agrupació

Temporary Annual Renewable group accident insurance
Extract of General and Specific Conditions
Policy No. 2512700160-7

Policy holder: FEDERACIÓ D'ENTITATS EXCURSIONISTES DE CATALUNYA.
Rambla, 41 — Principal 08002 BARCELONA — Tax Code: G-58134081

Insurer: Agrupació AMCI, S.A., de Seguros y Reaseguros.
Carretera de Rubí, núm. 72-74, Edif. Horizon, 08174 Sant Cugat del Vallés - Barcelona (Spain) – Tax Code: A-65782807

Intermediary: BORRAS-VÁZQUEZ-CAMESELLE-ARTAI, S.A.
Avda. García Barbón 48, 36201 Vigo (Pontevedra) – Tax Code: A-36768257

System of the contract

This contract is governed by the provisions of Insurance Contract Act 50/1980, of 8 October 1980, and by the provisions of Law 20/2015, of 14 July 2015, relating to the System, Supervision and Solvency of insurers and reinsurers, and the Regulations developing it, passed by Royal Decree 1060/2015, of 20 November 2015, and by the remaining rules regulating private insurance that apply. It is also governed by the agreements in the general and specific conditions and, as the case may be, the individual insurance certificates of this same contract and by the supplements or appendices to these certificates, providing the policy holder makes the payment of the premiums that have been agreed.

The parties expressly agree, after payment of the premium that is appropriate, as the case may be, to introduce into the policy all the amendments that are necessary, by means of the issue of supplements or appendices to the general and/or specific conditions, and/or individual insurance certificates of this contract, without these amendments giving rise to the extinguishment of the original contractual relationship that is set out in the policy.

Definitions

Insurable group: Persons belonging to the FEEC through a "Temporary Licence" granted to carry out specific activities on specific dates, organised by clubs, member organisations of the FEEC or by the FEEC itself in Spain, Andorra and the French Pyrenees.

Insured group: Persons who, belong to the insurable group on the date this contract was entered into and who, meeting the conditions for acceptance, the policy holder authorises their inclusion in the policy and the insurer accepts to insure, and are holders of the "Temporary Licence" for the activity carried out.

The inclusion in the insurance of the insured persons on the date this contract was entered into or at a subsequent time will only occur if they have full capacity for the practice of the activity defined, if appropriate, in these specific conditions, they enjoy a good state of health and they do not suffer any permanent or temporary incapacity, serious illness or are involved in any procedure to declare incapacity in any degree.

Expiry date: date on which the contract or the insurance relationship, as appropriate, are extinguished because the agreed term has elapsed or because the payment has been made of the last benefit that is payable by the insurer in accordance with the conditions of the contract.

Accrual date: date when the benefit is enforceable, in accordance with the agreement and providing the condition or conditions set out for this have been met.

Grace period: period that runs until the start date of the period of cover of each benefit taken out.

Period of cover: period in which the event must occur, the risk of which is covered in each of the benefits guaranteed.

Accrual period: period during which the benefit agreed in the policy is received.

Accident: the references to the concept of "accident" should be understood as any bodily injury arising from a violent, sudden and external cause outside the intention of the insured person. **Under no circumstances will the following be considered an accident:**

a**) Myocardial infarction**, understood as the death or necrosis of the cardiac muscle (myocardium) as a consequence of the obstruction of one or more coronary arteries, confirmed by a history of precordial chest pain, alterations in electrocardiograms and

cardiac enzymes (creatine-kinase MB fraction) higher than normal laboratory levels.

b) **Apoplexy or cerebrovascular accident**, understood as an accident lasting more than 24 hours caused by a cerebral thrombosis, an embolism or a haemorrhage that leads to neurological consequences of a permanent nature and that entail a serious functional detriment to carrying out everyday activities.

c) **Any illness, including professional ones as classed by the Social Security**, lumbago, sciatic, sprains and muscle strains (unless it is proven that they are the direct consequence of accidents guaranteed by this contract), infectious diseases, bodily injuries or complications related to an illness or unhealthy condition (fainting, blackouts, syncope, epilepsy or epileptiform, aneurysms, varices, etc.) and hernias of any class and nature, as well as the corresponding worsening.

d) Food poisoning, unless the insured person is exposed to it as a consequence of an accident covered by this contract.

Travel: To the effects of this policy, travel is taken to be the movement of the insured person that entails leaving the province of their usual residence.

1.- Object of the insurance: insured benefits

With this contract, the insurer undertakes, in exchange for receiving the premium, to pay the beneficiary/beneficiaries, the benefits that are set out in the specific conditions and/or supplements that are issued, and, as the case may be, that are set out on the individual insurance certificate, in the event that the event insured in each of the benefits taken out occurs; all of this is on the terms and conditions that the policy holder communicates at all times and that the insurer accepts and with the prior payment, as the case may be, of the corresponding premium, in accordance with the provisions of the policy.

1.1.- Extent of taking out benefits

The extent of contracting of the risk – for all the benefits – refers exclusively to the activity set out as follows:

Activity: the period of cover is restricted exclusively while the insured is carrying out sports activities as an amateur of hiking and other sports varieties set out in the specific conditions, in the mountain environment, as well as in the urban sections of the trials and circuits in which the insured participates as a federated member, and in travelling with the specific forms of transport for the practice of sport, such as ski lifts, rack railways, cable cars and similar, and stays made by the Insured in shelters during the practice of sport.

1.2.- Basic benefit

Benefit for death due to accident, where the insurer undertakes to pay the beneficiary the agreed benefit if the death of the insured person occurs during the practice of sport as a consequence of an accident occurring during the period of cover and providing it is proven that the death is the consequence of this accident.

1.3.- Other benefits that can be taken out

Having taken out the basic benefit, the following may also be taken out:

1.3.1. - **Benefit for death**, where the insurer undertakes to pay the beneficiary the agreed benefit if the death of the insured person occurs during the practice of sport, but without direct cause with it during the period of cover. **This benefit is incompatible with the benefit for death due to accident defined in Section 1.2 of this clause.**

1.3.2.- **Benefit for partial permanent disability due to accident during the practice of sport**, where the insurer undertakes to pay the beneficiary the agreed benefit if the anatomical loss or functional incapacity of the members or organs set out in the scale below occur as a consequence of an accident occurring during the period of cover and providing it is proven that such loss or incapacity is a consequence of this accident.

The amount payable for this benefit will be the result of applying the percentages shown below to the insured amount established in the specific conditions:

Loss or loss of use of both arms or both hands, or one arm and one leg, or one arm and one foot, or both legs or both feet: 100%

Incurable mental alienation, which excludes any work: 100%

Complete paralysis:
100%
Absolute blindness:
100%
Loss or absolute loss of use:

- of the arm, of the hand;
  right: 60%, left: 50%
- of the thumb;
  right: 22%, left: 18%
- of the index finger;
  right: 15%, left: 12%
- of one of the other fingers on the hand;
  right: 8%, left: 6%
- of a leg: 50%
- of all the toes and a part of the foot: 25%
- of the big toe: 8%
- of one of the other toes: 3%
- complete loss of vision in one eye: 30%

- reduction of half of binocular vision: 25%
- complete deafness: 60%
- complete deafness of one ear: 15%
- non-consolidated fracture of a leg or an arm: 25%
- complete rigidity of the spinal column: 40%
- extraction of the lower jaw: 25%
- non-consolidated fracture of the lower jaw: 20%
- complete loss of movement of the shoulder joints: 20%
- absolute functional incapacity of the elbow: 20%
- absolute functional incapacity of the hip: 20%
- absolute functional incapacity of the knee: 20%
- absolute functional capacity of the foot and ankle: 20%
- non-consolidated fracture of the kneecap: 20%
- five-centimetre shrinkage, at least, of a lower limb 20%
- three-centimetre shrinkage, at least, of a lower limb 10%
- complete loss of the use of the fingers on one hand: 10%
- amputation of four phalanxes on one hand: 10%
- complete loss of wrist movement: 10%

The expression "complete loss" of the use of a limb means complete functional incapacity, such that the limbs that cannot be used have to be considered to be lost or amputated.

If the insured person is left-handed, the percentages established in the scale for the right and left sides are inverted.

The following rules apply as a complement to the previous scale:

a) The percentage applicable in the event of the existence of various types of anatomical loss or functional incapacity arising from the same accident is determined by adding the percentages of each anatomical loss or functional incapacity up to a maximum percentage of 100%.

b) The sum of the percentages due to various types of anatomical loss or functional incapacity in the same member or organ cannot be greater than the percentage established in the event of total loss.

c) The types of anatomical loss or functional incapacity not expressly specified in the scale must be assessed by analogy with other cases that are shown in it.

d) Partial anatomical limitations and losses are assessed in proportion to the loss or complete functional incapacity of the limb in question.

e) If an affected limb or organ previously displayed amputations or functional limitations, the percentage applicable is the difference between that of the pre-existing disability and that resulting from the accident.

f) When the payment of sums arising from partial permanent disability due to accident reaches 100% of the insured amount of that benefit, the insurance relationship will be extinguished.

g) In the event of the death of the insured person that is a consequence of the same accident for which the partial permanent disability benefit due to accident was paid, the amount to be compensated will be reduced by the amount already paid.

This benefit is independent of the fact that the insured person is in a situation of partial permanent disability in accordance with the Social Security system. Therefore, the recognition of the situation by the competent authority does not determine that the beneficiary's right is necessarily generated to receive the benefit.

The partial permanent disability guarantee due to accident is excluded for insured persons over the age of 75.

1.3.3.- **Benefit for healthcare, due to accident during the practice of sport**, where the insurer undertakes, with regard to the cases of accidents guaranteed by the insurance contract, to assume the costs of the benefit set out in the cover shown below. All this within the limit indicated in the Specific Conditions and for a maximum period of eighteen months from the date of the accident, occurring during the period of cover, and provided that, in the case of travel, the accident occurs during the first ninety consecutive days from its start, with the exception of expeditions to areas where more than 90 days are required, temporary stays abroad for special training or the provision of temporary services such as trainers or monitors in the case of stays in Andorra. On trips abroad, the 90 days will start to count from the time the assured leaves Spain.

The provision of healthcare, as a consequence of a sports accident, is given worldwide in emergency cases, depending on the regional scope of each licence type. Healthcare provision that is not emergency is only covered when provided in Spain.

For the purposes of this contract, healthcare due to accident is taken to be the medical and therapeutic

acts necessary for the cure and recovery of the injured person's injuries caused by the accidents covered in the policy, until their stabilisation and consolidation; outside the cover are the benefits aimed at curing the insured person that do not entail an improvement to their state of health due to the fact that this is irreversible, and palliative care.

Specifically, the following costs are included in this cover:

a) Medical-pharmaceutical care and surgical operations.

b) Stay in clinics and hospitals and transfer from the place of the accident, providing the nature of the injuries makes this necessary.

c) Hospital care, prosthesis and osteosynthesis material costs, in full.

d) Costs arising from rehabilitation.

e) Costs arising from the acquisition of orthopaedic material to cure a sports accident (not for prevention), up to 70% of the total amount of the bill and on display of the relevant proof of payment.

f) Costs arising in odontostomatology due to injuries to the mouth caused by a sports accident. These costs will be covered up to 300.00 euros.

In cases of trauma surgery, due to an accident covered by this insurance contract, where osteosynthesis material is implanted that then has to be removed, the maximum period will be 24 months as of the date of the accident. Similarly, in the case of mountain injuries due to frostbite, the maximum period of cover will also be 24 months as of the date of the accident.

The healthcare, pharmaceutical costs, rehabilitation, acquisition of orthopaedic material or other costs covered must, in any event, be prescribed by the doctor in charge of the care. The transport costs of the person injured in an accident from the place of the accident to the place where they are to be attended must be prescribed by the care doctor and be in line with a justified cause.

This cover can be taken out through one of the following options:

- Provision of the care at the certified centres specified by the insurer in the specific conditions of the contract. The insurer assumes the healthcare costs up to the maximum limit set out in the specific conditions of the contract.

For the purposes of this policy, certified centres are the health centres and/or hospitals with which the insurer maintains a contractual relationship whereby the corresponding charges are agreed for the provision of the healthcare services covered by this insurance contract, which the certified centre provides to the insured persons who have had an accident covered by this policy.

In the event of the insured person not going to a certified centre, the care may be provided at any centre and the cover will entail the reimbursement to the insured person of the costs borne up to the maximum limit that is set out in the specific conditions of the contract.

In this case, the insurer will not assume the healthcare costs that exceed the maximum limits established for certified centres.

Despite this, the insured person may subsequently choose to receive the necessary healthcare at a certified centre of the insurer, providing the cost of the healthcare services is within the maximum limits set out in the policy for certified centres.

Both the medical professionals chosen directly by the insured person off the list of certified centres, and those that work at these certified centres, enjoy complete autonomy, independence and responsibility in the provision of the healthcare. Consequently, the insurer does not assume any direct, joint and several or subsidiary liabilities for actions and/or omissions of the professionals in question. To this effect, the insurer has no control over the acts of the aforementioned professionals insofar as it is barred by the prohibition of intrusion by third parties in healthcare, the protection of professional secrecy and the confidentiality of health data.

In accordance with the provisions of the Insurance Contract Act with regard to healthcare costs, the insurer is subrogated, due to the simple fact of payment of compensation, in all the rights and actions corresponding to the insured person against third persons responsible for the accident, and it may exercise these rights on its own behalf or that of the insured person; in this case, the insured person must grant it the necessary power of attorney to do so, and the cost is payable by the insurer. In any event, the insured person must cooperate fully and faithfully with the insurer in order to process better the action to be exercised.

For the purposes of this benefit, the first healthcare that is sought to be covered by the policy should be received during the 7 days following the event of the corresponding accident guaranteed by the insurance contract.

1.3.4.- **Benefit for care and rescue due to accident**, where the insurer undertakes, with regard to the cases of accidents guaranteed by the insurance contract, to assume the costs of the benefit set out in

the cover shown below. All of this is with the maximum limit set out in each one and as a consequence of an accident occurring during the period of cover and providing that, in the case of travel, the accident occurs during the first ninety consecutive days as of the start of same, with the exception of journeys to areas where more than 90 days is required, temporary stays abroad for special training or the provision of temporary services as trainers or monitors or in the case of stays in Andorra.

a) **Search and rescue in Spain and abroad**. The insurer will take care of the costs arising as a consequence of the search and/or rescue of the insured person when they have had an accident or the situation represents an evident risk to the life or physical wellbeing of the insured party. In this latter case, the urgent primary healthcare will also be understood to be covered.

The reimbursement of the costs will be made on display of the original documents of proof of payment (bills, receipts or similar) and within the agreed limit. The maximum insured limit for this concept is established in section 2.- Capitals, Activities and Extent of cover per modality.

b) **Healthcare transport or repatriation of injured persons in Spain and abroad**. In the event that the insured person has an accident, the insurer will take care of the following costs:

- Transport by ambulance to the nearest clinic or hospital.

- Control by their medical team, in contact with the doctor attending the injured insured person, to determine the appropriate measures with a view to the best treatment that they need and the most suitable means for their possible transfer to another more suitable hospital or to their home.

- Transfer by means of the most suitable transport to the prescribed hospital or to their usual place of residence. If the insured person is admitted to a hospital that is not close to their home, the insurer will, at the right time, meet the costs of the subsequent transfer to it.

The means of transport used in Europe and Mediterranean countries, when the urgency and seriousness of the case so require, will be by special healthcare aircraft.

In another case or in the rest of the world, it will be by regular airline or by the quickest or most suitable means, depending on the circumstances.

1.4. Form of payment of the benefit

The benefits taken out that entail a payment obligation by the insurer in favour of the beneficiary are received in the form of immediate capital on the date of the event of the claim.

2.- Capitals. Activities and extent of cover by type

Modality 1

Activities: Popular Walks and Marches

Scope: Spain

Guarantees and capitals:

- Death due to accident during the practice of sport: € 6,000.00.
- Death when this occurs during the practice of sport but not as a direct cause of it: € 1,800.00.
- Partial permanent disability due to accident during the practice of sport: € 12,000.00.
- Healthcare due to accident during the practice of sport, limited to (*):
  - At non-certified centres, limited to: € 3,000.00.
  - At non-certified centres, limited to: € 1,200.00.
  - Abroad, limited to: € 2,500.00.
- Healthcare and rescue due to accident during the practice of sport, limited to: € 9,000.00.

(*) Coverage of healthcare in certified and non-certified centres is not cumulative.

Modality 2

Activities: Catalan Cups of Resistance Walks and Technical Marches.

Scope: Spain.

Guarantees and capitals:

- Death due to accident during the practice of sport: € 6,000.00.
- Death when this occurs during the practice of sport but not as a direct cause of it: € 1,800.00.
- Partial permanent disability due to accident during the practice of sport: € 12,000.00.
- Healthcare due to accident during the practice of sport, limited to (*):
  - At non-certified centres, limited to: € 3,000.00.
  - At non-certified centres, limited to: € 1,200.00.
  - Abroad, limited to: € 2,500.00.
- Healthcare and rescue due to accident during the practice of sport, limited to: € 9,000.00.

(*) Coverage of healthcare in certified and non-certified centres is not cumulative.

Modality 3

Activities: FEEC official calendar competitions, Mountain races, Ultra endurance mountain races, Vertical kilometre races, Mountain Raids, Mountain Skiing, Snowshoeing, Sport Climbing.

Scope: Spain.

Guarantees and capitals:

- Death due to accident during the practice of sport: € 9,000.00.
- Death when this occurs during the practice of sport but not as a direct cause of it: € 1,800.00.
- Partial permanent disability due to accident during the practice of sport: €20,000.00
- Healthcare due to accident during the practice of sport, limited to (*):
  - At non-certified centres, limited to: € 3,000.00.
  - At non-certified centres, limited to: € 1,200.00.
  - Abroad, limited to: € 2,500.00.
- Healthcare and rescue due to accident during the practice of sport, limited to: € 9,000.00.

(*) Coverage of healthcare in certified and non-certified centres is not cumulative.

Modality 4 Activities of the Entities

Official outings for hiking entities and/or sports clubs, outings for hiking, mountaineering, climbing, mountain skiing, snowshoeing, canyoning, Nordic walking, mountain biking and the rest of FEEC sports, as well as training activities (promotional courses, social courses, technical days...), stays (meetings, youth, techniques...).

Scope: Spain, Andorra and French Pyrenees

Guarantees and capitals:

- Death due to accident during the practice of sport: € 6,000.00.
- Death when this occurs during the practice of sport but not as a direct cause of it: € 1,800.00.
- Partial permanent disability due to accident during the practice of sport: €12,000.00
- Healthcare due to accident during the practice of sport, limited to (*):
  - At non-certified centres, limited to: € 3,000.00.
  - At non-certified centres, limited to: € 1,200.00.
  - Abroad, limited to: € 2,500.00.
- Healthcare and rescue due to accident during the practice of sport, limited to: € 9,000.00.

(*) Coverage of healthcare in certified and non-certified centres is not cumulative.

Extension of cover for all types:

The limits established in each guarantee cover the injuries caused in the event of sunstroke, frostbite, problems caused by altitude (including high-altitude pulmonary or cerebral oedema), as well as insect stings, animal bites and lightning strikes during the practice of the aforementioned sports types.

Regularisations

The policy holder has the right to amend the insured benefits that had initially been set out or those of the last regularisation.

Similarly, amendments to the insured person's/beneficiary's details that the policy holder communicates to the insurer may also give rise to regularisations.

In any event, for the insurer to accept the amendment of the insured benefits, the insured person and/or beneficiary are obliged to declare to the insurer, in accordance with the questionnaire to which the latter subjects them, all the circumstances that they know that may influence the risk assessment. The insurer also reserves the right, should it deem appropriate, to request the documentation accrediting the age of the insured persons and/or beneficiaries.

Declarations

The insurance policy holder and/or the insured persons have the duty to declare to the insurer, before signing the contract or before each insurance relationship, in accordance with the questionnaire to which they are subject, all the circumstances that they know that may influence the risk assessment. They are released from this duty if the insurer does not subject them to this questionnaire or providing that, even if they are subject to it, there are circumstances that although they may not influence the risk assessment, are not included in the aforementioned questionnaire.

The insurer reserves the right, should it deem appropriate, to request the insured person to complete a questionnaire or for documentation that accredits their age.

In the event that the age of the insured person is not the exact one, the insurer may protest the contract or

the insurance relationship if the correct age of at the time of entry into effect exceeds the established acceptance limits.

The insurance policy holder and/or the insured persons must inform the insurer, as soon as is possible to them, each and every one of the facts – if there are any – that increase the risk covered in the contract and that are of such a nature that had the insurer known them when signing the contract, it would not have signed it or it would have concluded it with more costly conditions for the policy holder. The obligation of providing this information extends from the date of drafting of the contract, or of each insurance relationship, until the expiry date.

If the content set out in the policy differs from the insurance proposal or from the agreed clauses, the insurance policy holder may request the insurer to solve the divergences that exist within one month after the issue of the policy. Once this period has elapsed, if the request has not been made, it will be considered that they accept the provisions of the policy.

Duration

The duration of the contract is annual, unless the specific conditions establish a different period. The insurance comes into effect at midnight on the date of effect and ends at midnight on the expiry date.

The insurance relationships included with possession of a "Temporary Licence" granted for the performance of specific activities on specific dates and periods, organised by clubs, member entities of the FEEC or by the FEEC itself in Spain, Andorra and the French Pyrenees will have the duration established for each specific activity as determined in each "Temporary Licence".

The regularisation of benefits and the contracting of new benefits will take effect on the date indicated in the corresponding supplement to Specific Conditions, provided that the corresponding premium has been paid, and will remain in force during the period established with the maximum limit of 24 hours on the following 31 December.

On expiry, and providing the policy holder is up to date in the payment of the premium or premiums, the contract and the insurance relationships that comprise it are automatically renewed for successive annual periods, unless either of the parties requests its rescission and opposes the renewal by means of written communication to the other party, made at least one month before expiry of the current year of insurance when it is the policy holder opposing renewal and two months when the insurer opposes renewal.

Variations in the composition of the insured group and beneficiaries

The insurance policy holder is obliged to inform the insurer of the variations that occur in the insured group and in the beneficiaries. With the exception of the provisions of the specific conditions, if necessary, these variations may consist of:

a) Inclusions of insured persons: caused by the inclusion in the list of insured persons of persons who are part of the insurable group and who meet the insurance conditions subsequent to the date the group insurance enters into effect, in accordance with the provisions of the specific conditions or the relevant supplements.

b) Removals of insured persons: these arise due to the occurrence of any of the following causes:

b.1) Ceasing to be a part of the insured group.

b.2) Death of the insured person.

b.3) Occurrence of the event described in section 1.3.2 of the clause and these General Conditions and operate the termination provided for in those sections.

b.4) Expiry of the insurance relationship.

c) Removals of beneficiaries: caused by the death or revocation of the beneficiaries.

Similarly, indiscriminately and jointly and severally with the insurance policy holder, the insured person is obliged to inform the insurer of the variations that occur due to removals in the insured group and in the beneficiaries.

Designation, change and revocation of beneficiaries

The status of beneficiary corresponds to the physical persons in favour of whom the benefits are generated.

Throughout the lifetime of the contract, the insurance policy holder may designate beneficiaries and/or amend the designation made previously without requiring the insurer's consent.

The designation of the beneficiary or beneficiaries may be established in the policy, in a subsequent written declaration communicated to the insurer or in an affidavit.

The beneficiary of the benefits of disability, healthcare and care, search and repatriation is the insured person.

If there is no expressly designated beneficiary, it will be understood that the persons designated, in the following exclusive order of preference, will be the spouse – unless there is a separation ruling – their

children in equal parts, their parents in equal parts and, finally, their heirs.

The insurance policy holder expressly waives the authority to designate beneficiaries in favour of the insured person.

If the insured person suffers a loss caused maliciously by a beneficiary, the latter will be deprived of the right to the benefit set out in the policy, which will increase that of the other beneficiaries according to the following order:

- Firstly to the rest of the expressly designated beneficiaries.

- If there are none, according to the following exclusive order of preference, the spouse of the insured person – unless there is a separation ruling – their children in equal parts, their parents also in equal parts and, finally, their heirs. Despite this, if the order of precedence of heirs of an intestate inheritance applies, in the last instance the policy holder is the beneficiary instead of the public administration.

All of the established beneficiary designations are providing the beneficiary meets the requirements of undertaking to enjoy this status, and to the exclusive effects of the insured benefits and the amounts set out in the policy.

Similarly, the provision of the previous paragraph will also apply to the designations of beneficiaries made irrevocably.

Assignment and pledge of the policy

The insurance policy holder may not assign or pledge the policy by expressly waiving the designation of beneficiaries.

Premiums

1.- Payment of premiums

The insurance policy holder is obliged to pay a premium for each insurance relationship that joins this contract and, if appropriate, for each regularisation of the conditions. The premium is single and annual.

The payment of the single annual premium may be agreed to be made in split payments. In this case, surcharges depending on the split payment do not apply, unless the specific conditions establish another regulation.

Payment of the split payments of the single annual premium, or split premiums, does not entail any release. Therefore, in the event that the claim occurs before having paid all the split payments of the single premium, the insurer must collect from the policy holder the amount of the spilt payments pending payment.

If the insurer has drafted one or more questionnaires, the first premium is accrued when the insurer gives its acceptance of the result of the questionnaires. It is considered to be accepted when the insurer accepts the payment of the first premium or, in the case of direct debit, when the payment is managed and received. To state this acceptance, the insurer has 107 days as of the date that it drafted the questionnaire or questionnaires. Once this period has elapsed, if the payment of the first premium on the terms set out above has not been verified, the consent of the insurer will be considered to have been denied.

If a date of effect of the insurance prior to the date of payment of the first premium has been agreed, the amount must necessarily comprise the retroactive period of effect of the insurance.

2.- Late payment and non-payment of premiums

If the first premium of the insurance relationship has not been paid by the due date for reasons attributable to the policy holder, the insurer may exercise the right to terminate the operation or demand enforced payment based on the policy. If the premium has not been paid before the loss occurs, the insurer is released from its obligation. It is not a cause for release if the loss takes place during the retroactive period of effect of the insurance, unless the insurer accredits the occurrence of a just cause that prevents it from providing its acceptance of the questionnaire sent to the insured person, or that entails the occurrence of fraud or serious fault of the policy holder or of the insured person in completing the questionnaire.

In the event of non-payment of a single premium for a renewal, the insurer's cover is suspended one month after the due date of the premium. If the insurer makes no claim for payment of the premium in the six months following the due date, it is understood that the insurance relationship is extinguished.

If any split-payment of the single premium has not been paid on the due date for reasons attributable to the policy holder, the insurer has the right to terminate the contract or to require enforced payment of the split-payment or split-payments of the premium owing based on the policy. To this effect, non-payment of the split-payment of single premium receives the same treatment as non-payment of the non-split annual single premium set out in paragraph two of this section.

Without prejudice to the powers of the insurer set out in relation to non-payment of premiums, delay

in the payment of any premium owing accrues an interest rate equal to the late-payment interest set out in the current General State Budgets Act, plus two points.

Unless another regulation is set out in the specific conditions, in policies taken out with contribution by the policy holder and the insured person in the cost of reinsurance, non-payment of part of the premium by any of the obligated persons is considered a non-payment of the whole, with the effects set out in the previous paragraph, and without prejudice to the refund, if appropriate, of the part of the premium received by the insurer.

3- Direct debit or bank transfer

The premiums payable by the policy holder must be paid to the insurer by direct debit or bank transfer. In the case of a bank transfer from abroad, the country of origin must be a European Union country.

In the case of direct debit payment of the premiums, it must meet the following conditions:

1) The person obliged to pay the first premium must issue the insurer with a written document addressed to the bank stating the relevant direct debit arrangement.

2) The second and subsequent premiums are considered to be paid on their due date unless, after having attempted to collect the payment within the grace period of one month as set out in the Insurance Contract Act, there are not sufficient funds in the account.

In the event of rebate or retrocession of the premium, the amount payable must be paid by issuing a credit order deposited in a bank authorised to operate in Spain. In the case of a bank transfer from abroad, the country of destination must be a European Union country.

Guaranteed values

Due to the nature of this policy, the policy holder does not have the right to obtain advances on the insured benefit, does not have the right to redemption and does not have the right to request the reduction of the operation.

Excluded risks

1. The losses occurring as a consequence of the following are excluded from the cover of this contract:

a) Nuclear reaction or radiation or radioactive, chemical or biological contamination, either directly or indirectly.

b) Events that due to their magnitude or severity are classed by the competent authority as a "catastrophe or disaster", epidemic or pandemic.

c) Losses occurring in the event of armed conflict – even though they have not been preceded by an official declaration of war – and demonstrations and popular movements, acts of terrorism and sabotage, strikes, detentions by any authority for an offence not derived from a road traffic accident, restrictions on free movement or any other case of force majeure, unless the insured person proves that the loss has no relation to the events.

d) Pre-existing temporary or permanent disability on the insured person's inclusion that was not communicated to the insurer prior to their inclusion.

e) Pathological states known to the insured person with medical antecedents liable to worsen in the event of travel.

f) Illnesses or injuries that occur as a consequence of chronic complaints or ones prior to the travel, and their complications and relapses.

g) Any type of illness suffered by the insured person, such as Acquired Immune Deficiency Syndrome (AIDS), problems derived from alcoholism and drug addiction and mental illnesses.

h) Vaccinations and controls of previously known illnesses, thermal and therapeutic cures with UVA rays.

i) The treatment of illnesses or pathological states caused by an intended ingestion or administration of toxins (drugs), narcotics, or the use of medicines without medical prescription.

j) Mental illnesses and psychoanalysis and psychotherapy.

k) Damages:

- Covered by the Insurance Compensation Consortium, in which case the provisions of the clause relating to the Coverage of Extraordinary Risks of the General Conditions shall apply. This limitation must be understood without prejudice to the payment obligations of the mathematical provision constituted by the insurer, or of any other value, on the terms and conditions established at all times by the regulatory rules of the Consortium.

- That the Insurance Compensation Consortium does not cover, in compliance with any of the rules set out in its current regulations on the date of the occurrence of the loss.

l) The action of the insured person as driver of a vehicle not suited or authorised to driving on the

public highway or without having a licence authorising them to do so.

m) An act of imprudence or serious negligence by the insured person, accidents caused intentionally by the insured person, as well as those arising from their participation in duels or fights, providing in this latter case that they have not acted in legitimate self-defence or in an attempt to save persons or goods.

n) Suicide or illnesses or injuries resulting from a suicide attempt or caused intentionally by the insured person. Similarly, voluntary acts of the insured, whatever their mental state, or if they are under the influence of alcoholic drinks, psychotropic drugs, narcotic substances, stimulants or other similar substances not prescribed medially, or in a state of mental alienation. To this effect, it will be understood that the insured person is under the influence of alcoholic drinks if they exceed the limits established at all times by legislation on traffic, driving motor vehicles and road safety that permit the driving of any non-special vehicle, irrespective of the external symptoms and behaviour of the insured person and of the loss occurring or not while the insured person is driving a motor vehicle.

o) The practice as a professional of any sport, both in competition, official or otherwise, and in training and related activities.

p) The practice — whatever the frequency of such practice — of aerial sports in general (skydiving, ascent in aerostatic balloons, bungee jumping, hang-gliding, flying microlights or gliders, or any other similar activity); of participation in competitions — including training — with land vehicles, boats or motor aircraft, be it as driver, co-driver or passenger; and the practice of underwater diving, or of any sport that involves an evident risk to the safety of the insured person both due to its nature and because it does meet the statutory safety measures.

q) Participation in scientific expeditions or the exercise of the following professions: fire-fighters, divers, quarry workers who use explosives, fierce animal tamers and keepers, private security personnel, security guards, miners, members of the armed forces, members of the police force, bullfighters, trapeze artists who work without a net, air crew, and others that may involve equivalent risks.

r) Injuries occurring due to carrying out professional work, climbing or descending buildings, bridges, brick or metal constructions, except in places intended for training or specific climbing walls.

t) In the mountain biking (BTT) discipline, the following cases are excluded:

1. **Any claim for material or physical damages caused to third persons in the practice of the aforementioned activity.**
2. **Any accident occurring on asphalted road except in the following cases:**
    a. **Crossroads or intersections of a track with an asphalted road.**
    b. **Journeys from the town where the club is to the start of the forest track, trail or similar, without asphalt (except urban sections).**
    c. **Intermediate sections, on the asphalted road, between two non-asphalted tracks, at all times when it is a short distance.**
3. **Participation in trials and races.**

t) Excluded from cover are problems due to muscle overloads, joint overloads and non-traumatic tendinitis, since these problems do not arise from sudden and violent events due to external action outside the will of the insured person.

u) Excluded are costs of prosthesis, glasses and contact lenses, births and pregnancies except for unforeseeable complications during the first six months, with the exception of bone endoprosthesis and osteosynthesis material.

v) Expressly excluded are all those losses not communicated to the insurer within a maximum of 7 days, unless, due to the severity of the loss, there is sufficient motive to justify the lack of communication in the established period, and the lack of available means.

w) The participation of the insured person in illegal or criminal acts.

x) The practice of any activity with motor vehicles.

2. In addition to the excluded risks in Section 1 above, the following are excluded from the cover for benefit for care, rescue and repatriation:

a) The intervention of any Official Emergency Relief Agency or the cost of its services.

b) Excluded are rescue, search or salvation operations that have occurred as a direct or indirect consequence of the insured person's recklessness.

c) Excluded are rescue, search or salvation operations when there has not been an accident and the situation does not represent a risk to the life or physical safety of the insured person.

d) Expressly excluded are all those accidents that occur in any public or private means of transport that entails significant travel, and those accidents that occur in urban centres, (except if the accident occurs while the insured is participating in trials or

circuits as a federated member). In other words, only accidents that occur in the mountain environment are covered, as well as in the means of transport necessary for the practice of sport, such as ski lifts, rack railways, cable cars, etc.

e) The costs and procedures involved in funeral ceremonies and interment.

Processing of claims.

Agrupació AMCI, S.A. makes the telephone number 901120130 (24 hours) available to the federated member so that they can contact the company directly, which undertakes to provide all the necessary means to provide assistance to the claimant. This service will cover the first level of care and the subsequent monitoring of the person affected to direct them to a second level of specialisation and/or rehabilitation. In addition, if needed, the telephone number + 34 648275421 usable by SMS or Whatsapp is made available.

In the event of an accident abroad, the international telephone number is provided +34 934957662 (24 hours), whereby the rescue, repatriation of injured or dead and care in the event of need will be made available to the claimant.

The Insured must present the "Temporary Licence" and prove that the accident occurred during the period of cover in order to receive the benefits of the contract. In any case, FEEC undertakes to provide Agrupació AMCI S.A. with the necessary information in order to confirm that the injured person was carrying out the activity covered at the time of the accident. In the event that this cannot be proven, the injured person would not be covered and any possible expenses of any kind arising from the notification of the accident may be passed on to the injured person.

Payment of benefits

1.- The insurer must comply with the obligation derived from the agreed benefit once the declaration of a loss has been made, duly documented as set out in the following clause and, if appropriate, in the specific conditions, and once the existence has been accepted by the insurer of the loss covered because the requirements and conditions set out in the policy for payment to be made.

The insurer is released from compliance with the obligation arising from the benefit in the event that the declaration of loss does not provide the necessary information about the circumstances and consequences of the loss, due to fraud or serious fault.

2.- Before payment is made of the corresponding benefit, the beneficiary must accredit the settlement or exemption of any tax due for the purposes of payment of benefits, and the tax identification number.

3.- The benefit or benefits are paid with the requirements set out in the policy, and at all times by means of the issue of the relevant credit order deposited in the bank indicated by the beneficiary.

Documentation to be provided in the event of a loss

The following documents must be provided in the event of a claim:

1.- Death:

Those accrediting the personality and, if appropriate, the status of beneficiary, and the tax identification number, the family book if appropriate and the address of the usual residence of the beneficiary/beneficiaries.

- Literal death certificate of the insured person.

- The medical certificates, the medical records or the care report that accredit the causes of death, the date when the accident/road traffic accident occurred or when the illness causing the loss was diagnosed, its evolution and the possible medical antecedents.

- If necessary, the testimony of the actions or the court procedures, or documents that accredit them, and the post-mortem report issued by the pathologist, as well as a medical certificate stating that the insured was in perfect health and did not suffer any illness that may have caused the sudden death.

- Document accrediting the payment, if necessary, of the Tax on Inheritances and Donations.

- The certificate issued by the Registry of Certificates of Last Will and, if appropriate, the copy of the last will of the insured person, the Deed of Declaration or the court deed of declaration of heirs in intestate proceeding.

- The document that accredits the ownership of the designated bank account for payment of the benefit.

- Any other document or means of proof that the insurer needs to determine the existence of the loss, or for any other just cause.

2.- Partial permanent disability due to an accident

- The documents that accredit the personality and, if appropriate, the status of beneficiary and the tax identification number.

- If it exists, the ruling or certificate from the competent public body of the Social Security or final

court ruling that recognises that the injuries mean that the insured person is in a situation of disability in accordance with the corresponding Social Security system.

- In order to accredit the court ruling as final, as well as the ruling that gives a judgement on it, the literal certificate from the social court, which states expressly that the ruling is final, or the notification that the ruling given on the initiative of the judge is final must also be provided.

- If this situation has not been recognised in accordance with the corresponding Social Security system, a certificate or ruling issued by the Migration and Social Services Institute or the competent body from the autonomous communities (the original and an attested copy must be submitted), which accredits the degree of disability caused by the injuries that give rise to the insured benefit.

- The medical certificates, the medical records or the care report that accredit the injuries, the date when the accident occurred and the possible medical antecedents.

- The document that accredits the ownership of the designated bank account for payment of the benefit.

- Any other document or means of proof that the insurer needs to determine the existence of the loss, or for any other just cause.

3.- Verification by the insurer of partial permanent disability due to an accident:

With regard to the documentation provided, the insurer verifies the partial permanent disability of the insured person in accordance with the definitions of this contract.

If between the insurer and the policy holder – or as the case may be, the beneficiary – there is no agreement regarding the permanent nature of the injuries to the insured person, both must submit – and accept in writing – to the opinion of two medical experts, each of whom must be designated by each party.

If one of the parties has not designated the corresponding medical expert, they must do so within eight days as of the date when they were required to by the party that has already designated an expert. If after this deadline has elapsed, no claimed designation has taken place, it will be understood that the party accepts the opinion of the expert designated by the other party and is therefore bound by it.

If the medical experts establish a common opinion, they must record it in a joint document specifying the causes of the loss and the permanent nature, or otherwise, of the disability, at all times in accordance with the definitions and stipulations of this contract.

If these experts establish different opinions, both parties must designate a third expert by mutual agreement. If no agreement is reached regarding the designation, the judge of first instance assigned to the address of the insured person will take care of this in an act of voluntary jurisdiction and in accordance with sortition procedures (random designation) of experts established in the Code of Civil Procedure. In this case, the expert opinion must be issued within the deadline set by the parties or, if there is no deadline, within thirty days as of the date when the third expert accepts the designation.

The experts' opinion – be it unanimous or majority – must be notified immediately and unquestionably to the parties. This opinion is binding for both parties, unless it is legally challenged by one of the parties (the policy holder or beneficiary have a maximum of one hundred and eighty days to do so; and the insurer, thirty, as of the date, for both parties, when the opinion was notified). Once these deadlines have elapsed, if the corresponding action has not been filed, the expert opinion will become untouchable.

Each party must pay the fees of the medical expert designated by them. The fees of the third expert, if one needs to be designated, the other costs derived from this possible expert intervention, are payable, in equal parts, by the policy holder or the beneficiary and the insurer. However, if the third expert opinion was required because one of the parties had maintained a manifestly disproportionate valuation of the damages, only this party will have to meet the costs incurred.

If the expert opinion is not challenged, the insurer has to pay the corresponding benefit depending on the result of the expert opinion within five days.

4.- Health care

- The documents that accredit the personality and the tax identification number of the insured person.

- The medical certificates, medical records and care report that accredit the condition of the injuries suffered, the date when the accident occurred that caused them and when the illness that caused the accident was diagnosed, the evolution of the illness and the possible medical antecedents.

- If required, bills to prove payment of medical-pharmaceutical costs incurred and the medical prescription from where they originated.

- End of sick leave, continuity and start of sick leave notifications that determine care.

- The document that accredits the ownership of the designated bank account for payment of the benefit.

- Any other document or means of proof required by the insurer to determine the existence of the claim, or by another just cause.

5.- Assistance and Rescue due to accident:

- The documents that accredit the personality and the tax identification number of the insured person.

- The medical certificates, the medical records or the care report that accredit the causes of death, the date when the accident occurred or when the illness causing the claim was diagnosed, its evolution and the possible medical antecedents.

- Bills to prove payment of costs if required.

- If the accident occurred while travelling, the document that accredits the date when travel began.

- The document that accredits the ownership of the designated bank account for payment of the benefit.

- Any other document or means of proof required by the Insurer to determine the existence of the claim, or by another just cause.

Taxes and surcharges

The legally transferable taxes and surcharges that are payable because of this insurance, both in the present and in the future, are payable by the insurance policy holder. The taxes and surcharges that apply to the benefits, in accordance with current legislation, are payable by the beneficiary.

Extraordinary risks covered by the Insurance Compensation Consortium

The Insurance Compensation Consortium compensates for losses derived from extraordinary events in accordance with the provisions of the revised text of the Legal Insurance Compensation Consortium Statute at all times.

Conflict resolution mechanisms

Any discrepancies that may arise regarding the Insurer, and without prejudice to the right to attend the competent courts and tribunals, may be subject to ruling by any of the following instances:

In the field of insurance and as established by the Orders of the Ministry of the Economy ECO/ 734/ 04, of 11 March 2004 and ECC/ 2502/2012, of 16 November 2012:

a) Before the Customer Care and Ombudsman Service (SADC) of the Insurer, in person or through a representative, in a letter, a printed version of which is available at the offices of the insurer or sent in an email to the address for this purpose that appears on the www.grupo-acm.es website. The latter will adopt a motivated and written ruling proposal, in accordance with the procedure set out in the Insurer's operating rules, which will be available to the interested parties and may be consulted at any time at the offices of the Insurer.
The case will take two months to process as of the date when the complaint or claim is submitted to the Customer Care Service by the interested party.
However, that said, the SADC will not give leave to proceed for questions that have been submitted or ruled on by court, administrative or arbitration decision.

b) Before the Insurance and Pension Funds Directorate General Claims Service (Ministry of the Economy and Competitiveness), providing that the two-month deadline has elapsed without any reply from the SADC or that the SADC has rejected its request. As well as ruling on complaints or claims, the Claims Service will also be authorised to deal with consultations put to it about questions of general interest regarding the rights of insured persons and legal channels to do this.

We offer an exclusive telephone hotline for information about complaints and claims: 900 30 00 30, available 24 hours a day, Monday to Friday.

Processing and assignment of personal data

Protection of personal data

Data controller: AGRUPACIÓ AMCI DE SEGUROS Y REASEGUROS, S.A.

Purposes: subscription and execution of the insurance contract; sending of electronic newsletters and own advertising; carrying out loyalty actions; and, if consented to, sending of electronic newsletters and advertising of companies of the Crédit Mutuel-CIC Group (to be consulted in www.grupo-acm.es) and of third-party companies of the sectors reported in the complementary information of Data Protection.

Legitimation: execution of the insurance contract; fulfilment of legal obligations; express consent; legitimate interest.

Recipients: co-insurance and reinsurance entities; service providers acting as data processors; Crédit Mutuel-CIC Group companies; insurance entities or public or private bodies related to the insurance sector; public bodies and competent authorities in general.

Conservation period: during the entire validity of the insurance policy and, at its expiry, during the periods

of limitation of the legal obligations applicable to the insurance company in accordance with the regulations in force at any given time.

Rights: access, rectification, deletion, opposition, portability and limitation.

Additional information: you can consult the rest of the complementary information on Data Protection in the Personal Data Protection Policy of the GACME group published on the www.grupo-acm.es website.

Prevalence of policy conditions

This Extract of General and Specific Conditions is a summary of the conditions of the policy, the provisions of the policy prevailing in the event of discrepancy with this extract.

This document is issued for the purpose of providing information on the insurance policy taken out by the Policy holder. It is subject to the requirements, terms and conditions that the Policy holder has agreed upon at any given time.

Place and date of issue: In Sant Cugat del Vallès, on 1 January 2019

The Insurance Company,

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