Annex 10. Current insurance policy (not subject of this call for tenders)

Purpose of the policy

1. This insurance policy is drawn up between the European Commission (the policy holder) and Cigna International Health Benefits (the insurer) to provide collective insurance cover for Conference Interpreting Agents (ACI, the insured) recruited by the European Institutions.

2. These rules lay down, pursuant to Article 16 of the "Agreement on working conditions and the pecuniary regime for Conference Interpreting Agents recruited by the Institutions of the European Union"[1], the conditions under which the insured are covered throughout the world against the risks of sickness and accident contracted or suffered in the course of or in connection with the performance by the insured of their duties and consequent loss of income.

Definitions

3. An "accident" means any sudden occurrence adversely affecting the insured's bodily or mental health, the cause or one of the causes of which is external to the victim's organism.

   The following shall inter alia be considered accidents:

   - poisoning,
   - infections, sicknesses and injuries and any other consequences of the bites of animals or of the stings of insects,
   - sprains, tears or lacerations and ruptures of muscles or tendons caused by exertion,
   - the unexplained disappearance of insured, if on expiry of a period of one year and following an enquiry into circumstances of the disappearance, the insured is presumed dead and unless there are grounds for presuming that the death was due to illness.

4. "Illness" includes any illness of the insured which manifests itself as a sudden and unexpected deterioration of health during a period covered by the policy. Any aggravation of a pre-existing illness shall also be considered as a covered illness if it fulfills the above definition of the illness and it is sufficiently established that the illness arose in the course of the performance by the insured of his duties towards the European Institutions.

5. "Total invalidity" or "total incapacity" means invalidity or incapacity which entirely prevents the insured from practising interpretation professionally. Total loss of voice or hearing caused by an accident or illness shall be regarded as total invalidity or incapacity in the case of interpreters, whose ability to practice their profession depends entirely on their voice and hearing.

   "Partial invalidity" or "partial incapacity" means invalidity or incapacity which prevents the insured from practising interpretation professionally in part.

   Insured in receipt of "total/partial invalidity" or "total/partial incapacity" compensation must inform the insurer about any income resulting from professional activity. Any professional revenue or similar which, in combination with the received compensation, on a yearly basis, exceeds the average net remuneration from the three years period prior to the beginning of the invalidity/incapacity, as determined from the insured's tax declarations and the policy holder's records", shall be deducted from the compensation.

[1] In the following referred to as the Agreement.

The recipient of the compensation shall be required to provide on request any written proof which may be requested and to notify the insurer of any factor that may affect entitlement to the compensation.

6. "Permanent invalidity" means incapacity which has lasted not less than twelve consecutive calendar months and at the expiry of that period is beyond hope of improvement. No compensation shall be payable in case of the permanent invalidity unless the claim under that item is lodged within three years of the onset of the illness. An independent medical examination may be requested by the insurer.

7. By a "relapse" is meant any new temporary total or partial incapacity which arises within 12 months after the end of an incapacity covered under item (j) or (k) of the schedule, which is caused by the same illness.

   In the event of a period of temporary total or partial incapacity following the same accident, the compensation as mentioned under item (d) or (e) of the schedule shall be resumed.

8. "Daily remuneration" means the remuneration paid to the insured by the Commission on its own behalf or on behalf of the other European Institutions for each day worked. As a guide, the daily gross remuneration on the 1st March 2014 is €548.59 for experienced interpreters and €394.98 for beginners. The above rates can be subject to the retroactive adjustments.

9. The "annual remuneration" is based on the insured's daily remuneration and his yearly average number of insured days over the last 3 full years. Insured days are days during which the insured was covered by this or the previous policy signed by the policy holder (article 14 (a) to (d) below).

   For the calculation of the annual remuneration, the first 40 insured days count as full days, whereas any additional day is subject to 35% reduction. At the same time, a minimum value of 40 insured days is guaranteed for each insured irrespective of their actual average.

   The annual remuneration is then equal to the insured's daily remuneration multiplied by the insured's number of insured days calculated according to the above formula.

10. "Pension contributions" mean the contributions to the insured's old age and life-provident scheme transferred by the insurer in the event of permanent total or partial invalidity. They comprise two elements:
    - the first, borne by the Insurer, corresponds to 16.5% of the compensation due;
    - the second, deducted from the compensation paid, corresponds to 8.25% thereof.

11. "Retirement age" means for purposes of this contract the 67th birthday of the insured person.

12. "Annuity" means payment in 12 equal monthly instalments.

Schedule of compensation (referred to as "the schedule")

13. The insurance cover shall be not less than the compensation set out in the following schedule of compensation, subject to the remaining provisions of this policy.

Accidents

(a) Death: a lump sum equal to five times the deceased's annual remuneration.

(b) Permanent total invalidity: a lump sum equal to eight times the insured's annual remuneration and an annuity equal to 70% of the insured's annual remuneration paid until the retirement age.

If the permanent total invalidity starts after the retirement age, the annuity is not due.

The annuity paid in the event of permanent total invalidity shall be subject to contributions to the pension scheme, calculated on the basis of that annuity, as outlined in article 10.

(c) Permanent partial invalidity: a lump sum equal to a fraction of the compensation payable in the event of permanent total invalidity proportionate to the degree of invalidity, in accordance with the scale in *Annex 3*, and an annuity equal to a fraction of the compensation payable in the event of permanent total invalidity proportionate to the degree of invalidity, in accordance with the scale in *Annex 3* and the table below:

Degree of invalidity	**Fraction of the compensation payable as an annuity in the event of permanent total invalidity**
Lower than 33.3%	0%
Between 33.3% and 66.7%	Equal to the degree of invalidity
Higher than 66.7%	100%

If the permanent partial invalidity starts after the retirement age, the annuity is not due.

The annuity paid in the event of the permanent partial invalidity shall be subject to contributions to the pension scheme, calculated on the basis of that annuity, as outlined in article 10.

(d) Temporary total incapacity: an annuity equal to the insured's daily remuneration for a maximum of 21 days and thereafter 35% of daily remuneration for a further forty-nine weeks.

(e) Temporary partial incapacity: an annuity equal to a fraction of the compensation payable in the event of temporary total incapacity proportionate to the degree of incapacity, in accordance with the scale in *Annex 3*.

(f) Accident related events: incapacity directly related to a prior covered accident and attested by a medical certificate: the continuation of the compensation scheme as under (d) or (e) above.

Illness

(g) Death: a lump sum equal to five times the deceased's annual remuneration.

(h) Permanent total invalidity: a lump sum equal to eight times the insured's annual remuneration and an annuity equal to 70% of the insured's annual remuneration paid until the retirement age.

If the permanent total invalidity starts after the retirement age, the annuity is not due.

The annuity paid in the event of permanent total invalidity shall be subject to contributions to the pension scheme, calculated on the basis of that annuity, as outlined in article 10.

(i) Permanent partial invalidity: a lump sum equal to a fraction of the compensation payable in the event of permanent total invalidity proportionate to the degree of invalidity, in accordance with the scale in *Annex 3*, and an annuity equal to a fraction of the compensation payable in the event of permanent total invalidity proportionate to the degree of invalidity, in accordance with the scale in *Annex 3* and the table below:

Degree of invalidity	**Fraction of the compensation payable as an annuity in the event of permanent total invalidity**
Lower than 33.3%	0%
Between 33.3% and 66.7%	Equal to the degree of invalidity
Higher than 66.7%	100%

If the permanent partial invalidity starts after the retirement age, the annuity is not due.

The annuity paid in the event of the permanent partial invalidity shall be subject to contributions to the pension scheme, calculated on the basis of that annuity, as outlined in article 10.

(j) Temporary total incapacity: an annuity equal to the insured's daily remuneration for a maximum of 21 days and thereafter 35% of daily remuneration for a further forty-nine weeks. However, no compensation shall be payable in respect of the first three days of incapacity.

(k) Temporary partial incapacity: an annuity equal to a fraction of the compensation payable in the event of temporary total incapacity proportionate to the degree of incapacity, in accordance with the scale in *Annex 3*. However, no compensation shall be payable in respect of the first three days of incapacity.

(l) Relapse (partial or total): incapacity directly and incontestably related to a prior covered illness: the same compensation as under (j) or (k) above.

Reimbursement of medical expenses

(m) Reimbursement up to a maximum of €50,000 in respect of a single accident or illness, of medical, surgical and pharmaceutical expenditure incurred by an insured, providing entitlement to one of the forms of compensation referred to in (a) to (l) above, including hospitalisation and convalescence expenses, home care, travel expenses necessarily incurred in obtaining proper treatment and the cost of orthopaedic and surgical appliances. The cost of dental and optical services and of other appliances shall also be reimbursed if such expenditure is incurred as the direct result of an accident or illness.

As regards reimbursement of medical expenses, any amount payable to the insured, in respect of the same occurrence, under a social security scheme applicable to him or under insurance policies taken out by other organisations or undertakings to which the insured supplies services shall be deducted from the compensation payable under the policy. The reimbursements obtained under a private supplementary sickness insurance scheme covering that part of the expenditure which is not reimbursable by this insurance scheme should be exempted from the above rule.

Terms and exclusions

14. The ACI shall be compulsorily insured from 00:00 hours to 24:00 hours on the days on which he:

    (a) has a contract to supply services to the European Institutions;
    (b) receives a flat-rate travel allowance (Article 7 of the Agreement) or a flat-rate compensatory allowance (Article 7a of the Agreement);
    (c) receives remuneration for days not worked (Article 11 of the Agreement);
    (d) for reasons of service, is obliged, on days other than those referred to under points (a), (b) and (c) above, to remain away from his domicile because of the requirements of his contract.

15. The insured covered by this policy shall be free to choose their practitioners and hospitals or clinics.

16. The policy shall apply to accidents whether fatal or non-fatal and to illness directly or indirectly caused by natural disasters, strikes, riots, insurrections, revolutions, civil wars, international wars, movements of national or foreign troops or acts of terrorism, unless it be proved that the insured has voluntarily taken an active part in such events other than by way of legitimate defence.

17. The policy does not apply to an accident whether fatal or non-fatal or to an illness directly or indirectly caused by or traceable to the insured's own conduct and an inadequate standard of behaviour. Conduct is tested against what a reasonable person in the position of the insured would have foreseen and what he could have done to avoid the damaging consequences.

18. Except in cases triggered by accidents or illness covered by this policy, the policy does not apply to accidents whether fatal or non-fatal or to illness directly or indirectly caused by or traceable to the pregnancy or confinement of the insured or the complications thereof.

19. The compensation payable in the event of accident shall be payable only in respect of bodily injury caused by the accident, to the exclusion and independently of any other cause except illness directly resulting from such accident or surgical treatment rendered necessary by it.

20. No compensation shall be payable unless the accident takes place or the illness commences during the period of validity of the policy. In addition, the accident must have caused death or invalidity within three years of the date of its occurrence.

21. No compensation shall be payable for permanent invalidity in the event of illness unless incapacity persisted for one year and the invalidity ensues within three years of the onset of the illness.

22. The lump sum payable in the event of death (item (a) and (g) of the above schedule) shall be transferred to the persons duly entitled in accordance with the law of succession.

23. In the event of temporary incapacity the total amount paid in compensation under the policy, plus any other sums which the insured may receive as daily remuneration, flat-rate allowances (Article 7 and 7a of the Agreement), remuneration for days not worked (Article 11 of the Agreement) or any allowance due to the requirements of the contract (see article 14(d) above) from the European Institutions or as payment or benefit under any other social security or insurance schemes, shall not exceed the daily remuneration, including all allowances the insured would be normally entitled to; otherwise the compensation due shall be reduced accordingly.

24. In the event of an uninterrupted period of temporary incapacity, provisional payments (compensation and reimbursement of medical expenses) shall be made after four weeks, provided a medical certificate attests that the incapacity will continue beyond the four week period.

25. The amount payable in the event of death or permanent total invalidity (items (a), (b), (g) and (h) of the schedule) represents the maximum liability of the insurer to the insured in respect of a single accident or illness, except for the reimbursement of medical expenses (item (m) of the schedule).

    Upon payment of the compensation due to the insured in the event of death or permanent total invalidity resulting from an accident or illness (items (a), (b), (g) and (h) of the schedule) all liability of the insurer to such insured shall cease, save as regards reimbursement of medical expenses (item (m), of the schedule).

26. No compensation shall be payable in respect of the consequences of a single accident or illness of the insured under more than one item of the schedule of compensation, except for compensation payable in respect of temporary partial incapacity (items "e" or "k" of the schedule) which precedes or follows temporary total incapacity (items "d" or "j" of the schedule) and the reimbursement of medical expenses (item "m" of the schedule).

    In case of compensation payable in respect of permanent invalidity (items "b" or "c" or "h" or "i" of the schedule) following temporary incapacity (items "d" or "e" or "j" or "k" of the schedule) the compensation for invalidity shall be paid as from the first day of incapacity after deduction of the compensations already paid for incapacity."

27. The maximum intervention per event which is defined as an occurrence giving rise to claims by 5 or more insured is limited to €50,000,000.

Optional insurance cover

28. Each ACI who has been recruited by the European Institutions may require the Insurer to provide cover on an annual basis, without financial contribution from the European Institutions, for the days on which he is not covered under article 14 above. He shall pay the Insurer the appropriate premium in respect of such cover.

29. The premium for the optional annual insurance provided for in article 28 shall be paid directly to the Insurer by each ACI who has asked to be covered by such insurance. Such premiums shall not be taken into account when calculating the premiums and provisional premiums due to the Insurer by the Commission. The Insurer must provide for accounting procedures intended to prevent a premium from being paid twice, i.e. both by the Commission and by the ACI, in respect of days on which an interpreter who has taken out optional insurance is also covered under article 14 above.

Claim processing and deadlines

30. Communications to the Insurer and supporting documents may be written in one or more official languages of the European Union. The Insurer must be able to communicate in at least English and French.

31. A claim in respect of temporary incapacity shall be supported by a medical certificate attesting to total or partial incapacity for work. Until the total amount of compensation has been determined and agreed between the Insurer and the insured, provisional monthly payments may be made to the insured.

32. The insured shall send all medical certificates concerning the incapacity to work to the insurer within 5 calendar days from the date of the 1st day of absence. The postmark will act as proof of submission. The Insurer shall send once a week, on a fixed day, a list of all claims under the compulsory insurance provided for in article 14 to the Commission, which shall attest to the facts of which it has knowledge related to the following days:

    - contract days which are/would have been remunerated by the European Institutions,
    - days where a flat rate allowance (Article 7 and 7 bis of the Agreement) is/would have been due,
    - days on which remuneration for days not worked as per Article 11 of the Agreement is paid,
    - and any other days on which the interpreter is obliged to remain away from his domicile because of the requirements of his contract.

33. The Insurer may request the insured to supply any other certificates and proof which he may reasonably require. He may, at his own expense, require the insured to undergo a medical examination or, in the event of death, arrange for a post-mortem examination to be carried out.

    Where the amount of the claim exceeds a maximum of five times the daily remuneration or the accumulated number of compensated days over the last 12 months exceeds 30, the Insurer may call for an expert's report in addition to the medical certificate supplied.

34. The time limits for the submission of claims to the insurer are:

    - Compensation for loss of earnings arising from an accident (article 13 (a) to (f) of the schedule) or illness (article 13 (g) to (l) of the schedule): 18 months as from the last date on which the right to compensation has arisen;
    - Reimbursement of medical expenses (article 13(m) of the schedule): 18 months as from the last date of treatment.

    An ACI whose absence due to illness or accident extends over a period greater than one month shall have the right to submit claims on a monthly basis if he so desires.

    The insurer's decision will be notified to the insured within one month of receipt of the claim by the insurer. Any payments should be made within 14 calendar days of the insurer's notification.

35. The Insurer shall pay compensation directly to the insured. The insured or his legal successors shall give a valid receipt for this.

    Any sum overpaid shall be recovered if the insured was aware that there was no due reason for the payment or if the fact of the overpayment was patently such that he could not have been unaware of it. The request for recovery must be made no later than five years from the date on which the sum was paid. Where the insurer is able to establish that the insured deliberately misled the insurer with a view to obtaining the sum concerned, the request for recovery shall not be invalidated even if this period has elapsed.

36. Upon written request and within 30 days from the receipt of the payment, the insured is entitled to interest on late payment at the rate applied by the European Central Bank for its main refinancing operations in Euros (the reference rate), plus eight points. The reference rate shall be the rate in force on the first day of the month in which the payment period ends, as published in the C series of the Official Journal of the European Union.

    Interest on late payment shall cover the period running from the day following the due date for payment up to and including the date of actual payment.

Disputes

37. The law applicable to the policy shall be that of Belgium.

38. The insured's rights of action against third parties liable shall vest in the Insurer up to the amount of payments made to him by the Insurer. The Insurer shall renounce all claims against the European Institutions, its officials and servants and against the members of the insured's family, household and staff. If the insured is partially indemnified under the present scheme, he has priority in the recovery against the liable third party.

    The insured shall provide the insurer with any information or evidence available to them, in order to enable the insurer, where appropriate, to take action against the third party responsible, and give the insurer all assistance necessary to this end.

39. Any insurer's decision of a medical nature can be referred, within a period of 60 calendar days from the notification of the decision, by the insured or those entitled under him/her to the Medical Committee. The request for the matter to be referred to the Medical Committee shall contain the name of the doctor representing the insured or those entitled under him/her together with a report from that doctor setting out the medical issues disputed in relation to the insurer' decision.

40. The Medical Committee shall consist of three doctors:

    - one appointed by the insured or those entitled under him/her as indicated in the request;
    - one appointed by the insurer;
    - one appointed by agreement between the first two doctors.

    The insurer shall designate their doctor within three weeks of the insured filing the request for referral to the Medical Committee. The first two doctors shall, within three weeks, designate a third doctor who has no past or present connection with either party.

    Where agreement cannot be reached on the appointment of the third doctor within a period of two months following the appointment of the second doctor, the relevant Belgian Court shall appoint the third doctor at the request of either party. Irrespective of the method of appointment, the third doctor shall have expertise in assessing and treating bodily injury.

41. Once the Medical Committee has been established, it shall have twelve weeks within which to settle the dispute according to the procedures which it considers to be most appropriate. It shall cover medical matters raised by the report from the doctor representing the insured or those entitled under him/her and other relevant medical reports.

    The insurer shall inform the insured or those entitled under him/her of the fees and expenses which are liable to be borne by them. The insured or those entitled under him/her may not under any circumstances object to the third doctor on account of the amount of the fees and expenses requested by him/her. However, the insured or those entitled under him/her shall be free at all times to discontinue the procedure for referral to the Medical Committee. In that case, the fees and expenses of the doctor chosen by the insured or those entitled under him/her and half of the fee and expenses of the third doctor, shall be borne by the insured or those entitled under him/her in respect of the part of the work that has been completed. The insured or those entitled under him/her shall remain liable to his/her doctor for sums agreed with him/her, irrespective of what the insurer agrees to pay.

42. The Medical Committee shall examine collectively all the available documents liable to be of use to it in its assessment and all decisions shall be taken by majority vote. The Medical Committee shall be responsible for deciding on and adopting its own rules of procedure. The third doctor shall be responsible for providing the secretariat and drafting the report. The Medical Committee may request additional examinations and consult experts in order to complete its work or obtain opinions which are necessary for carrying out its task. The Medical Committee may deliver medical opinions only on the facts submitted to it for examination.

    If the Medical Committee, whose task is limited to the purely medical aspects of the case, considers that the latter may entail a legal dispute, it shall declare that such a dispute is beyond its remit. On completing its proceedings, the Medical Committee shall set out its opinion in a report to the insurer and the insured and those entitled under him/her. On the basis of that report, the insurer shall notify the insured or those entitled under him/her of its decision together with the findings of the Medical Committee.

43. Expenses incurred in connection with the proceedings of the Medical Committee shall be borne equally by both parties with the exception of costs for additional examinations and experts called by the Medical Committee that shall be borne by the insurer according to the normal reimbursement rules under this policy. The insured or those entitled under him/her shall pay the fees and incidental expenses of the doctor chosen by them and half of the fee and incidental expenses of the third doctor.