Policy conditions
TAF Special Life Insurance

Do you choose TAF? If so, then you are choosing for one of the most inexpensive life insurance policies in the Netherlands, that moreover you can also coordinate to your personal wishes. In this way, you protect your next of kin optimally against the undesirable financial consequences of death.

Your TAF Special Life Insurance is an agreement between the insurer and you. This agreement includes insurance conditions or policy conditions. In the policy conditions, you can read exactly what you are insuring and what your rights and obligations and those of the insurer are. The policy conditions are part of the policy issued by the insurer.

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1. Definitions

The following definitions are used in these General Insurance Terms and Conditions:

Application form:
The document that was signed by the policyholder(s), the insured person(s) and the premium payer that resulted in the policy.

Addendum:
Any additional appendix to the policy issued by the insurer that includes a revision of, or an addition to, the general insurance conditions and/or the policy schedule.

Administrator:
TAF BV, based in Eindhoven, The Netherlands.
Postbus 4562, 5601 EN Eindhoven, The Netherlands
Telephone: +31(0)40-707 38 90
E-mail: info@taf.nl

Beneficiary:
The (legal) person(s) to whom the insured amount must be paid.

End date of the insurance
The date stated in the policy schedule on which the insurance is terminated without payment, if the insured person(s) is/are alive at that time.

Mortgage related:
The insurance is mortgage-related if any payment is intended for the repayment of a mortgage loan taken out for the purchase, renovation or improvement of the first home that serves as the main residence. The confirmation of receipt states whether or not the insurance is mortgage-related.

Commencement date of the insurance
The date on which the insurance takes effect, as stated in the policy schedule.

Malevolent contamination:
The spreading (whether active or not) – committed outside the scope of one of the six forms of acts of war as referred to in Article 3:38 of the Financial Supervision Act – of germs of a disease and/or substances which as a result of their (in)direct physical, biological, radioactive or chemical effect may cause injury and/or impairment of health, whether resulting in death or not, to humans or animals and/or may cause loss of or damage to property or may otherwise impair economic interests, in which case it is likely that the spreading (whether active or not) – whether or not in any organisational context – has been planned and/or carried out with a view to effect certain political and/or religious and/or ideological purposes.

Duration of the insurance:
The period between the commencement date and the end date of the insurance.

Accident:
Violence that occurs suddenly and involuntarily to the body of the insured person(s) during the term of the insurance. This violence occurs beyond the control of the policyholder(s), the insured person(s) and beneficiary or beneficiaries and comes from outside. This violence can also be medically objectified directly and without the cooperation of other causes and results in serious physical injury to the insured person(s).

Excessive alcohol consumption:
Alcohol consumption as a result of which the alcohol percentage in the blood arrives at a minimum limit of 0.5. In case of starting drivers the said limit cannot exceed 0.2 during the first five years after the receipt of the driving licence.

Policy:
The written record of the insurance agreement concluded between the policyholder and the insurer, consisting of the application form, the policy schedule, these general insurance terms and conditions and any additional clause sheets.

Policy schedule:
The summary of the benefits under the policy, the premium due and any special conditions that apply.

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Premium:
The periodical amount owed by the policyholder to the insurer under the policy, as stated on the policy schedule.

Premium due date:
The date on which the premium is payable according to the policy schedule.

Terminal Illness:
The diagnosis of a disease that is expected to lead to the death of the insured person within 12 months. This diagnosis must be supported by a specialist and confirmed by an independent medical advisor to be appointed by the insurer.

Terrorism:
Any violent act and/or conduct – committed outside the scope of one of the six forms of acts of war as referred to in Article 3:38 of the Financial Supervision Act [Wet op het financieel toezicht] – in the form of an attack or a series of attacks connected together in time and intention as a result whereof injury and/or impairment of health, whether resulting in death or not, and/or loss of or damage to property arises or any economic interest is otherwise impaired, in which case it is likely that said attack or series – whether or not in any organisational context – has been planned and/or carried out with a view to effect certain political and/or religious and/or ideological purposes.

Broker:
The legal person through whose mediation services the insurance was concluded.

Insurer:
Chubb Life Europe SE (handelsnaam: Chubb Life), Nederlands bijkantoor, Marten Meesweg 8-10, 3068 AV Rotterdam, ingeschreven bij KvK Rotterdam onder nummer 24414052. Chubb Life Europe SE heeft een vergunning van de 'Autorité de Controle Prudentiel et de Résolution' (ACPR) in Frankrijk, registratienummer 497 825 539 RCS Nanterre. Statutaire zetel: La Tour Carpe Dien, 31 Place des Corolles, Esplanade Nord, 92400 Courbevoie, Frankrijk.

Insured person:
The natural person(s) on whose life the insurance has been taken out.

Insured capital in the event of death:
The insured capital stated on the policy schedule.

Insurance:
The agreement on a life insurance policy.

Policyholder:
The (legal) person(s) who takes out the insurance or his legal successor(s).

Suicide:
The intentional or unintentional ending of one's own life.

2. Basis of the insurance

2.1 The information and statements provided by the policyholder and/or the insured to the insurer, including on the application form, medical questionnaire(s) and (issued) health certificate(s) and during medical examination(s), form the basis of the policy and are considered to form part of the policy. This information includes, but is not limited to, demographic information and information about lifestyle. The policyholder must inform the insurer, prior to taking out the insurance, of all facts of which he is or should have been aware and of which he knows or should have understood that the insurer's decision as to whether or not he is prepared to take out the insurance depends on, and if so, under what conditions, whether or not he can depend on it (statutory duty of disclosure).

2.2 The insurer reserves the right to ask for proof of the information provided before accepting the policy. However, if the policy has been accepted without such information having been requested, or if it has been requested but has not been provided, the insurer reserves the right to request such evidence at any time in the future. If such proof is then requested and the policyholder and/or the insured is not able to provide the information on which the insurer has relied, the insurer reserves the right to take the steps deemed appropriate by the insurer, taking into account the relevance of the information in question. Such steps can include cancellation of the policy (with or without reimbursement of premiums) or reduction of cover.

2.3 If it appears that the statutory duty of disclosure has not been complied with, the insurer can cancel the insurance or change the insurance to an insurance policy, with or without retroactive effect, under conditions that are acceptable to the insurer given the apparent risk.

2.4 If it appears that the statutory duty of disclosure has not been complied with, no payment shall be due if the insurer would not have accepted the insurance if it had been aware of the actual facts. If a withheld event would have resulted in a higher contribution or a lower insured amount, the payment will be reduced proportionately. If a concealed event would have resulted in different conditions, only the payment that would have been included in the insurance contract based on the other conditions will be due.

2.5 During the term of the insurance, the policyholder can request an increase in the insured capital, an extension of the term of the insurance or a change in the pattern of purchase of the insured capital spread over the term of the insurance. Such an increase or extension of the insurance cover shall be subject to medical proof of insurability and a written justification to the insurer for the change in the insurance cover. Additionally, the insured person must be younger than 70 years of age at that time. The insurer is not obliged to accept the change. After receiving the relevant information, the insurer will confirm whether the change is accepted and communicate the conditions for acceptance of the insurance. By agreement between the parties, the insurer shall issue an addendum to the Policy confirming the policy change, the date of entry into force and the applicable conditions and premiums.

2.6 If the age of the insured has been incorrectly stated, the insured capital will be reduced to the amount that would have been insured for the premiums paid if the age had been correctly stated.

2.7 If the policy is lost, the insurer will issue a duplicate policy at the written request of the policyholder, after which no rights can be derived from the original policy.

3. Scope of the cover

3.1 The cover in the event of death applies anywhere in the world, under whatever circumstances, with due observance of the provisions elsewhere in the policy and the general insurance terms and conditions.

4. Inception, duration and end of the insurance

4.1 Inception of the insurance:
The insured risks are covered from the inception date of the insurance, which is mentioned on the policy schedule, however never earlier than the date on which the first premium was paid.

4.2 Notice period:
The policyholder is entitled to terminate the insurance agreement in writing within one month after the date of issue of the first policy schedule. As of the moment that the cancellation reaches the insurer, the insurance contract is deemed to be terminated. Any premiums already paid shall be refunded.

4.3 End of the insurance:
The insurance contract shall end without prejudice to the provisions elsewhere in these terms and conditions regarding cancellation and termination of the insurance if one of the following situations occurs:

a. on the end date of the insurance, as specified on the policy schedule;

b. on the date of the death of one of the insured parties mentioned on the policy schedule; the insurance will only end for the other insured party if a payment is made. The insurance also ends if both insured parties die at the same time;

c. on the first day of the month in which the insured person reaches the age of 85;

d. if the insured or the policyholder has deliberately provided or had provided incorrect information as referred to in Sections 7:928 to 7:930 of the Netherlands Civil Code;

e. in the event of non-payment of the first premium within 3 months of the commencement date of the insurance stated on the policy schedule;

f. In the case of a policy based on monthly or annual premium payments, the policyholder can cancel the insurance during the term of the policy after each expiration of one full month, to be calculated from the commencement date, by registered letter sent to the insurer. The policyholder must observe a notice period of at least one month.

g. If national or international sanctions legislation prohibits the insurer from implementing the insurance or if it appears that the policyholder, the insured or any other interested party is on a (inter)national sanctions list or if the policyholder or the insured party does not cooperate in determining the ultimate interested party of a (legal) person who is interested in the insurance;

h. In case of a pledged policy, the insurer will inform the finance company of the termination of the policy.

5. Non-smoker's rate

5.1 The policyholder is entitled to the non-smoking rate if:

a. The insured person declares before the start of the insurance agreement not to have smoked or to have used tobacco (cigarettes, cigars, pipes or any other nicotine substitute) in any other way for at least two consecutive years immediately prior to the insurance agreement.

b. The insured person has stopped smoking or using tobacco in any other way (cigarettes, cigars, pipe or any other nicotine substitute) for at least two consecutive years after the commencement date of the insurance agreement. The policyholder must inform the company of this in writing. The non-smoker's rate will commence on the next due date after receipt of this statement.

The insurer reserves the right to request the insured person(s) to undergo a nicotine test during the period in which this insurance is taken out or during the term of this insurance. The insured person(s) is (are) obliged to cooperate in this nicotine test, on pain of forfeiture of the non-smoking rate.

c. the policyholder is obliged to notify the company immediately in writing of the fact that the insured has (re)started smoking. The company will adjust the premium as of the next premium due date on which the insured has (re)started smoking.

d. If, after the death of the insured party, it appears that the policyholder was not (or no longer) entitled to the non-smoking rate and failed to inform the company of this in writing, the payment of the risk capital will be reduced to 60%.

6. General exclusions

6.1 For this insurance, the right to payment does not exist, or the insurance contract will be terminated, if:

a. It appears that the insured person has made (one) incorrect statement(s) regarding his health when taking out the insurance or if it appears that the insured is otherwise acting or has acted in conflict with obligations under Title 7.17 of the Dutch Civil Code;

b. an insured person has died as a result of a crime committed by a beneficiary and/or as a result of a deliberate act, deliberate negligence or gross negligence on the part of a beneficiary; this only applies to the extent that the payment would directly/indirectly benefit the beneficiary;

c. the death is the result of:
- participation in combat operations as a soldier in war zones during war missions and humanitarian missions. For Dutch soldiers or civil servants employed by the Ministry of Defence, an agreement has been concluded between the Dutch Association of Insurers and the Ministry of Defence. If there is a mission specially designated by the Ministry of Defence and the requirements set out in the agreement are also met, the insured amount will be paid out or a maximum of EUR 400,000 if the insurer can receive part of this amount back from the Ministry. The complete text of the agreement is available at www.verzekeraars.nl;

- suicide or attempted suicide. However, this only applies if the (attempted) suicide has taken place within two years after the commencement date or if the insurance has been put back into operation. The will and/or mental state of the insured person will not be taken into account in the assessment of the act or the death as a result thereof. The above does not apply if the death of the insured person is the result of euthanasia in accordance with the standards set by law and/or jurisprudence. An increase in the insured amount (death risk cover) is considered an independent insurance for the purposes of this provision. This means that in the event of (attempted) suicide within two years after the increase in the insured amount, the amount applicable before the increase will be paid out;

- an aircraft accident, unless the insured is involved in this accident as:
  - o the passenger on an aircraft;
  - o a member of the regular flying personnel (unless as a test pilot);
  - o working for a civil air transport company;
  - o a member of the armed forces' reserve staff for refresher training;
  - o a civilian pilot of an aircraft, provided that he is legally entitled to do so.

d. it appears that the policyholder, the insured or any other interested party is included on an (inter)national sanctions list or as (inter)national sanctions legislation prohibits the insurer from implementing the insurance or if the policyholder or the insured party does not cooperate in determining the ultimate interested party of a (legal) person who is interested in the insurance.

7. Option right

7.1 The policyholder has the right to increase the insured capital each year of insurance. This is an exception to Article 2.5. These increases will be accepted by the insurer without further examination of the health of the insured person, provided that the following conditions are met:

- the insurance is accepted upon commencement without any increase in premium;

- the increase does not exceed 15% of the last insured capital;

- after application of the option right, the insured capital must not exceed twice the capital insured upon commencement;

- The increase shall take effect on the next contract expiry date and the written request for increase shall be made at least one month before the contract expiry date.

7.2 The right of option referred to in the previous paragraph expires:

- when the insured person reaches the age of 60;
- if the option right has not been exercised for three consecutive years;
- if the insured is wholly or partially incapacitated for work.
- if the insured has undergone treatment and/or examination by a medical specialist in the year immediately preceding the request for an increase:
  1. heart and/or vascular diseases,
  2. malignant diseases,
  3. diseases of the brain or nervous system,
  4. diabetes;
- if antibodies against HIV have been found in the blood of the insured (the insured is HIV positive).

7.3 The increase shall take effect on the next contract expiry date.

8. Optional child cover

8.1 If the policy schedule states that child cover is co-insured, the conditions as stipulated in this article apply:

8.2 During or after the pregnancy of an insured person, a benefit will be paid to the beneficiary or beneficiaries if her child is born lifeless or dies at the latest on the thirtieth day after the birth, under the following conditions:

a. The right to benefit only arises if the pregnancy has lasted 24 weeks or more;

b. Contrary to the insured amount stated on the policy schedule, an amount of EUR 1,500 will be paid out;

c. if the pregnancy involves two or more deaths, the amount referred to above shall be paid only once.

8.3 All children of the policyholder residing in the Netherlands who are older than 30 days up to the age of 18 are also insured.

a. The right to payment arises on the death of the policyholder's children older than 30 days and younger than 18 years of age.

b. The insured amount will be paid out to the beneficiary or beneficiaries, however, up to a maximum payment of EUR 7,500 per child.

8.4 If the same children are co-insured with the insurer under more than one insurance policy, only one payment will be made, being the highest amount insured under the individual insurance policies, up to a maximum of EUR 7,500 per child.

8.5 This cover ends:

a. in the event of termination of the child cover;

b. upon termination of the insurance;

c. on the end date of this insurance.

8.6 In the event that a current insurance policy without child cover is included, no cover will be provided for children who were born more than 1 year before the policyholder's date of inclusion or who were included in the policyholder's family more than 1 year before the policyholder's date of inclusion.

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9. Optional extra payment in the event of accidental death

9.1 If the policy schedule states that an extra payment in the event of death as a result of an accident is co-insured, the following conditions apply:

9.2 If the cause of the death of the insured party or parties is the exclusive result of an accident that took place no later than 90 days before the death, the insurer will make a one-off supplementary payment in the amount of EUR 50,000, but never more than the insured amount calculated in accordance with Article 22.2.

9.3 The right to a benefit shall not apply to this cover if:

a. the accident is caused by excessive alcohol consumption or by the use of medicines, intoxicants, narcotics or stimulants other than in accordance with medical prescription;

b. the accident was caused intentionally by the policyholder, the insured person or someone with an interest in the payment;

c. the accident was caused by or in connection with the commission of, or complicity with, a crime or an attempt to commit a crime;

d. the accident is due to conscious recklessness of the insured (such as a brawl), except in the case of:
- a reasonably necessary fulfilment of his profession;
- legitimate self-defence;
- an attempt to save himself, others or property;

e. the accident occurred while:
- driving a motorbike;
- participating in ski races;
- diving;
- mountain climbing;
- off-piste skiing;
- participating in speed contests, rides or tests with:
  - o motor vehicles,
  - o motor boats,
  - o motorbikes;
  - o ski jumping;
  - o bobsleigh or skeleton rides;
  - o ice hockey or roller hockey;
  - o bungee jumping;
  - o parachuting;
  - o paragliding;
  - o activities similar to, or derived from, those listed above.

f. one of the exclusions referred to in Article 6 occurs.

10. Advantage and acceptance

10.1 The insured amounts owed by the insurer on account of the insurance will be paid out to the beneficiary or beneficiaries specified in the policy.

10.2 If more than one beneficiary has been designated, higher numbered beneficiaries will only be eligible if all lower numbered beneficiaries are absent, have died or refuse to accept the benefit. Equally numbered beneficiaries are eligible jointly.

10.3 If a beneficiary dies before a payment for which he has been designated becomes due and payable, his right does not pass to his heir or successor in title.

10.4 If two or more beneficiaries are jointly eligible, the insurer shall only be obliged to pay a single amount against joint discharge.

10.5 A beneficiary is unworthy of receiving the benefit if the beneficiary has deliberately or recklessly caused or participated in the risk of death and the insurer is aware of this.

10.6 The following definitions shall apply to the beneficial entitlement referred to in the policy:

a. Spouse:
The spouse at the time of death;

b. Registered partnership:
The registered partner at the time of death;

c. Children:
The legal, legitimate and adopted children, as well as the legal, legitimate and adopted descendants of predeceased children at the time of substitution; the distribution among them shall be in proportion to each other;

d. Heirs:
Those who by inheritance or by law are entitled to participate in the estate, including their heirs and successors under universal succession; the apportionment between them shall be on the basis of the proportion in which they are entitled to participate in the estate.

10.7 A beneficiary can accept a beneficial entitlement by means of a written notification to the insurer signed by it and by the policyholder. The insurer shall record the acceptance on the policy.

11. Risk of war and terrorism

11.1 From the moment that a state of war occurs in the future in one or more parts of the jurisdiction of the European Union, regardless of whether or not the insured is in military service at that time, the insured capital will be reduced by 10% of the capital insured at that time, for as long as the state of war persists.

11.2 The provisions of the previous paragraph shall be deemed not to have entered into force if, within six months of the termination of the state of war (within the European Union) but at the latest when any capital insured by this insurance becomes due and payable, it is demonstrated to the satisfaction of the insurer that at the time referred to in the previous paragraph and further throughout the duration of the state of war the insured person resided in the territory of a country or of one or more states outside the European Union, which was not at war during that time and where no act of war took place during that time.

11.3 No later than nine months after the end of the financial year in which the state of war was ended, the insurer shall pay out all or part of the discounts already withheld and shall cancel all or part of the discounts imposed for the future.

11.4 The presence, as well as the times of commencement and termination of the state of war referred to in this article, shall be determined by the Dutch Central Bank in a binding manner.

11.5 If there is a question of death as a result of terrorism, a one-time benefit will be paid in accordance with the Protocol for the settlement of Claims. This protocol has been prepared by the Dutch Terrorism Reinsurance Company(Nederlandse Herverzekeringsmaatschappij voor Terrorismedaden N.V., NHT). The complete text of this protocol is available on www.terrorismeverzekerd.nl.

12. Premium payment

12.1 The first premium for this insurance is due from the commencement date of the policy. Each and every subsequent premium is payable on the premium due date. For insurance with periodic premium payment per month or year, the premium is automatically debited at the beginning of the month from the specified IBAN bank account.

12.2 If, for whatever reason, the follow-up premium is not paid on time, there is, after a reminder, still one month to pay it. If the subsequent premium including costs is not paid to the administrator in full within the said period, the cover is suspended automatically from the premium due date until the premium arrears are paid to the administrator in full. An event during the period that the cover is suspended and that results in entitlement to a benefit on the basis of this insurance is not covered. Moreover, the insurer shall be entitled to terminate the insurance. Already paid premiums shall not be repaid. In case of a pledged policy, the insurer will inform the finance company of the lapse of the policy.

12.3 Any and all judicial and extrajudicial costs that are incurred by the insurer for the collection of overdue premium instalments and possible statutory interest due shall be borne by the policyholder.

12.4 Duration of the premium payment:

a. If a constant capital has been ensured, the duration of the premium payment is equal to the duration of the insurance.

b. In case of a declining linear capital or an annuity declining capital the duration of the premium payment will amount to:
- 2/3 of the duration of the insurance in case of a duration of less than 13 years
- 5 years less than the duration of the insurance In case of a duration of more than 13 years.

12.5 If the policy schedule states that the premium exemption for incapacity for work is co-insured, the additional policy conditions for the premium exemption for incapacity for work ACE-PVA 03-2020 will apply.

13. Pledges, pawning, buy-back, premium release and premium refund

13.1 The policyholder can transfer or pledge the rights and obligations arising from this insurance agreement to another party. If the rights have been pledged previously, the permission of the existing pledgee(s) is required for a further pledge. No transfer, addition, pledge or modification of the insurance contract shall be effective until a statement signed and dated by the company has been placed on the policy.

13.2 The insurance cannot be lent.

13.3 There is no profit-sharing in the insurance. This means that the policyholder and beneficiary are not entitled to profit-sharing.

13.4 The insurance cannot be made premium-free. This is because the insurance does not have a non-contributory value, at least not in excess of the limit set by law, because the premium includes a discount for the chance of premature termination.

13.5 If an insurance policy with monthly payments ends as the exclusive result of an event as referred to in Articles 4.3.f, then there is no right to a premium refund.

13.6 If an insurance policy with annual payments ends as the exclusive result of an event as referred to in Article 4.3.f, then there is a right to a refund of the unused part of the annual premium. The amount of the premium refund for a policy with an annual premium payment that is terminated before the premium due date shall be the unused part of the annual premium.

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14. Recovery of costs and taxes

14.1 The insurer is entitled to charge the policyholder or beneficiary all taxes and levies relating to this insurance that are owed by the policyholder or beneficiary by the government or for which the insurer has a statutory duty to withhold taxes, to the policyholder or beneficiary. This can be done by deduction from the amount to be paid out.

14.2 If the policyholder or beneficiary is subject to tax abroad in connection with this insurance, it is the policyholder's or beneficiary's responsibility, if necessary, to report the insurance to and pay any taxes or levies owed to foreign authorities (government, tax authorities, etc.) withholding from the amount to be paid out.

14.3 Contrary to Article 14.2, possible (tax) levies abroad in the context of a payment under this insurance as a result of the fact that the insurer is established in a country other than the Netherlands shall be for the account of the insurer. During the term of this insurance, it is not possible to deviate from this rule.

14.4 The medical examination costs will be borne by the policyholder if the prospective insured person can be accepted after a medical examination without additional exclusions or surcharges, but the policyholder or the insured waives this.

15. Fraud

15.1 Fraud (fully or partly) always implies that no payment will be made on the basis of the insurance taken out. A potential already paid benefit (plus any and all (research) costs incurred) will be claimed back and will be immediately due and payable by the insurer. Fraud may also imply that:

1. a report is filed with the police;
2. the insurance(s) is (are) terminated;
3. Registration takes place in the common warning systems in place between insurance companies.

16. Forfeiture of rights and prescription

16.1 An action against the insurer to make a payment shall be time-barred, except in the case of an interruption of the limitation period, by the lapse of five years after the day on which the claim has become due and payable.

16.2 The limitation period shall be interrupted by a written communication in which payment is claimed. A new limitation period shall commence on the day on which the insurer either acknowledges the claim or unambiguously states that it has xrejected the claim.

17. Change of policyholder

17.1 The policyholder can be replaced by another person to whom all his rights as the policyholder are transferred. The change will take effect from the moment that the insurer has noted this on the policy.

18. Change of beneficiary

18.1 The policyholder has the authority to appoint another beneficiary during the life of the insured person.. However, if the beneficiary has declared, with the written consent of the policyholder, that he accepts the benefit of the contract, the policyholder can exercise his rights under the contract only with the cooperation of the beneficiary, who has so accepted. The change will take effect from the moment that the insurer has noted this on the policy.

19. Change of address and processing of personal data

19.1 Correspondence to the policyholder(s), insured person(s) and beneficiary (beneficiaries) shall exclusively be conducted in Dutch.

19.2 The policyholder is held to inform the insurer within 1 (in words: one) month of each and every change of address of both the policyholder and the insured person. Notifications by the insurer to the policyholder are sent directly to his address lastly known to the insurer or failing a known address, to the address of the broker who provided broking services for the conclusion of the agreement.

19.3 The policyholder is held to inform the insurer within 1 (in words: one) month if the policyholder and/or the insured person no longer reside in the Netherlands and/or are no longer registered as such in the GBA.

19.4 In case of a notification by the insurer and/or the administrator to an interested party in respect of the insurance, a non-registered letter to be sent to the address lastly communicated to the insurer by the interested party can suffice.

19.5 Correspondence to the insurer must be addressed to:
Quantum Leben AG
p/a TAF BV (administrator)
Postbus 4562, 5601 EN Eindhoven, The Netherlands

19.6 The insurer and the administrator process personal data for the conclusion and implementation of the insurance agreement, for the administration of the relationships deriving from the same, for activities aimed at the expansion of the customer base, for statistical analyses, to comply with statutory obligations and in the context of the safeguarding of the security and integrity of the financial industry, our organisation, employees and clients. It may be that personal data are transferred to a receiver in a country outside the European Economic Area. The insurer and/or administrator shall monitor that this kind of transfer is in accordance with the applicable legislation and regulations. The insurer and/or administrator remain responsible for these processing operations. Premium arrears can be outsourced to a collection agency that uses personal data for a credit worthiness screening. The insurer and the administrator shall see to it that the personal data are only processed by companies that guarantee an appropriate processing level. The processing of personal data is in accordance with the General Data Protection Regulation. In addition, the Code of Conduct Personal Data Processing Insurers of the Dutch Association of Insurers. This code of conduct sets out the rights and obligations of the parties to the data processing. The complete text of the code of conduct is available on www.verzekeraars.nl. On www.taf.nl/privacy you can read more about the processing of personal data.

20. Provisional cover

20.1 For a period of up to 3 months, counting from the date on which the administrator received the application form, the insured is provisionally covered for death as the direct and exclusive result of an accident. From the date of issue of the declaration of acceptance, within the aforementioned period, the insured is also covered for death as the direct and exclusive result of an illness.

20.2 The provisional cover has a maximum insured capital of EUR 300,000, but is never higher than the amount due pursuant to Article 22.2 of these insurance conditions.

20.3 The terms and conditions, and in particular the general exclusions as laid down in Articles 6 of these terms and conditions, are applicable to the provisional cover.

20.4 The provisional cover shall not apply to the optional child cover and the optional accidental death benefit as described in Articles 8 and 9.

20.5 The provisional cover comes to an end:

a. on the date of inception of the requested insurance that is specified on the policy schedule;

b. if the requested insurance expires or is not accepted;

c. if the insurer informs the policyholder in writing of the termination of the provisional cover;

d. at the latest 3 months calculated as of the date that the administrator received the application form.

20.6 If the confirmation of receipt and the declaration of acceptance state that the insurance is related to a mortgage, a period of 6 months will apply to Articles 20.1 and 20.5.d instead of 3 months.

21. Notification of death

21.1 The policyholder, beneficiary and/or surviving relative is obliged to notify the insurer of the death of the insured party as soon as possible, but at the latest within 4 months after the death occurred. If this is not complied with, the insurer shall be entitled to withhold payment.

21.2 The insurer shall not be released from its obligation to deal with a report if it can be demonstrated that due to force majeure the report could not be made within the set period and that the insurer's interests were not harmed by the late report.

22. Insurance benefit

22.1 If the insured capital has become due and payable, the insurer shall pay out as soon as the insurer has received documents which, in its opinion, prove that and to whom any payment is due. The insurer has the right to retain these documents as its property.

22.2 In the event of the death of the insured person, the benefit amounts to a sum which is:

a. if a constant capital is insured, equal to the insured capital as stated on the policy schedule;

b. if a declining linear capital is insured, equal to an amount calculated based on a linear monthly repayment schedule;

c. if an annuity declining capital is insured, equal to an amount calculated based on a monthly annuity repayment schedule with an interest rate indicated on the policy schedule.

22.3 When a diagnosis of a terminal illness has been made, the insurer will pay the beneficiary 50% of the insured sum up to a maximum of EUR 100,000 on one insured life. The insurance remains in force for the difference between the insured sum specified in the insurance and the benefit paid in respect of terminal illness, on condition that the payment of the premiums is continued. The outstanding insured capital will be paid out upon the death of the insured.

22.4 Articles 2.5 and 7 lapse after a payment as referred to in Article 22.3. It is not possible to make any changes to the insurance.

22.5 In the case of a pledged policy, the insurer will request approval from the finance company. The payment referred to in Article 22.3 will only take place after permission from the financing company.

22.6 No benefit in respect of terminal illness shall be paid if:

a. the terminal illness was (partly) caused by an HIV infection;

b. the diagnosis is made within 12 months before the end date of the insurance;

c. the insured person’s age in the event of a claim for benefits on account of terminal illness is 65 years or older.

22.7 The payment will be reduced by any premiums and/or costs still due that are for the account of the policyholder.

22.8 The insurer is always entitled to claim back undue payments.

22.9 Payment shall be made by crediting an account designated by the entitled party to a bank institution established in the Netherlands or in another member state of the European Union, using a legal Dutch method of payment.

23. Obligations in the event of damage and supporting documents

23.1 The insured amount will be paid out after the following documents have been received by the insurer and the right to payment has been established by the insurer:

a. the policy;

b. an original extract from the death register or other legal proof of the insured person's death;

c. a declaration by the beneficiary and/or doctor regarding the cause of the death of the insured person;

d. a written request for payment with the name and date of birth of the beneficiary or beneficiaries included in the policy and their own bank account number(s).

e. in the event of an entitlement to an additional accidental death grant as referred to in Article 9: a statement on the cause and circumstances of the death. In addition, the insurer is then obliged to inform the insurer of the accident immediately – in any case before the funeral or cremation. This report must include details, including the nature, location, time and cause of the accident and the circumstances under which the accident took place. In addition, the names of the witnesses present at the accident must be provided. If requested, the insurer must be given the opportunity to investigate the cause of death and to carry out everything that it deems useful for this purpose.

23.2 The insurer may retain the submitted documents as its own. The insurer can request or obtain additional information or evidence if deemed necessary to determine entitlement to a benefit or the amount of the benefit. As long as the insurer has not received this information or evidence, the insurer is entitled to suspend a payment.

23.3 The insurer shall only be liable to pay compensation in return for full discharge, signed jointly by all interested parties or their legal representatives.

23.4 The policyholder and the insured party are obliged to cooperate in determining the ultimate interested party of a (legal) person who is interested in the insurance. This applies both at the time the insurance is taken out and in the event of any payment.

23.5 If the ultimate beneficial owner changes during the term of the insurance, the policyholder and/or the insured will be obliged to report this immediately to the insurer.

24. Applicable law and complaints handling

24.1 Dutch law is applicable to this insurance. Disputes regarding the agreement are subject to the ruling of the competent Dutch court.

24.2 The policyholder can contact the administrator in writing in case of complaints relating to the policy. If the parties fail to reach agreement, the policyholder can, within three months after the insurer or administrator has definitively made its position known, apply to the Financial Services Complaints Institute (KiFiD), Postbus 93257, 2509 AG The Hague.