CONDITIONS 2022

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Optional Group Insurance Contract
Health Insurance
A 4916.0001 à 0005 - ASPI

Expatriate Health Insurance

INFORMATION LEAFLET

SwissLife Expatriate Health cover

Your membership comprises this Information leaflet and your Certificate of Membership.

assur-travel
Partenaire de votre mobilité

22/06/2022

This information leaflet contains the general terms and conditions of the optional group insurance contract A 4916.0001 to 0005 taken out by the Association Santé Prévoyance Internationale («ASPI»).

CONTENTS

The information leaflet is a document which defines the cover and the terms of entry into force as well as the formalities to carry out in the event of a claim. It must be established by the Insurer and then provided by the Subscribing Association to the Members (Article L.141-4 du code de l'assurance).

The "**Assur Travel Santé**" contract has been concluded by:

Association Santé Prévoyance Internationale
Zone Actiburo - 99 rue Parmentier - 59650 Villeneuve d'Ascq - France

The **Association**

it has been taken out with:

SwissLife Prévoyance et Santé
Head office: 7 rue Belgrand - 92 300 Levallois-Perret - FRANCE
Plc with capital of € 150,000,000 - Regsitered with the Nanterre Trade and Companies Register (RCS) under number 322.215.021
Company governed by the Insurance Code

The **Insurer**

SwissLife

Insurance Supervisory Authority:

Autorité de Contrôle Prudentiel et de Résolution (A.C.P.R.)
4 place de Budapest - CS 92459 - 75436 Paris cedex 09 - France

DEFINITIONS

Accident:

any bodily injury beyond the control of the Insured party and arising from the sudden and unpredictable action of an external cause.

You / Member:

a natural person who is a member of the Association who signs the Contract, pays the membership fee and benefits from the cover.

Insured Party:

a natural person mentioned on the Certificate of Membership for which a membership fee is paid by the Member and on which the risk is based. It means you and your assigns (spouse and dependent children as defined in Article 3-I).

Association:

"Association Santé Prévoyance Internationale" (ASPI) is the association (under the law of 1901) having taken out the Contract which allows its Members to benefit from the cover described in the table of Health benefits (article 2-II).

Membership Certificate:

this document specifies the cover provided by the Assignee, the deductible if applicable, the affiliation to the French social security department in charge of medical insurance for French citizens living abroad (CFE), if applicable, the effective date as well as the data concerning you and those of your assigns mentioned therein before committing certain health expenses mentioned in article 6, the member must first ask for the agreement of the insurer via the assignee to obtain effective coverage.

C.F.E.:

Caisse des Français de l'Etranger French social security company in charge of medical insurance for French citizens living abroad.

Spouse:

your spouse provided you are not legally separated (subject to providing a sworn statement of non-separation), your partner bound by a civil solidarity pact (subject to providing a copy of the pact registered with the Registry of the District Court of the common home), or your de facto spouse (subject to providing a common proof of address and a sworn statement of open cohabitation), who is under 65 years of age on the day of registration.

Membership fees:

annual amount to be paid by the member in exchange for the cover granted by the insurer.

Healthcare:

it is the optional group insurance contract A4916, underwritten by the Association Santé Prévoyance Internationale («ASPI») and governed by French law and by the General and Special Terms and Conditions.

Waiting period:

the amount of time an insured must wait before some or all of their coverage comes into effect. The waiting periods for the different types of cover are explained in Article 8-II.

Administrator/Assignee:

Third party mandated by the Insurer and/or the Association to manage the various management tasks entrusted to it. In the context of the Contract, the Assignee of the Insurer and of the Underwriter is GAPI: 16 rue de la Fontaine au Roi - 75011 Paris - France, simplified joint stock company (SAS) with capital of € 55,000 - registered with the Paris Trade and Companies Register (RCS) under number 490 676 228, ORIAS no. 10056960.

Dependent children:

your children and/or those of your spouse, tax-dependent upon you and/or your spouse, until their 16th birthday whatever the case, and until their 26th birthday if they continue their secondary education (subject to providing a valid certificate of schooling or photocopy of the student card at the time of registration and at each annual renewal) and that they do not have a full-time occupation. Also included are your children and/or those of your spouse with disabilities and holders of the disability card provided for in Article L. 241-1 of the Social Action and Families Code.

Request for prior agreement:

first ask for the agreement of the insurer via the assignee to obtain effective coverage.

Eligible Health Facility:

public or private health facilities (hospital or clinic) which, on the one hand, is authorized to perform acts and to provide medical treatment to sick or injured persons and, on the other hand, holds all the administrative and health permits required for this purpose.

Expatriate:

you, a Member of the Association who resides outside your country of nationality, alone or with your assigns (excluding private or professional trips of less than 90 consecutive days in a country other than that of expatriation). When your country of expatriation is France, you are an Impatriate.

Daily hospital charge:

when healthcare is provided in France, it represents the share of accommodation and maintenance costs resulting from hospitalization, not covered by the French Social Security or by the CFE if applicable, in accordance with Article L. 174-4 of the Social Security Code.

Unusual or unreasonable charges:

medical expenses which do not correspond to the rates customarily charged for a service or a similar benefit and which exceed the normal rates for such a service or for such a benefit in the best possible conditions in the locality where the service or benefit is provided.

Annual deductible:

an annual sum that remains your responsibility.

Hospitalization:

stay as a patient prescribed by a doctor in an Eligible Health facility, provided that the purpose of the stay is the medical or surgical treatment of an illness or the consequences of an Accident.

Illness:

any deterioration of health acknowledged by a competent medical authority.

Unexpected illness:

are recognized as suffering from an unexpected illness, Insured parties who are victims of a mycotic neurological attack or having contracted one of the following infectious diseases: cholera, pertussis, diphtheria, amoebic or bacillary dysentery, avian flu, cerebrospinal meningitis, mumps, malaria, poliomyelitis, measles, scarlet fever, tetanus, typhoid, typhus, varicella, smallpox, shingles or any other deterioration in health which the Assignee's medical adviser recognizes as being sudden and unpredictable.

Maternity:

non-pathological pregnancy, childbirth and its consequences. Maternity is considered neither a disease nor an accident.

PACS:

Civil Pact of Solidarity within the meaning of Articles 515-1 et seq. of the Civil Code.

Country of expatriation:

country included in one of the Geographic Guarantee Zones in which You and your Assigns reside in accordance with the definition of Expatriate. Your country of nationality cannot be the same as your country of expatriation.

Period of coverage:

period during which the Insurer is contractually obliged to indemnify the risks that arise during the completion of the Contract. The Risk Coverage Period begins no earlier than the date stated in the Certificate of Membership and ceases no later than the date of termination of membership.

Direct hospital cover:

after prior approval by the insurer, the member (or an assign) hospitalized for a minimum period of 24H can benefit from the direct coverage of the associated hospitalization expenses according to the conditions specified in article 7 "Direct hospital cover".

Medical questionnaire:

a document retracing your medical history and that of your Assigns to allow the Assignee's medical adviser to assess the health risk you represent. It must be less than 90 days old on the date of membership or registration.

Re-education :

the Insured party who has undergone surgery may benefit from re-education sessions in a rehabilitation center only after Hospitalization.

Teleconsultation:

consult a general practitioner or specialist in writing, by telephone or video 24 hours a day, 7 days a week.
Refer to the Appendix «Teleconsultation».

Geographical area of cover:

the Geographical area of cover (Zone A, B, C or D) is determined by your country of expatriation and is described in Article 5-II. The cover applies to the reimbursement of health expenses that have been incurred in the Geographical area of cover applicable to you.

I. THE CONTRACT

ARTICLE 1 - PURPOSE OF THE CONTRACT

The "**Assur Travel Santé**" contract is for the payment of benefits reimbursing health expenses incurred during the Coverage Period by You and your Assigns residing in the same country as yours, when they are registered in the Contract. These benefits are paid in addition to reimbursements from the CFE or the French Social Security, or as of the first Euro.

ARTICLE 2 - CHOICE OF COVER LEVEL

The health benefits apply within the limit of the level of cover that you have chosen from one of the six Options below. The level of benefits increases depending on the option chosen. The choice is applicable to you and to your Assigns.

- **Basic option:** it can only be chosen if you are an expatriate in Zone A, B or C;
- **PREMIUM ACCESS option :** eit can only be chosen if you are an expatriate in Zone A, B or C;
- **PREMIUM option:** it can only be chosen if you are an expatriate in Zone A, B or C;
- **CONFORT ACCESS option;**
- **CONFORT option;**
- **SUMMUM option.**

In addition, you can choose an Annual deductible applicable to the amount of your refunds. This deductible applies per calendar year.
Annual deductible 150:
The deductible applies up to €150 for individual subscription, up to €300 for couple subscription, up to €450 for family subscription.
Annual deductible 300:
The deductible applies up to €300 for individual subscription, up to €600for couple subscription, up to €900 for family subscription.

NB: health benefits apply within the limits of the Geographical area of cover applicable to you (Zone A, B, C or D).

ARTICLE 3 - MEMBERSHIP / CONTRACT ENROLLMENT – GUARANTEED PERSONS

You, Member
In order to join the Contract taken out by the Association, you must meet the following cumulative conditions:

- be aged at least 18 and less than 65 years old on the day of your membership;
- be of a different nationality from that of your country of expatriation;
- have paid membership fees to the Association to become a member.

Your Assigns
Are considered as Assigns and can thus benefit from the guarantees which you have taken out:

- **your spouse:** your spouse provided you are not legally separated (subject to providing a sworn statement of non-separation), your partner bound by a civil solidarity pact (subject to providing a copy of the pact registered with the Registry of the District Court of the common home), or your de facto spouse (subject to providing a common proof of address and a sworn statement of open cohabitation), who is under 65 years of age on the day of registration.
NB: when you join the Contract in addition to the French Social Security or the CFE, and your spouse is not recognized as being dependent on you by one of the aforementioned bodies, your spouse can benefit from the cover provided that s/he is individually affiliated with one of these basic organizations;;

- **dependent children:** your children and/or those of your spouse, tax-dependent and/or that of your spouse, until their 16th birthday whatever the case, and until their 26th birthday if they pursue secondary education (subject to providing a valid certificate of schooling or photocopy of the student card at the time of registration and at each annual renewal) and that they do not have a full-time occupation. Also included are your children and/or those of your spouse with disabilities and holders of the disability card provided for in Article L. 241-1 of the Social Action and Families Code.

NB: When you join the Contract in addition to the French Social Security or the CFE, the cover of dependent children may be maintained beyond their 20th birthday only if they are registered individually with this basic organization.

Your Assigns must reside in the same Geographical zone as you to benefit from the type of Cover you have chosen

ARTICLE 4 - ADMISSION TO INSURANCE

4.1 When joining the Contract, you must send to the Assignee::
- the **Membership form** duly filled in and signed by you;;
- the **Medical questionnaire** filled in less than 90 days before the requisite effective date, completed and signed by you, for You and for your Assigns. It must be sent confidentially to the medical adviser of the Assignee;
- lthe **certificate of affiliation to the CFE** when the cover is taken out in addition to the benefits paid by that body;
- the **documents to justify that your Assigns meet the definition of Article 3-I.**

The Assignee may request the transmission of any additional information s/he deems useful in order to examine the file and assess the risk. Likewise, s/he reserves the right to ask your Assigns to transmit any other document enabling them to prove their capacity as Assigns.

All the documents provided to the Assignee constitute your Membership File.

4.2 You must inform the Assignee, in writing, of any change of address, country of expatriation and/or status, and inform same of any changes relating to your family situation. **Declarations and communications made during your membership shall only have effect if they have been received in writing by the Assignee.**

4.3 After studying the Membership File, the Assignee will notify you of its acceptance by issuing a **Membership Certificate** mentioning the effective date of the membership and the cover, your surname and forename (s) and those of your Assigns, the level of cover chosen, your country of expatriation and the corresponding Geographical area of cover, as well as the amount of your membership fee.

Depending on the results of the medical screening, the Assignee reserves the right to:
- apply an additionnal premium;
- accept an Insured party while excluding from the health expenses all of the expenses related to a pathology specified on your Certificate of Membership;
- to refuse your membership or the registration of an Assign. In this case, the Assignee will notify you of the refusal by registered letter with acknowledgement of receipt in the month during which the Membership File is received.

ARTICLE 5 - EFFECTIVE DATE, DURATION AND RENEWAL OF YOUR MEMBERSHIP - EFFECTIVE DATE OF COVER

5.1 Your membership and the registration of your Assigns

You, Member
Your membership becomes effective on the date indicated on your Certificate of Membership. It begins no earlier than the first day following the date of receipt of the complete Membership File by the Assignee, subject to:

- the acceptance of your membership following the medical screening;
- full payment of your first membership fee;
- the acceptance of the additional premium proposed by the Assignee if applicable;
- your entitlement to CFE benefits if applicable.

Your Assigns
The registration of your Assigns takes effect on the same date and under the same conditions as your membership.

In the event of a change in your family situation (marriage, signing of a PACS, open cohabitation, birth or adoption of a child), the registration of your Assigns will take effect at the earliest on the first day following the express acceptance their registration by the Assignee and under the same conditions as your membership.

Your children who are born after you join the Contract are considered admitted, without medical formalities, provided that their birth is declared to the Assignee in the month following their date of birth. In this case, their registration will take effect on the day of their birth. If this period of one month is exceeded, their registration will take effect at the earliest the day after the receipt by the Assignee of the declaration of their birth.

Your membership and the registration of your Assigns are valid until December 31 of the current year. They are then renewed by tacit renewal on January 1 of each year for successive periods of one (1) year.
However, you may terminate your membership in the Contract when renewing your annual membership by registered letter sent to the Assignee at least two months before the due date. In addition, if you have to be affiliated to a compulsory scheme in your country of expatriation, you can terminate your membership in the Contract by sending a registered letter to the Assignee and any document substantiating your compulsory affiliation to this scheme.

5.2 The cover you have chosen

The cover of the Contract that you have chosen takes effect on the date of your membership (and that of the registration of your Assigns) subject to the waiting periods. **The Assignee will only cover expenses incurred from the effective date of the cover and for the duration of the Coverage Period.**

ARTICLE 6 - CHANGING THE CHARACTERISTICS OF YOUR COVER

6.1 In case of change of country of expatriation, you must inform the Assignee, **in writing**, 1 month before the effective date of the change. When this change results in a change to the Geographical area of cover, the cover in the new Zone and its pricing will apply to you on the first day of the month following the effective date of the change.

6.2 You choose the level of cover on the day of your membership, for You and your Assigns. However, you can change the level of cover previously chosen according to the assumptions defined in paragraph 6.3 below. You must inform the Assignee of same **in writing**.
The new level of cover and its pricing will apply on the first day of the calendar month following the date of receipt of the letter expressly mentioning the agreement of the Assignee to subscribe to the new level of cover required.

6.3 Assumptions for changing the level of cover
You can change the level of cover previously chosen:

- **at each annual renewal of your membership** (1st January). You must notify the Assignee at least 1 month before the date of the change;
- in case of a **change in your family** situation (marriage, signing of a PACS, open cohabitation, widowhood, birth or adoption of a child, divorce or legal separation, break-up of the PACS, end of open cohabitation). You must notify the Assignee in the month following the change in your family situation; the addition of a new assign implies a new enrollment form filled in together with the medical questionnaire of the additional assign concerned (except for children born after membership and whose birth is declared within 30 days after said membership).
In the event that the addition of an assign changes the initial structure of the contract, the membership fees will be re-assessed.
- in case of **change of country of expatriation resulting in a modification of the Geographical area of cover**; you must notify the Assignee at least 1 month before the actual change of Country of Expatriation.

6.3.1 In case of an increase of the level of cover
You must fill in a new membership form and provide a new Medical Questionnaire for You and your Assigns. The Assignee reserves the right to refuse this increase in cover.
Waiting periods (Article 8-II) are applied to the benefit differential from the effective date of the new level of cover.

6.3.2 In the event of a reduction in the level of cover
If you wish to opt for a new level of cover lower than the previous one, the new cover takes effect on the first day of the calendar quarter following the receipt of the new membership form (without medical questionnaire).

6.4 Change in the type of cover (in addition to the CFE or the French Social Security, or as of the 1st Euro)
In the event of a change in your situation vis-à-vis the CFE or the French Social Security which results in the beginning or the end of the rights to one of these schemes, you may, during the membership period, change the type of cover. You must inform the Assignee by registered letter accompanied by the documents substantiating your change of situation, and the certificate of affiliation to one of these schemes, if applicable. The change of the type of cover and its pricing will take effect on the first day of the calendar month following the express acceptance of the Assignee, subject to the entitlement to the rights to the new scheme, if any.

ARTICLE 7 - TERMINATION OF YOUR MEMBERSHIP AND COVER

For You, member

Your membership and your cover cease:

- **on December 31 in the event of termination of your contract by the company;**
- **on December 31, if you cancel your contract during the annual renewal period (section 5.1-1);**
- **on the day of your final return to your country of origin;**
- **in case of non-payment of your membership fee (article 9.1-I) pursuant to article L.141-3 of the Insurance Code. Any membership fee paid for the current fiscal year is vested and non-refundable;**
- **on the day of receipt by the Assignee of a letter stating that you wish to terminate your membership as part of your right of withdrawal (Article 11-I);**
- **on the date of your death;**
- **as soon as you no longer comply with one of the conditions of membership in the Contract (Article 3-I);**
- **the cover of the SUMMUM option ceases on the first renewal after your 70th birthday or that of one of your Assigns;**
- **on the day of your affiliation to a compulsory scheme of the country of expatriation (article 5-1) or to a compulsory professional mutual society. The request must be sent to the assignee accompanied by proof of membership in the scheme in question.**

For your Assigns

The registration and the cover of your Assigns cease:

- **at the same time that your membership ceases under the conditions defined above;**
- **as soon as they no longer meet the definition of spouse or dependent child (Article 3-I).**

ARTICLE 8 - CALCULATION OF YOUR MEMBERSHIP FEE

8.1 If You and/or your Assigns join/ are registered temporarily, or in case of departure during the course of the year, the amount of your membership fee will be adjusted pro rata temporis and the membership fee for the last month of membership/ registration will be due for the whole month..

8.2 The tariff conditions are established according to the level of cover chosen (BASIC, PREMIUM ACCESS, PREMIUM, CONFORT ACCESS, CONFORT, or SUMMUM), the type of cover (in addition to the services paid by the CFE or by the French Social Security, or the 1st Euro), the Geographical area of cover (Zone A, B, C or D) applicable, your age group, your family situation (individual or family) and the application of a premium, where appropriate, following the medical screening.

8.3 The ages taken into account for the calculation of the membership fee are yours and those of your Assigns on the day of the call for membership fees.

8.4 When the insured party turns 70, the family rate is the sum of the individual rates for family members.

The Insurer reserves the right to adjust the amount of your membership fee on the 1st of April of each year according to changes in the medical costs of the health expenses of each country, changes in the local legislation and technical profit of the Contract taken out with the Insurer.

In case of a change in tariff, the new amount of your membership fee will be communicated to you with ONE MONTH's notice and will be applicable to the next due date for the payment of membership fees i.e. on January 1 of the year N+1 in case of the annual payment of membership fees, on 1 July of year n in case of the semi-annual payment of membership fees, and on 1 April of year n in case of the quarterly payment of membership fees.

ARTICLE 9 - PAYMENT OF YOUR MEMBERSHIP FEE

9.1 You are responsible for paying your membership fee to the Association or its Assignee. The contribution is payable in advance only in Euro (€) by check, by bank transfer, by credit card on the secure website indicated by the Assignee, or by direct debit from your bank or postal Bank account, quarterly, semi-annually or annually according to the instalments and the terms and conditions chosen on your membership form. **Bank charges are your sole responsibility.**

In accordance with Article L. 141-3 of the Insurance Code, the Association or its Assignee may exclude you from the benefit of the Contract if you stop paying your membership fee. The exclusion will occur after a period of 40 days from the sending by the Association of a registered letter of formal notice to pay. This letter can only be sent 10 days at the earliest after the date on which the sums due must be paid.

At the time of the formal notice to pay, the Association informs you that after the expiry of the period of 40 days, failure to pay the membership fee may result in the termination of your membership. This exclusion may not prevent, if applicable, the payment of benefits acquired in return for membership fees previously paid.

9.2 ou pay all the dues, charges and taxes, present and future, applicable either to membership fees, or to sums due or owing.

9.3 Membership fees for the CFE must be paid directly to the CFE.

9.4 The membership fee is due until the end date of your membership. After termination of your membership, any payment of a membership fee, whether total or partial, will only constitute a regularization of your account and cannot, unless express requested by you and accepted by mail from the Assignee, constitute a tacit reinstatement of the cover provided by the Contract.

ARTICLE 10 - DECLARATIONS AND COMMUNICATIONS

10.1 In accordance with Article L. 113-8 of the Insurance Code, your membership or the registration of your Assigns in the Contract is void in case of concealment or intentional misrepresentation, when this concealment or misrepresentation changes the subject of the risks or diminishes the opinion of the Insurer, even if the risk omitted or distorted has no influence on the claim.

10.2 In accordance with Article L. 113-9 of the Insurance Code:

- **the omission or unintentional misrepresentation of the Insured party prior to the occurrence of the loss entails either the maintenance of the membership or the registration by means of an increase in the membership fee, or the termination of the membership or registration in the Contract 10 days after the notification sent by the Assignee by registered letter;**
- **the Insured party's omission or unintentional misrepresentation after the occurrence of the loss will result in a reduction of the indemnity in proportion to the amount of the membership fees paid in relation to the amount of the membership fees that would have been due had the risks been correctly reported.**

10.3 In the event of concealment or intentional misrepresentation on your behalf or by your Assigns, the membership fees you have paid remain with the Insurer as damages, subject to the approval of article L. 113-8 paragraph 2 of the Insurance Code.

ARTICLE 11 - WAIVER OF MEMBERSHIP

You may terminate your membership in the Contract by exercising your right of withdrawal in accordance with and under the terms of the following articles:

11.1 Article L.112-9, first paragraph, of the Insurance Code provides that: *"Any natural person who is solicited at home, at their place of residence or place of work, even at their request, and who signs an insurance proposal or a Contract for purpose which do not fall within the scope of their commercial or professional activity, may renounce same by registered letter with acknowledgement of receipt during the period of 14 calendar days after the date of signature of the Contract, without have to justify its reasons or incur penalties. (...) Therefore, whoever is aware of a loss involving the cover of the Contract, the member can no longer exercise this right of withdrawal".*

If you wish to use your right of withdrawal you are advised to write your letter as follows:

I, the undersigned) (Name and Surname (s) of the Member), living in (main home), hereby renounce my membership in the **Assur Travel Santé Contract** No. A 4916 *(completed with your membership number), which I signed on (DD/MM/YYYY).*
(If membership fees have been collected) I should be most grateful if you would refund the membership fees paid, under the conditions provided for by Article L. 112-9 of the Insurance Code, after deduction of the membership fee attributable pro rata to the cover period.
(In case of remote marketing) I undertake, for my part, to refund the amount of benefits that may have been paid to me..
In ……, On…… Signature of the Member

Consequences in the event of exercise of the right of withdrawal within the framework of article L. 112-9 of the Insurance Code:
Exercising the right of withdrawal entails the termination of the membership in the Contract from the date of receipt of the registered letter. Nevertheless, as soon as you become aware of a claim involving the cover provided by of the Contract, you can no longer exercise this right of withdrawal.
In the event of a withdrawal, the Assignee shall refund the membership fees within thirty days of the date of termination, less the amount corresponding to the period during which the membership actually took effect. The full premium remains due to the Assignee if you exercise your right of withdrawal while a claim involving the cover provided by membership and of which the Assignee was unaware occurred during the withdrawal period.

11.2 In the event of exercising the right of withdrawal within the framework of articles L. 112-2-1 of the Insurance Code and L. 121-20-8 of the Consumer Code (remote sale or provision of services):

In consideration of the immediate and full benefit of the membership before the expiry of this withdrawal period, the membership fee for which you are liable is equal to the proportion of the annual membership fee for the period elapsed between the effective date provided for when the membership was signed and the date of receipt of the withdrawal.
If benefits have been paid, you agree to reimburse the Assignee the amounts received within 30 days.
If membership fees have been collected, the Assignee will reimburse them within 30 days, after deduction of the prorated membership fee for the cover period..

ARTICLE 12 - STATUTORY LIMITATION PERIOD

The statutory limitation period is the period provided for by law after which a right is discontinued. All claims deriving from this Contract are limited in time by the terms of the following articles of the Insurance Code;

Limitation period
Article L.114-1 of the Insurance Code
Any claim deriving from the insurance contract is limited to two years from the event giving rise to the claim.
However, this period:
1) does not apply in the event of concealment, omission, false or inaccurate statement of the risk incurred, as of the day on which the insurer became aware of same;
2) in the event of a contingency, only applies on the day when the persons concerned were aware of it, if they prove that they were unaware of it until then.
When the claim of the Insured party against the Insurer is caused by the recourse of a third party, the limitation period only runs from the day on which the third party has taken legal action against the Insured party or has been indemnified by the latter.
The limitation period is extended to ten years in life insurance contracts where the assign is a separate person from the subscriber and, in accident insurance contracts affecting individuals, when the beneficiaries are the assigns of the deceased insured party.
For life insurance contracts, notwithstanding the provisions of the second paragraph above, the assign's claims are limited to thirty years at the latest from the death of the insured party.

Causes of interruption of the limitation period
Article L.114-2 of the Insurance Code
The limitation period is interrupted by one of the ordinary causes of interruption of the limitation period and the appointment of experts after a claim. The interruption of the limitation period of the claim may, in addition, result from the sending of a registered letter with acknowledgement of receipt sent by the insurer to the insured party with respect to the claim for payment of the premium and by the insured party to the insurer with respect to the settlement of the indemnity.

Public order nature of the limitation period
Article L.114-3 of the Insurance Code
By way of derogation from Article 2254 of the French Civil Procedure Code of Law, the parties to the insurance contract cannot, even by mutual agreement, modify the duration of the limitation period or add to the causes of suspension or interruption thereof.

Ordinary causes of interruption of the limitation period:
The ordinary causes of interruption of the limitation period referred to in article L. 114-2 mentioned above are those provided for under the terms and conditions of the following articles of the Civil Code:

Recognition by the debtor of the right of the person to whom the limitation period applied
Article 2240 of the French Civil Code of Law
Recognition by the debtor of the right of the person against whom he claimed interrupts the limitation period.

Action at law
Article 2241 of the French Civil Code of Law
The action at law, even in summary proceedings, interrupts the limitation period as well as the extinctive time limit.
The same applies when the claim is brought before a court not having jurisdiction or when the act of seising the Court is annulled by the effect of a breach of procedure.

Article 2242 of the French Civil Code of Law
The interruption resulting from the action at law is effective until the termination of the proceedings.

Article 2243 of the French Civil Code of Law
The interruption is void if the plaintiff withdraws their claim or allows the proceeding to lapse, or if their claim is definitively rejected.

Precautionary measure and compulsory enforcement
Article 2244 of the French Civil Code of Law
The limitation period or the extinctive time limit is also interrupted by a precautionary measure taken under the Code of Civil Enforcement Procedures or an enforcement act.

Extent of limitation period as to persons
Article 2245 of the French Civil Code of Law
The summons of one of the joint persons required to meet claims by an action at law or by enforcement measures or the recognition by the person required to meet claims of the right of the person to whom the limitation period applied interrupts the limitation period with respect all the others, including their heirs.
On the other hand, the summons of one of the heirs of a joint debtor or the recognition of that heir does not interrupt the limitation period with regard to the other co-heirs, even in the case of a mortgage debt, if the obligation is divisible. This summons or acknowledgement only interrupts the limitation period, with respect to other co-debtors, for the part owed by the heir.
To interrupt the limitation period as a whole, with respect to the other co-debtors, the summons must be made to all the heirs of the deceased debtor or the acknowledgement of all these heirs.

Article 2246 of the French Civil Code of Law
The summons made to the principal debtor or the acknowledgement of same interrupts the limitation period against the surety.

ARTICLE 13 - EXAMINATION OF CLAIMS - MEDIATION

First contact: your usual contact
In the event of a claim concerning the Contract, you are first of all invited to contact your usual contact person (commercial intermediary or customer service).

Second contact: the claims service
If a disagreement persists, you can intervene with the claims service: Collective Insurance Claims Service: SwissLife Prévoyance et Santé, Direction des Assurances Collectives, Service Réclamations, 7 rue Belgrand 92682 LEVALLOIS CEDEX.

As a last plea: the Mediation Department
The Mediation Department intervenes after all channels with the various departments have been exhausted.
The mediator's contact details will be systematically indicated by the claims department, in case of partial or total refusal to grant the claim.

After exhaustion of internal procedures:
Insurance Mediation
The Médiation de l'Assurance Association can be referred to, after exhausting the internal procedures, in case of a partial or total refusal to grant the claim. The Insurance Ombudsman is responsible for disputes between the Insurer and the third-party beneficiaries of a cover or an insurance benefit. The Ombudsman cannot be referred to if a lawsuit has been or is engaged. Recourse to the Ombudsman should be addressed to: La Médiation de l'Assurance TSA 501 10 - 75441 Paris Cedex 09.

ARTICLE 14 - PROTECTION OF PERSONAL DATA

In accordance with the regulations in force concerning the protection of personal data, Swiss Life and ASSUR TRAVEL are the data controllers in respect of the Contract.

The data collected is used by Swiss Life and by ASSUR TRAVEL:
- To conclude, manage and fulfil this contract;
- To be processed as part of the fight against money laundering and the financing of terrorism, the application of regulatory obligations and the management of operational risks, including insurance fraud;
- To crossed if appropriate to improve our products, assess the situation of the Insured party or predict and customize the offers that may be proposed.

The data relating to the Insured parties are also transmitted to the agents, partners, subcontractors and re-insurers or authorized bodies of the data controllers for the purposes of these operations.
The Insured parties have the right to access, rectify, erase or port the data concerning them. They also have the ability to set guidelines for the fate of their data after death or to choose to limit their use. If the Insured party has expressly consented to certain uses of their data, they may withdraw that consent at any time provided that the processing does not condition the application of the contract.
The Insured party may oppose the processing of their data for a legitimate reason.
The Insured party may also refuse to receive by SMS and mail commercial offers from the data controllers for services and similar products.
For all requests relating to these rights, the Insured party may contact the Data Protection Officer of ASSUR TRAVEL to exercise their rights by email: dpo@assur-travel.fr or by mail to ASSUR TRAVEL at the attention of the DPO, 99 rue Parmentier - Zone Actiburo - 59650 Villeneuve d'Ascq.
Medical claims must be made to the attention of the medical officer. The Insured party may also write to our Data Protection Officer (DPO): 7 rue Belgrand 92300 Levallois-Perret (DPOswisslife@swisslife.fr).
Regarding the data collected and processed in order to be processed in the fight against money laundering and terrorist financing, the Insured party may apply directly to the French Data Protection Authority (CNIL) (https://www.cnil.fr/).
The personal data protection policy reflects the core values of Swiss Life: attention, serenity and reliability. For further information, please see: http://www.swisslife.fr/Protection-des-donnees. We can send a copy free of charge on request from the insured party to the address indicated in this contract.

II. HEALTH BENEFITS: HOSPITALIZATION, MEDICAL EXPENSES, MATERNITY

ARTICLE 1 - GUARANTEED BENEFITS

1.1 The purpose of the Health Benefit is to reimburse all or part of your medical, surgical, optical and dental expenses, and those of your assigns, or your expenses resulting from maternity. The expenses taken into consideration are exclusively those appearing in the table of health benefits (article 2-II) and or defined by the nomenclatures of the professional acts of the French social security or the French social security department in charge of medical insurance for French citizens living abroad (CFE).

1.2 For You and your Assigns, you are entitled to the benefits for which the date of the start of healthcare is between the start and end dates of membership (or registration), provided that the medical procedures have been prescribed and carried out by authorized doctors eligible to practice them, or by eligible health institutions.

1.3 When the reimbursement of expenses is in addition to refunds from the CFE or the French Social Security:

- the repayment of the Assignee is subordinated to that of these bodies, it being understood that any intervention by one or the other of these schemes will be deducted from the amounts covered by the guarantee provided for in the Contract, in accordance with paragraph 1.4 below;
- only the expenses for which the date of beginning of the healthcare, as indicated on the slip of the CFE or that of the French Social Security, are included between the dates of entry into effect and the end of membership (or registration).

1.4 Cumulative insurance

The benefits guaranteed by the Contract are in addition to the benefits of the same nature that may be paid by the CFE or by the French Social Security, as well as by any other additional cover from which you or your Assigns may benefit, without any of you being entitled to collect in all an amount greater than the costs actually incurred.
You must inform the Assignee, if applicable, that You and/or your Assigns are insured with one or more other insurers for the same interest, against the same risk, as those guaranteed by the "Assur Travel Santé" Contract.

TABLE OF HEALTH BENEFITS 1/2

The benefits indicated include reimbursement from the CFE, the french securité sociale or apply as of the 1st Euro costs incurred, within the limits of actual costs.

OPTIONS	BASIC	PREMIUM ACCESS	PREMIUM	CONFORT ACCESS	CONFORT	SUMMUM
Maximum limit per Insured party and per calendar year	€ 750,000	€ 750,000	€ 1,500,000	€ 1,500,000	€ 2,000,000	€ 2,500,000
HOSPITALIZATION (as a % of real costs)						
Medical or surgical hospitalization (1) (3)	100%	100%	100%	100%	100%	100%
Outpatient Hospitalisation (1) (3)	100%	100%	100%	100%	100%	100%
Psychiatric hospitalization (limited to 30 days/year) (1) (3)	100%	100%	100%	100%	100%	100%
Medical and surgical fees (1) (3)	100%	100%	100%	100%	100%	100%
Tests, analyses and pharmacy (1) (3)	100%	100%	100%	100%	100%	100%
Private room (1) (3)	€ 50 / day	€ 70 / day	€ 70 / day	€ 130 / day	€ 130 / day	€ 190 / day
Bed in room with child under 16 (limited to 30 days/year) (1) (3)	€ 30 / day	€ 30 / day	€ 30 / day	€ 45 / day	€ 45 / day	€ 60 / day
Daily rate (1) (3)	100%	100%	100%	100%	100%	100%
Outpatient consultations related to Hospitalisation / Ambulatory DAY SURGERY (1)	100%	100%	100%	100%	100%	100%
Physiotherapy immediately after Hospitalisation (up to 30 days/year) (1) (3)	100%	100%	100%	100%	100%	100%
Reconstructive dental surgery after an Accident (1) (3)	100%	100%	100%	100%	100%	100%
Organ transplant (1) (3)	100%	100%	100%	100%	100%	100%
Medical prosthesis (gear and internal prosthesis)	100%	100%	100%	100%	100%	100%
Transport by land ambulance (1)	90%	90%	90%	100%	100%	100%
MATERNITY (as a % of real costs)						
Maternity - Childbirth costs and pre- and post-birth sessions (1) (3) - AIDS screening test - Diagnostic of chromosomal anomalies	not covered	not covered	100% (max. €2500 /year)	not covered	100% max. €5000/year (€3000/year in Zone A + France)	100% max. €7500/year (€4000/year in Zone A + France)
Childbirth surgery (1) (3)	not covered	not covered	100%	not covered	100%	100%
			(max. €5000 /year)		max. €10000/year (€6000/year in Zone A + France)	max. €15000/year (€ 6000/year in Zone A + France)
IVF - Sterility (pharmacy, in-vitro fertilisation, analyses, follow-up tests (1) for women under 45	not covered	not covered	not covered	not covered	100% (max. €1000 year and max. 3 IVF/ duration of policy)	100% (max. €1500/year and max. 3 IVF/ duration of policy)
Transport by land ambulance in case of Hospitalisation (1)	not covered	not covered	90%	not covered	100%	100%

(1) Request for a prior agreement
(2) Request for prior agreement required for care or acts over € 1000
(3) Direct coverage possible

TABLE OF HEALTH BENEFITS 2/2

The benefits indicated include reimbursement from the CFE, the french securité sociale or apply as of the 1st Euro costs incurred, within the limits of actual costs.

OPTIONS	BASIC	PREMIUM ACCESS	PREMIUM	CONFORT ACCESS	CONFORT	SUMMUM
Maximum limit per Insured party and per calendar year	€ 750,000	€ 750,000	€ 1,500,000	€ 1,500,000	€ 2,000,000	€ 2,500,000
ROUTINE MEDICAL EXPENSES (% of real costs)						
GP consultation	not covered	90% (max. € 40/ consultation)	90% (max. € 40/ consultation)	100% (max. € 100/ consultation)	100% (max. € 100/ consultation)	100% (max. € 150/ consultation)
Specialist consultation	not covered	90% (max. € 60/ consultation)	90% (max. € 60/ consultation)	100% (max. € 130/ consultation)	100% (max. € 130/ consultation)	100% (max. € 170/ consultation)
Acts by paramedics (2)	not covered	80% (max. € 40/proced.)	80% (max. € 40/proced.)	100% (max. € 80/proced.)	100% (max. € 80/proced.)	100% (max. € 120/proced.)
Teleconsultation médecindirect à vos côtés, où que vous soyez	not covered	100% of actual costs	100% of actual costs	100% of actual costs	100% of actual costs	100% of actual costs
Technical medical treatment (outside hospital) (2)	not covered	80%	80%	100%	100%	100%
Medical analyses (2)	not covered	80%	80%	90%	90%	100%
Radiology (including MRI) (2)	not covered	80%	80%	100%	100%	100%
Pharmaceutical expenses and vaccines	not covered	90%	90%	100%	100%	100%
Alternative medicine: chiropractic, osteopathy, acupuncture, homeopathy, and traditional Chinese medicine (limited to Chine, Thailand, Hong Kong, Singapore and Vietnam)	not covered	80% (max. € 30/act € 240/year)	80% (max. € 30/act € 240/year)	100% (max. € 70/act € 1000/year)	100% (max. € 70/act € 1000/year)	100% (max. € 70/act € 1600/year)
Check-up (one check-up every two years	not covered	not covered	not covered	100% (max. € 300/year	100% (max. € 300/year)	100% (max. € 400/year)
MEDICAL PROSTHESES (% of real costs)						
Medical prostheses, small equipment and treatment accessories	not covered	not covered	90% in the limit of € 300/year	not covered	year limit of € 600/year	year limit of € 1000/year
VISION CARE (as a % of real costs)						
Lenses and frames	not covered	not covered	90% in the limit of € 300/year	not covered	limit of € 500/year	limit of € 700/year
Contact-lenses	not covered	not covered	90% in the limit of € 100/year	not covered	100% in the limit of € 260/year	100% in the limit of € 300/year
Refractive eye surgery (1)	not covered	not covered	90% in the limit of € 300/year	not covered	100% in the limit of €500/year	100% in the limit of € 700/year
DENTAL CARE (as a % of real costs)						
Dentistry limit by policyholder and by year	-	-	€ 1000/year (€ 500 the 1st year)	-	€ 2000/year (€ 1000 the 1st year)	€ 3000/year (€ 1500 the 1st year)
Dental treatment (2)	not covered	non garanti	90%	not covered	100%	100%
Dentures (including inlays and onlays) (1)	not covered	not covered	90% (max. € 200/ tooth)	not covered	100% (max. € 400/ tooth)	100% (max. € 600/ tooth)
Orthodontia (children under 16, maximum of 3 years for entire duration of the policy)	not covered	not covered	90% (max. € 600/ tooth)	not covered	100% (max. € 1000/ tooth)	100% (max. € 1200/ tooth)

(1) Request for preliminary agreement obligatory
(2) Request for preliminary agreement obligatory for treatment or procedures costing over €1000
(3) Possible direct payment

ARTICLE 3 - LIMITATIONS OF REFUNDABLE EXPENSES

3.1 Unusual or unreasonable Expenses may be refused coverage or the amount of the coverage limited by the Assignee. In order to assess the «unusual or unreasonable» nature of the health costs and to decide on the refusal or limitation of the amount of the coverage, the Assignee will take into account the usual charges applicable for a similar service or benefit, under the best possible conditions in the locality where the service or benefit was provided.

3.2 The health costs incurred in a private Eligible Healthcare facility are only reimbursed if the facility has been regularly and previously authorized by the competent authorities of the country.

3.3 The Assignee reserves the right to perform any medical or administrative check in case of unusual or unreasonable expenses. You or your Assigns may be summonsed for a check except in case of incompatibility with your/ their state of health. Transport costs are under your exclusive responsibility.

3.4 Costs that have been refused by the Assignee are under your exclusive responsibility.

ARTICLE 4 - MAXIMUM COMMITMENT

The guarantees of the Contract are exercised up to the following amounts by Insured and by calendar year of insurance, including benefits paid by the CFE or by the French Social Security:

- € 750,000 for the BASIC option;
- € 750,000 for the PREMIUM ACCESS option;
- € 1,500,000 for the PREMIUM option;
- € 1,500,000 for the CONFORT ACCESS option;
- € 2,000,000 for the CONFORT option;
- € 2,500,000 for the SUMMUM.

ARTICLE 5 - GEOGRAPHIC SCOPE

ZONE A	ZONE B	ZONE C	ZONE D
Africa (excluding South Africa) Belgium and France.	Countries not listed in zones A, C and D (excluding USA and SWITZERLAND).	Brazil, China, Spain, Hong Kong, Israel, Italy, Lebanon, United Kingdom, Russia, Singapore, United Arab Emirates and Australia.	Canada, Japan and Bahamas.

Excluded expatriation countries: USA, SWITZERLAND

The Geographical area of cover is determined by your country of expatriation.

The cover applies to the reimbursement of health expenses that have been incurred in the Geographical area of cover applicable to you. Nevertheless, your cover will also apply as follows:

- in Zones A, B and C if your Geographical area of cover is Zone D;
- in Zones A and B if your Geographical area of cover is Zone C;
- in Zone A if your Geographical area of cover is Zone B.

5.2 In the case of an emergency due to an accident or unexpected illness, health costs incurred in countries outside the applicable Geographical area of cover will be granted if those medical fees are incurred by You or by your Dependent during a private or business trip of up to 60 days maximum, and if they were not foreseeable before the trip. The travel costs are exclusively at your charge.

ARTICLE 6 - REQUEST FOR PRIOR AGREEMENT

6.1 For all the procedures listed in paragraph 6.2 below, you must request the prior consent of the Assignee on how to perform the care. The request for a prior agreement must be accompanied by the limitation period of the prescribing physician and must include the pathology and the foreseeable duration of the treatment.

You must send to the Medical Adviser of the Assignee, under confidential cover, at least two weeks before the start date of the medical procedures, the request for a prior agreement filled in and signed by the practitioner. The Medical Adviser reserves the right to request additional documents necessary in order to process the application.

6.2 The prior agreement of the Assignee must be requested for all the fees listed below.

Hospitalization

- all costs included in the cover.

In the case of an emergency (accident or unexpected illness), the request for prior agreement must be sent to the Assignee within 5 days of entering the Eligible Health Facility (hospital or clinic), indicating the urgency of the Hospitalization. Exceptionally, this period may be extended if the Assignee certifies that the obviously urgent situation in which you were making it impossible to request a prior agreement within the time limits.

For any extension of hospitalization, beyond 10 consecutive days, the request for prior agreement must be renewed every 10 days. It must reach the Assignee within 48 hours after the end of the said period.

Maternity

- the cost of delivery;
- the costs of surgical delivery;
- the costs of in vitro fertilization.

In the case of an emergency (complication related to maternity or delivery at an unexpected date), the prior agreement must be requested under the same conditions as for emergency hospitalization.

Routine medical expenses

- the technical fees for medical procedure when the amount is greater than € 1000;
- the cost of radiology, medical imaging and medical analysis when the amount is greater than € 1000.

Dental care

- dental expenses costing more than € 1000;
- prostheses and dental implants (including inlays and onlays);

Optics

- the cost of treatment of refractive eye surgery.

6.3 In case of non-compliance with the prior agreement procedure, reimbursement of benefits will be refused. Refundable services which have been reduced with a 20% excess by the Assignee remain your exclusive responsibility.

ARTICLE 7 - DIRECT HOSPITAL COVER

7.1 Direct hospital cover means the payment of health fees, by the Assignee, directly to the Eligible Health facility.

7.2 7.2 Subject to compliance with the procedure of the prior agreement (Article 6-II), the Assignee provides direct coverage for the following costs:

Hospitalization

- all expenses related to a hospitalization **except for external consultations directly related to hospitalization (pre- and post-hospital), overland transport by ambulance and hospitalizations lasting less than 24 hours.**

Maternity

- childbirth expenses;
- surgical delivery costs.

ARTICLE 8 - WAITING PERIODS

- **3 months** for Hospitalization costs except in cases of accident or unexpected illness;
- **3 months** for dental expenses and peridontology;
- **6 months** for physiotherapy fees, if they are not due to a surgical operation covered by the Contract;
- **9 months** for denture, orthodontic, optical and other prosthetic costs;
- **10 months** for Maternity expenses.

8.2 These waiting periods apply:

- upon joining or registering with the Contract;
- in the event of an increase in the cover: in this case, during the Waiting period, you and your Assigns are covered by your previous level of cover.

The waiting periods listed in paragraph 8.1 above, **except for the maternity cover,** can be waived if you prove you have an equivalent coverage in the month preceding your membership by transmitting a certificate of cancellation to the Assignee.

ARTICLE 9 - PAYMENT OF BENEFITS

9.1 To obtain payment of the benefits, you must send the Assignee a request for reimbursement accompanied by the following **original documentary** evidence:

- The **medical prescription**;
- The **detailed, paid invoice**, as well as **fees** of any practitioner or eligible health facility;
- The **benefit statements** from the CFE or the French Social Security when the cover is taken out in addition to the benefits paid by one of these organizations;
- For **care provided in France**: the **CERFA form** filled in by the practitioner, pharmacy or Eligible health facility.
- The **receipts issued by pharmacies** with the related prescription;
- The **agreement of the Assignee** for care subject to a request for prior agreement (article 6-II);
- If the expenses were incurred outside the Geographical area of cover applicable to you: proof that the expenses incurred are benefits included in the cover.

For healthcare bills of less than € 1000, a scan or a photograph of the healthcare bills and prescriptions are accepted.
Nevertheless, the Assignee or the Company reserves the right to request the original documents in order to make the refunds.

9.2 Requests for reimbursement must be submitted to the Assignee, under pain of forfeiture, within two years from the start date of the healthcare.

9.3 Payment is made to your order or to that of a representative that you have expressly designated.

9.4 9.4 If your Country of Expatriation is outside the Euro zone, you can have the benefits paid by bank transfer to a foreign account and in the currency of your choice according to the exchange rate in effect on the day of processing the reimbursement request, on the basis of the financial journals used by the Insurer or its Assignee.

ARTICLE 10 - EXCLUDED RISKS

The following risks are excluded from the cover:

- Addictive pathologies and disorders: the treatment of, or the result of, addictive pathologies and disorders, or the consumption or abuse of any substance, drug or alcohol. Treatment include detoxification, psychoanalyses, psychotherapies;
- Conflict and disaster: the treatment of any disease, illness or injury resulting from a nuclear or chemical contamination, war, riot, revolution, terrorism, brawling or similar events, in which the Insured party took an active part. It is specified that the cases of self-defence, professional duties and assistance to a person in danger are covered;
- Care related to cosmetic surgery treatment or operation: the treatment undertaken for aesthetic or psychological reasons to enhance the appearance, unless the treatment is a repair surgery operation further to an Accident of the Insured party which occurred during the Period of Coverage or a restorative surgery operation following breast cancer;
- Treatment for teeth whitening even on medical prescription and performed by a qualified practitioner;
- Donation of organs: the expenses incurred for the acquisition of an organ, in particular the removal of an organ from a donor, the removal of an organ of the Insured party for the purpose of a transplantation on another person, compatibility tests, transport of the donor organ and the cost of administrative procedures;
- Experimental treatment: treatment, including drugs, which, in the reasonable opinion of the Insurer or its Assignee, is experimental or whose effectiveness has not been proven on the basis of established medical practices, and which has not been approved by the official authorities of the country where the Insured party has been cared for;
- Thalassotherapy: the expenses incurred by the stay, treatment or services received in thalassotherapy centers, spas, or assimilated facilities, even on a medical prescription,
- Treatment for the relief of symptoms due to ageing, or other natural physiological causes;
- Voluntary injuries: treatment resulting from deliberate assault and battery by the Insured party, during a suicide attempt;
- Sports and recreation: expenses resulting from pathologies related to the practice of sports or leisure activities in a professional capacity, and the consequences of participation in dangerous sports, competitions or hobbies including air sports, combat sports, climbing in the high mountains, off-track mountain sports, scuba diving (except that practiced as a recreational activity within 50 meters), sports requiring the use of airborne vehicles;
- Costs of comfort related to hospitalization that are not included in the cover, such as newspapers, meals for visitors, telephone subscriptions and consumption, television subscriptions and cosmetics;
- All expenses for personal use, including alcohol, toothpaste, shampoo, and clothing,
- Unrecognized Healthcare facility or practitioner: treatment administered by a practitioner who is not recognized by the official authorities of the country in which the care was given;
- Treatment in a Health facility, or carried out by a practitioner or any other service provider, who has been informed by the Insurer or its Assignee, by written notification, that it is no longer recognized for insurance purposes;
- Treatment relating to any type of contraception not reimbursable by the CFE or by the French Social Security, sterilization, termination of pregnancy or family planning except in cases of proven danger to the health of the pregnant woman;
- The diagnosis and treatment of obesity such as tests and cures for weight loss;
- reatment for growth diseases such as growth hormones;
- Treatment of personality disorders including affective disorders, histrionic personality disorders, behavioural disorders, schizoid personality, autism spectrum disorders, obsessive-compulsive disorder, hyperactivity disorder, adjustment disorder, eating disorders and treatment designed to encourage social-emotional relationships, such as communication therapies except in the case of psychiatric treatment by a psychiatrist as opposed to psychoanalysis, psychotherapy or coaching;
- Genetic tests to determine the risk of developing a disease when the disease has not declared, except when reimbursed by the French Social Security or the CFE;
- Diagnoses and treatment of hair loss unless it is due to the treatment of cancer;
- Treatment of sexual problems, including impotence, sex reassignment and sexual refection;
- Transport costs incurred during treatment, unless they are covered in the Hospitalization item;
- Expenses related to the treatment of complications due to an illness or injury excluded from the cover;
- Treatment relating to surrogacy, whether the Insured party is the surrogate or foster parent;
- Medical equipment not classified as prostheses or equipment; • Footcare treatment, such as calluses, horns and nails, not reimbursable by the CFE or the French social security;
- Stays in an Eligible Health Facility (hospital or clinic) for purposes other than receiving treatment, such as convalescence, general nursing care or supervision, or where treatment administered does not require a stay in an Eligible healthcare facility, such as assistance with activities of daily living or the services of a therapist or a medical assistant. The cover providing for an accompanying bed when the hospitalized child is under 16 years old is not excluded;
- Products classified as vitamins or minerals as well as food supplements except during pregnancy if they are the subject of a medical limitation period;
- Expenses incurred before the effective date or after the date of termination of membership;
- Costs that are not or that would not have been covered by the CFE or by the French Social Security, except for lenses, private rooms, daily fees, alternative medicines, the treatment of myopia by laser and checkups;
- Costs not covered by the CFE following non-payment of CFE membership fees;
- Preventive medical expenses not reimbursed by the Contract.

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HOW TELECONSULTATION WORKS

médecindirect
à vos côtés, où que vous soyez

Do you have a health issue? Consult a general practitioner or specialist in writing, by telephone or video 24 hours a day, 7 days a week.

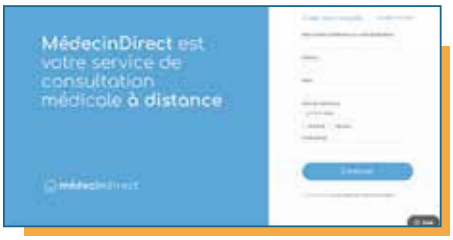
100% of the costs of the MédecinDirect medical teleconsultation service are covered by your insurer.

To benefit from the MédecinDirect medical teleconsultation service:

1

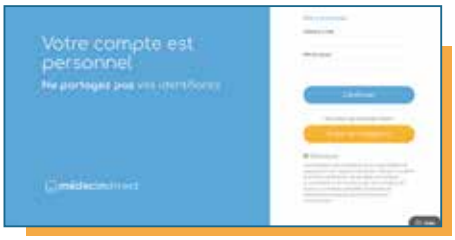
Go to the website www.medecindirect.fr or the free MédecinDirect app (available on iOS and Android).

2



Fill in the registration form and enter your GAPI membership number. Your registration will be automatically recognized and free of charge.

3

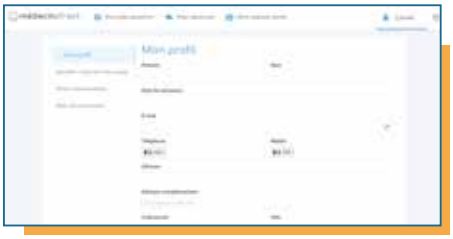


Log in with your email address (your username) and the password you chose when you registered.

4

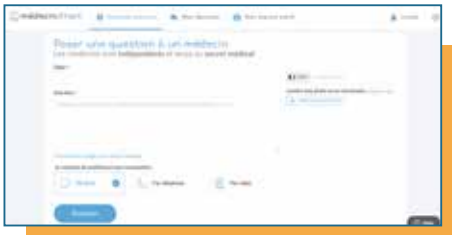
Enter the validation code, (not to be confused with your password) that will be asked for each connection, to ensure the total security of your personal data. You can choose to receive it by email or SMS.

5



Once your account is created, confirm your identity. This step is mandatory if you wish to receive a prescription.

6



Click on «new consultation» to get in touch with a doctor.

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24/7

In writing

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MédecinDirect is not an emergency service. In case of doubt or an emergency, please contact your doctor or dial 112.
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HEALTH INSURANCE SOLUTIONS

CONTACT OUR SALES DEPARTMENT

For additional information:

By telephone:

+33 (0)3 28 4 69 85 from 9:00 am to 6:00 pm.

By email:

contact@assur-travel.fr

To receive an online quote or take out a Policy on our website:

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Head Office: ACTIBURO BUSINESS AREA – 99 Rue Parmentier - 59650 VILLENEUVE D'ASCQ - France - Tel.: (+33) 03 20 34 67 48 - Fax: (+33) 03 20 64 29 17
Simplified Joint-Stock Company with a capital of €100,000 - Lille Trade and Company Register No. 451 947 378
Company governed by the French Insurance Code under the French Prudential Supervision and Resolution Authority (ACPR), 4 Rue Taitbout Place de Budapest CS92459 - 75436 Paris cedex 09, France, underwriter of a Civil Liability and Financial Cover insurance AMLIN INSURANCE SE N°2021MGARC001-10022
Under the provisions of Article L.520-1-IIb of the French Insurance Code, ASSUR TRAVEL operates as an insurance broker.
The list of insurance companies with which we work is available to you upon request.
Claims department: ASSUR TRAVEL - Claims Department - ACTIBURO BUSINESS AREA – 99 Rue Parmentier - 59650 VILLENEUVE D'ASCQ, France - Tel.: (+33) 03 20 34 67 48 Time frames for processing claims: 10 working days from reception of the claim.
If our claims department does not resolve your case, you can refer it to Médiateur de l'Assurance
by post at LA MEDIATION de L'ASSURANCE - POLE PLANETE CSCA -TSA 50110 - 75441 PARIS cedex 09, France,
by email at le-mediateur@mediation-assurance.org or on its website https://www.mediation-assurance.org/