by the Register of Wills and, where applicable, a copy of the last will and testament of the insured.
- Letter offering proof of payment of the relevant taxes, where legally applicable, or proof of exemption or extinguishment, especially with regard to the Estate Tax.

Additionally, in the event of the death of both spouses in the same accident and with underage children, the following must be presented:

- A certified copy of the death certificate of the spouse.
- The family book.

Claim due to disability

- I.N.S.S. resolution declaring disability, the degree of the disability and the effective date.
- Medical reports that describe the origin, evolution and current circumstance of the present pathologies.
- Photocopy of National ID Card.

Additionally, in the case of disability due to an accident or a road-traffic accident:

- Complete copy of the court proceedings or documentation that gives evidence of the accident.

Claims for serious illnesses

- Medical reports indicating the known medical history and the cause, evolution and nature of the major illness and/or surgical intervention, where applicable.
- Photocopy of the National ID Card of the insured.

The policyholder, insured or, where applicable, beneficiary must furnish the insured with all manner of paperwork and information that it may request in order to verify the facts and circumstances surrounding the claim or benefit.

2. Payment of benefits

In the event of the occurrence of the risk provided for under the policy, the insurer will pay the policyholder or the named beneficiary or beneficiaries, as may apply, the contracted benefit at its registered offices once the corresponding claim has been handled.

The insurer, within a maximum period of five days from the date in which the paperwork is completed, must pay or allocate the contracted benefit.

If within three months of the occurrence of the claim the insurer has not paid or allocated the amount without justified cause or for reasons imputable to the insurer, it will be deemed to be in default pursuant to the terms and with the effects set forth in Article 20 of the Spanish Insurance Contracts Act.

Beneficiaries of the insurance policy, in the event of death of the insured, can request an advance on the sum insured before the required paperwork is complete with the following limits and only under the following circumstances:

- As an initial aid for burial costs the insurer may concede an advance of 10% of the sum insured for death, with a limit of 3,000 euros, upon presentation of a certified copy of the death certificate.
- Once the insurer authorises the claim payment, it may concede an advance of 3,000 euros maximum to help with administration costs and tax payments.

3. Lost adjustment proceedings

In the event of discrepancy with regard to the classification of a claim, its causes, the date of its occurrence or any other relevant circumstance, the insurer and the insured or policyholder may submit the issue to the decision of loss adjusters, of whom each party may name one, subject to written approval by the other party.

Should either of the parties fail to make the appointment, he/she shall be bound to do so within eight days of the date on which it is required to do so by the party that has already made its appointment. Should it fail to make an appointment in this time, it shall be understood that the party accepts the opinion issued by the loss adjuster appointed by the other party, which shall be binding.

If the loss adjusters reach an agreement, this will be recorded in a joint deed, which will specify the causes of the claim and all other relevant circumstances. In the absence of such an agreement, both parties shall appoint, by mutual agreement, a third loss adjuster. Where this is not possible, this appointment will be made by the judge of the court of first instance with jurisdiction over the residence of the insured, by non-litigious proceedings and in accordance with the procedure for the random designation of adjusters set forth in the Civil Procedure Act.

In this case, the loss adjuster's report shall be issued within the period indicated by the parties or, in its absence, in the period of thirty days following acceptance of his/her appointment as the third loss adjuster.

The parties shall be immediately informed of the opinion of the loss adjusters, whether unanimous or majority, by a means beyond all doubt, and it will be binding, except when either of the parties legally contests it within a period of one month, in the case of the insurer, or one hundred and eighty days in the case of the insured, both periods counted from the date of said notification. If no challenge is made in said periods, the loss adjusters' opinion will become final and unappealable.

In the event of default by the insurer on payment of a benefit that has become final and unappealable, should the insured or beneficiaries be forced to bring legal proceedings, the benefit will be increased pursuant to the terms of Article 20 of the Spanish Insurance Contracts Act.

Each party shall bear the fees of its own loss adjuster. The fees of the third loss adjuster, where applicable, and any other expenses incurred will be equally for the account of the insured and insurer. However, should either of the parties have made the appraisal necessary by insisting on a manifestly disproportionate valuation of the claim, said party shall be solely liable for these costs.

4. Limitation period

Rights to take legal action derived from this contract shall become time-barred after a period of five years as of the date on which they may be exercised.

CONDITIONS OF THE AGREEMENT

4 RISK STATEMENT

1. Conditions of the agreement

The declarations made by the policyholder and the insured contained in the application and in the health and habits questionnaire submitted by the insured, including, where applicable, the declarations of the examining physician, are essential data for the assessment of the risk and are the basis for the policy.

Should the policy's content differ from the insurance application or from the agreed clauses, the policyholder may place a claim against the insurer, within a period of one month as of the date on which the policy is handed over, in order to rectify the existing divergence. If no claims are lodged prior to the conclusion of this period, the terms and conditions of the policy shall apply.

2. Statement of circumstances which affect risk

The policyholder and, where applicable, the insured are bound, prior to termination of the contract, to declare to the insurer, in accordance with the questionnaire it will ask them to complete, all those circumstances known to them, which might influence the assessment of the risk. He/she is exonerated from this obligation, if the insurer does not require him/her to fill out the questionnaire, or when requiring him/her to do so, the circumstances, which may have influenced in the assessment of risk , are not asked about in the questionnaire.

In case of withholding or misrepresentation of information, the insurer may rescind the contract through a statement addressed to the policyholder within a period of one month as of the time it learns of said withholding or misrepresentation. Those premiums corresponding to the period in progress when this declaration is made will correspond to the insurer, unless there has been fraud or serious fault on its part.

Should the accident occur before the insurer has made the statement described in the previous paragraph, the benefits provided by the insurer will be reduced proportionally, according to the difference between the premium agreed upon in the policy and that which would have applied had the true magnitude of the risk been known. When the withholding or misrepresentation is due to wilful misconduct or serious fault by the policyholder and/or the insured, the insurer shall be released from its obligation to pay any benefits.

3. Incontestability and misstatement of age

In the event of non-disclosure or misstatement in the declarations of the policyholder and/or insured, the insurer may not challenge the contract after one year has elapsed from the inception date, except in case of wilful misconduct on the part of the policyholder and/or insured or in the case of misstatement of the insured's age if his or her true age, on the policy's inception date, was higher than the age limit stipulated therein.

In all other cases, if, as a result of the misstatement of age, the premium paid is less than that which would have been payable, the benefit paid by the insurer will be reduced proportionally to the premium collected. If, on the other hand, the premium paid is higher than that which would have been payable, the insurer will be obliged to reimburse the surplus paid premium without interest.

4. Avoidance

The policy will be void, except where provided under the law, if at the time of its conclusion, the risk does not exist or the claim has already occurred.

In the event of avoidance of the policy, the insurer may claim all expenses it has incurred in order to issue the policy.

5 EFFECTIVE DATE, DURATION AND TERMINATION OF THE POLICY

1. Execution and inception of the policy

The contract is executed by agreement of the parties, as evidenced by the subscription thereby of the policy. **Notwithstanding the foregoing, the contracted cover will not commence until the first premium has been paid.**

Any modifications or additions, where applicable, will incept pursuant to the terms of the relevant endorsement or rider.

The obligations of the insurer will begin at midnight on the day that both of the aforementioned requirements are met.

If the duration of the contract is more than six months, the policyholder shall be entitled to terminate the agreement without offering any cause and without incurring any penalty within 30 days from the date on which the insurer provides the policyholder with the policy or a provisional cover document.

This unilateral power to terminate the contract must be exercised in writing by the policyholder in the stated period and shall take effect on the date of issue.

As of this date, the coverage of the risk on the part of the insurer shall cease, and the policyholder shall be entitled to a refund of whatever premium he had paid, less the portion corresponding to the time for which the contract was in force.

2. Period of cover and generic grounds for cancellation

The policy shall have the period of cover stated in the schedule.

The policy will be cancelled:

- Upon completion of the period of cover provided for therein.
- Upon the occurrence of one of the covered risks, as stipulated in Article 1 of these general conditions.
- Due to non-payment of premiums due and outstanding.
- In the case of the policy's additional covers it will be upon completion of the insurance year during which the insured reaches the age of sixty-five.

6 INCREASE AND DECREASE OF RISK

1. Notification in the event of an increase in risk

The policyholder or the insured must inform the insurer of any circumstances aside from the state of health which increase risk, and are of such a nature that, had they been known to the insurer when the agreement was drawn up, it would not have been executed or would have been executed under more burdensome conditions.

The insurer may, within a period of two months as of the day on which the increase is declared, propose an amendment to the contract. In such case, the policyholder shall have fifteen days, upon receipt of the proposal, to accept or reject it.

In case of rejection, or should the policyholder fail to respond, the insurer may, upon conclusion of this period, terminate the contract pending notification of the policyholder, giving him a new period of fifteen days to respond, after which, and within the following eight days, the definitive termination shall be communicated to him/her.

The insurer may likewise terminate the policy by communicating its decision in writing to the insured within one month of the day on which it receives notice of the increase in the risk.

Should an accident occur before the declaration of an increase in risk has been made, the insurer shall be released of its obligation to provide benefits if the policyholder of the insurance or the insured has acted in bad faith. To the contrary, the benefits provided by the insurer will be reduced proportionally to the difference between the accorded premium and that which would have applied had the true magnitude of the risk been known.

2. Notification in the event of a decrease in risk

The policyholder or, where applicable, the insured or the beneficiary may inform the insurer of all those circumstances that decrease the risk and are of such a nature that, had they been known by the latter when the contract was formed, it would have been executed under more favourable conditions for the policyholder.

In such case, upon conclusion of the period covered by the last premium paid, the amount of future premiums shall be reduced proportionally. Where this is not the case, the policyholder shall be entitled to terminate the contract and to reimbursement of the difference between the premium paid and that which would have applied, as of the moment he reported the decrease in risk.

7 POLICY PREMIUMS

1. Payment of the premium

The policyholder is obliged to pay the premiums established in the schedule.

The first premium will be due at the time the contract is signed. Successive premiums will be due on the corresponding expiry dates. The premium due date will be established in the schedule.

Should the policy fail to designate a specific place for payment of the premium, it shall be construed that it is to be made at the policyholder's residence.

If payment of the premiums by direct debit order has been agreed, the following rules will apply:

- The policyholder will furnish the insurer with a letter addressed to the relevant bank or savings bank, in which he/she gives the necessary instructions.
- The premium shall be understood to be paid at its due date, except where, due to a lack of funds in the account designated for payment or due to any other cause, it could not be collected within a period of one month from said date. In this case, the unpaid premium must be paid at the insurer's registered office.

The schedule will state whether the policyholder has contracted a premium that will remain constant throughout the period of cover or an index-linked premium. In the event of the latter, at each policy renewal date, the premium will be adjusted in accordance with the percentage established in the schedule, and the policyholder may choose between a cumulative or linear adjustment.

With cumulative adjustments, the percentage will be applied to the annual amount of the premium in force just prior to said renewal date. With linear adjustments, the percentage will be applied to the annual amount of the policy's first premium.

The policy schedule will indicate whether the premium is to be paid as a single premium and, if not, the frequency with which the premiums will be paid and the dates on which they will fall due. The policyholder may subsequently request to change the frequency of payment of the premium established in the schedule to any of the payment methods offered by the insurer. Such a change will take effect on the date agreed in the relevant endorsement or rider. Where any guaranteed values exist, the change in frequency will be subject to acceptance by the policyholder of any changes it may cause to said guaranteed values.

2. Non-payment and suspension of cover

If, because of the policyholder, the first premium is not paid, the insurer is entitled to terminate the contract or to demand the enforced payment based on the policy.

If the premium has not been paid before a loss occurs, the insurer is released from his obligations.

In case of failure to pay any of the following premiums, the insurer's coverage will be suspended one month after the date it came due.

If the insurer does demand payment within a period of six months following the date a premium comes due, the contract will be understood to have been terminated. In all cases, the insurer, when the contract has been suspended, may only demand payment of the premium for the period underway.

If the contract has not been terminated or cancelled pursuant to the preceding paragraphs, the cover under the policy will come back into force at midnight on the day the policyholder or insured pays the premium.

3. Taxes and surcharges

All legally applicable taxes and surcharges arising from this policy, both at present and in the future, shall be paid by the policyholder or beneficiary.

8 BENEFICIARIES OF THE POLICY

1. Designation and change of beneficiaries

During the period of insurance, the policyholder may designate or change the beneficiary without need for the consent of the insurer, except where the policyholder has expressly waived this power in writing.

The designation or revocation of a beneficiary may be stated in the schedule or in a subsequent written statement addressed to the insurer or in a will.

If the beneficiaries are not designated but rather generically as spouse, children or hairs: said designation will be interpretated as follows:

- **Spouse:** Said person at the time of death of the insured.
- **Children:** All descendents entitled to an inheritance.
- **Heirs:** Those qualifying as such at the time of the death of the insured.

In all three cases, it must be specified whether the spouse, children or heirs in question are those of the policyholder, the insured or another person. Where this is not specified, it shall be understood that they are the policyholder's.

Where multiple beneficiaries are designated and no method for distribution of the benefit is indicated, the agreed benefit will be divided between them in equal parts. Where the designated beneficiaries are the heirs and no method for distribution of the benefit is indicated, the benefit will be divided in proportion to each one's share of the inheritance.

Any portion not acquired by any one beneficiary will be allocated to the others.

If, at the time of the insured's death, no beneficiary has been designated and no rules for determining the beneficiary have been established, the sum insured will be incorporated into the policyholder's estate.

2. Assignment and pledge of the policy

The policyholder may, at all times, assign or pledge the policy, providing the beneficiary has not been designated irrevocably. The assignment or pledge of the policy entails revocation of the beneficiary.

The policyholder must notify the insurer in writing of any assignment or pledge made.

9 NOTIFICATIONS AND DUPLICATES OF THE POLICY

1. Notifications between the policyholder and the insurer

Notifications addressed to the insurer by the policyholder, the insured or the beneficiary shall be sent to the insurer's registered office as it appears in the policy.

The policyholder must notify the insurer, by verifiable means, of any changes to his/her home address or the direct debit order for the policy premiums.

Communications addressed to the policyholder and, where applicable, to the insured or beneficiary shall be sent to the address appearing in the policy for same, unless they have notified a change of address to the insurer.

Any notices sent by an insurance agent to the insurer on behalf of the policyholder shall have the same effect as if they had been sent by the policyholder, unless otherwise stated.

The express approval of the policyholder shall be required, at all times, to enter into a new contract or modify or terminate the insurance contract currently in force.

All changes requested by the policyholder will be reflected in an endorsement, which will be furnished to him/her as proof of the change.

2. Loss or destruction of the policy

In the event of the loss, theft or destruction of the policy, the policyholder must notify the insurer by registered letter, and the insurer will issue a copy or duplicate of same.

10 INDEMNITY CLAUSE

THE INSURANCE COMPENSATION CONSORTIUM FOR LOSSES DERIVED FROM EXTRAORDINARY EVENTS.

PERSONAL INJURIES CLAUSE

In accordance with the provisions set forth in the revised text of the Legal Statute of the "Insurance Compensation Consortium", approved by Royal Legislative Decree 7/2004 of 29 October, and amended by Law 12/2006 of 16 May, the policyholder of an insurance contracts, which by law must include a surcharge in favour of said public business entity, has the power to reach an agreement for the coverage of extraordinary risks with any insurance entity that meets the conditions required by legislation in force.

The indemnity derived from losses resulting from extraordinary events that occur in Spain and that affect the risks located therein, and also those that occur abroad when the insured has his main residence in Spain, shall be paid by the "Insurance Compensation Consortium" when the policyholder has paid the corresponding surcharges in favour thereof and when any of the following occurs:

a. If the extraordinary risk covered by the "Insurance Compensation Consortium" is not covered by the insurance policy contrated with the insurer.

b. When, even though it is covered by said insurance policy, the duties of the Insurance entity could not be fulfilled because it has been legally declared to be bankrupt or because it is subject to a compulsory winding-up proceeding or a winding-up assumed by the "Insurance Compensation Consortium".

The "Insurance Compensation Consortium" shall comply with the provisions set forth in said Legal Statute, in Law 50/1980 of 8 October on Insurance Contracts, in the Regulations on extraordinary risk insurance approved by Royal Decree 300/2004 of 20 February and in all complementary provisions.

SUMMARY OF LEGAL REGULATIONS

1. Covered extraordinary events

a. The following natural phenomena: earthquakes and tsunamis, extraordinary floods (including storm-generated ocean waves), volcanic eruptions, atypical hurricanes (including winds with gusts exceeding 135 km/h and tornadoes) and falling meteorites.

b. Those caused suddenly as a consequence of terrorism, rebellion, insurrection, riots or civil unrest.

c. Acts or actions of Armed Forces or of Security Forces and services in times of peace.

2. Excluded risks

a. Those that do not give rise to indemnity according to the Insurance Contracts Act.

b. Damage and losses caused to people insured by insurance agreements other than those that include the obligatory surcharge in favour of the Insurance Compensation Consortium.

c. Those caused by armed conflicts, even when not preceded by an official declaration of war.

d. Those derived from nuclear energy, notwithstanding that set forth in the Nuclear Energy Act 25/1964 of April.

e. Those caused by natural phenomena other than those set forth in Article 1 of the Regulations on extraordinary risk insurance, and in particular those caused by a rise in the water table, hillside movements, landslides or settlement movements, falling rocks and any other similar phenomena, unless these are evidently caused by the action of rain water that simultaneously caused extraordinary flood in the area.

f. Those caused by the actions of people arising over the course of meetings and demonstrations held in accordance with the provisions of Organic Law 9/1983 of 15 July, which regulates the right to assembly, as well as during legal strikes, except when said actions may be considered extraordinary events pursuant to the terms of Article 1 of the Regulation for Insurance Against Extraordinary Risks.

g. Those caused by bad faith on the part of the insured.

h. Those occurring prior to payment of the first premium or when, in accordance with that set forth in the Insurance Contracts Act, the cover provided by the Insurance Compensation Consortium has been suspended or the insurance has been terminated due to non-payment of premiums.

i. Losses that, due to their magnitude and seriousness, are qualified by the National Government as a "national catastrophe or disaster".

3. Extension of coverage

The cover of extraordinary risks will apply to the same persons and be subject to the same sums insured established in the policy for the purposes of insurance against ordinary risks.

With life insurance policies that, pursuant to the terms of the contract and in accordance with the laws regulating private insurance, generate policy reserves, the consortium's cover will refer to the sum insured for each insured, that is, to the difference between the sum insured and the policy reserves that, pursuant to the aforementioned laws, the insurer that issued the policy must establish. The amount of said policy reserves will be paid by the aforementioned insurer.

PROCEDURE FOR ACTIONS IN THE EVENT OF A CLAIM COVERED BY THE "INSURANCE COMPENSATION CONSORTIUM"

In the event of a claim, the insured, policyholder, beneficiary or their respective legal representatives must report said claim, either directly or through the insurance company or insurance agent, within a period of seven days of receiving knowledge of it, to the relevant regional office of the consortium, according to the place where the claim occurred. The notice shall be drawn up on the form established for such purposes, which is available from the consortium's webpage **www.consorseguros.es** or from the consortium's offices or the insurance company. The documents that are required according to the nature of the damage must be attached to this form.

To clarify any doubts that may arise regarding the procedure to be followed, the Insurance Compensation Consortium offers the following telephone service for the insured: **902 222 665**.

LIBERTY

Liberty Seguros

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