Annex 7. Insurance policy specification SCIC/B4/2019/01

Purpose of the policy

1. This insurance policy is drawn up between the European Commission (the policy holder) and xxx (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 against the risks of:

   - sickness contracted while under the insurance cover,
   - accident suffered while under the insurance cover,
   - and consequent loss of income.

Definitions

3. Subject to provisions defined in the chapter "Exclusions and limitations", an "accident" means any sudden event caused by one or more external factors that harms the physical or psychological integrity of the Insured and occurs in the course or by the fact of the contract of employment.

4. Subject to provisions defined in the chapter "Exclusions and limitations", an "illness" means any illness, disease or syndrome which manifests itself as a sudden and unexpected deterioration of health directly and definitely caused by or occurring in the course of the contract of employment.

5. "Total invalidity" or "total incapacity" means invalidity or incapacity, which entirely prevents the Insured from engaging in any occupation, business, profession or employment for which the Insured is qualified by education, training or experience.

   "Partial invalidity" or "partial incapacity" means invalidity or incapacity, which prevents the Insured from engaging in part in any occupation, business, profession or employment for which the Insured person is qualified by education, training or experience.

   Total loss of voice or hearing caused by an accident or illness shall specifically 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.

   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, for any given calendar year, exceeds the average yearly net remuneration from the three calendar years period prior to the beginning of the 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 total/partial incapacity, which has lasted not less than 360 days in total duration and at the expiry of that period is certified by a medical practitioner as being beyond hope of improvement.

   The Insurer may request an independent medical examination to determine the right to permanent invalidity and to review it at a later point.

7. By "relapse" is meant any new temporary total or partial incapacity which arises within 365 days after the end of an incapacity covered under item (d), (e), (j) or (k) of the schedule, the cause of which can be traced to the same accident / illness.

8. "Daily remuneration" means the amount, referred to in article 6 of the Agreement, paid to the Insured by the European Commission on its own behalf or on behalf of the other European Institutions for each day contracted as ACI. As a guide, the daily gross remuneration on 1 July 2018 is €603.80 for experienced ACI and €434.73 for beginners.

   The above rates and compensation payments based thereon are subject to the retroactive adjustments effective from 1 July each year, in line with the annual adjustment of the remuneration of officials and other servants of the European Union. In case of negative adjustment of rates, the Insurer has the possibility to regularise the difference in compensation paid with the Insured.

9. The "annual remuneration" is based on the Insured's daily remuneration and his yearly average number of insured days over the period of the last 3 rolling years preceding the incapacity. The Insured's yearly average number of insured days is calculated taking into account only those years within the above mentioned period where the Insured had at least one insured day. Insured days are days during which the Insured was under insurance cover as defined in article 14.

   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 the 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, paid until the retirement age, equal to 70% of the Insured's annual remuneration.

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 lump sum payable in the event of permanent total invalidity proportionate to the degree of invalidity, in accordance with the scale in *Annex 8*, and an annuity, paid until the retirement age, equal to a fraction of the annuity payable in the event of permanent total invalidity proportionate to the degree of invalidity, as determined by a medical practitioner in accordance with the scale in *Annex 8*.

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: a compensation 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: a compensation 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 8*.

(f) Accident related relapse: incapacity directly and incontestably related to a prior covered accident: 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, paid until the retirement age, equal to 70% of the Insured's annual remuneration.

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 lump sum payable in the event of permanent total invalidity proportionate to the degree of invalidity, in accordance with the scale in *Annex 8*, and an annuity, paid until the retirement age, equal to a fraction of the annuity payable in the event of permanent total invalidity proportionate to the degree of invalidity as determined by a medical practitioner in accordance with the scale in *Annex 8*.

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: a compensation equal to the Insured's daily remuneration for a maximum of 21 days and thereafter 35% of the Insured's 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: a compensation 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 8*. However, no compensation shall be payable in respect of the first three days of incapacity.

(l) Illness related relapse (partial or total): incapacity directly and incontestably related to a prior covered illness: the continuation of the compensation scheme 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, illness or relapse, of medical, surgical and pharmaceutical expenditure incurred by an Insured.

Except for reimbursement of transportation costs to the nearest hospital / first aid in case of complications to the pre-existing conditions referred to in article 18, the Insured can claim reimbursement of medical expenses only if entitled to one of the forms of compensation referred to in (a) to (l) above. Reimbursement of medical expenses can include hospitalisation and convalescence expenses, home care, travel expenses necessarily incurred in obtaining proper treatment (with exception of repatriation costs for Insured on non-local contracts[2]) 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 a covered 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.

If the Insurer considers certain medical expenses to be abnormally high, he may refer to the Medical Committee provided in the Disputes section of this policy. In this case, the expenses incurred in connection with the proceedings of the Medical Committee shall be borne exclusively by the Insurer.

[2] Repatriation costs for ACI with non-local contract can be claimed under the complementary travel insurance.

Period of the insurance cover and its extent

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

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

15. The Insured covered by this policy are 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.

Exclusions and limitations

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 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. Examples:
        - the Insured's voluntary participation in brawls;
        - any deliberate, illegal or criminal acts committed by or on behalf of the Insured person, or any other person acting with their consent or at their direction;
        - inebriation or the use of narcotics not prescribed by a doctor.
    - inherently dangerous behaviour unrelated and unnecessary to the normal exercise of the contract of employment. Examples:
        - being in an aircraft or any other airborne equipment, unless as a passenger and for reasons related to the execution of the ACI contract;
        - training for or participating in a sport competition as a professional.

    The following are nonetheless presumed accidents:

    - poisoning, including food poisoning;
    - infections, sicknesses and injuries and any other consequences of the bites or stings of animals or insects,
    - sprains, tears, lacerations and ruptures of muscles and tendons caused by normal physical effort,
    - 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.

18. Except in cases triggered by accidents or illness covered by this policy, the responsibility of the Insurer in cases related to pre-existing medical conditions or the complications thereof is limited only to reimbursement of transportation costs to the nearest hospital and the first aid.

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. In the event of temporary incapacity the total gross 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 gross remuneration, including all allowances the Insured would be normally entitled to; otherwise the compensation due shall be reduced accordingly.

21. 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).

22. 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), relapse (items (f) or (l) of the schedule) and the reimbursement of medical expenses (item "m" of the schedule). In case of temporary partial incapacity preceding or following temporary total incapacity, the total length of compensation period for consequences of a single accident or illness is limited to 364 days.

    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) or relapse (items "f" or "l" 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 and relapse."

23. 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.

Claim processing and deadlines

24. 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 reply in at least English and French.

25. The Insured should be able to reach customer service representatives of the Insurer on every working day between 9 and 17h. Written queries by the Insured have to be addressed by the Insurer within 5 working days.

26. The Insured shall send the medical certificate concerning the incapacity to work to the Insurer within 5 calendar days from the date of the occurrence of the accident or manifestation of the illness. The postmark or e-mail date will act as proof of submission. The Insurer shall send once a week, on a fixed day, a list of all certificates of incapacity under the compulsory insurance provided for in article 14 to the European 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,
- days spent travelling to and from the place of the assignment,
- and any other days on which the insured is obliged to remain away from his domicile because of the requirements of his contract.

27. A claim in respect of temporary incapacity shall be supported by a medical certificate attesting to total or partial incapacity for work.

    The Insurer may request the Insured to supply any other certificates and proof which he may reasonably require. The Insurer 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 10 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.

    Falsified declarations made by the Insured or their beneficiaries regarding the accident / illness or its consequences may result in forfeiture of the claim as a whole, including elements which may have been legitimately due.

28. 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 start of illness / accident;
    - Reimbursement of medical expenses (article 13(m) of the schedule): 18 months as from the last date of treatment.

29. Claims relating to temporary total/partial incapacity arising from accidents or illnesses (article 13 (d) to (f) and (j) to (l) of the schedule) should be handled by the Insurer within one month of receipt of the claim. At this time at the latest, the Insured should be notified by Insurer about its decision. Payments are to be made within 14 calendar days of the notification date.

30. For claims relating to death and permanent total/partial invalidity arising from accidents or illnesses (article 13 (a) to (c) and (g) to (i) of the schedule) the Insurer should send a settlement proposal to the Insured / their beneficiaries within one month of receipt of the claim. If the Insurer is not in a position to send the settlement proposal within the time period specified above, it will inform the Insured or their beneficiaries about the precise reasons for the delay and the deadline will be extended by one month. Payments are to be made within 14 calendar days of the acceptance date of the settlement proposal.

31. The Insurer shall pay compensation directly to the Insured.

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

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

Any sum overpaid shall be recovered if it can be established that the Insured was aware that there was no legitimate reason for the payment or if the fact of the overpayment was patently such that he could not reasonably 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.

32. 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.

Optional insurance cover

33. The Insurer will offer the Insured an optional scheme to provide coverage for days where the Insured do not fall under the criteria of article 14.

    The annual premium occasioned by this optional scheme will be disbursed by the Insured directly to the Insurer.

    The Insurer must provide for accounting procedures intended to prevent a premium from being paid twice, i.e. both by the European Commission and by the Insured, in respect of days on which an interpreter who has taken out optional insurance is also covered under article 14 above.

Disputes

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

35. 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.

36. 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 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 together with a report from that doctor setting out the medical issues disputed in relation to the Insurer’ decision.

37. The Medical Committee shall consist of three doctors:

    - one appointed by the Insured or those entitled under him 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.

38. 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 and other relevant medical reports.

    The Insurer shall inform the Insured or those entitled under him of the fees and expenses which are liable to be borne by them. The Insured or those entitled under him may not object to the third doctor on account of the amount of the fees and expenses requested by him. However, the Insured or those entitled under him 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 and half of the fee and expenses of the third doctor, shall be borne by the Insured or those entitled under him in respect of the part of the work that has been completed. The Insured or those entitled under him shall remain liable to his doctor for sums agreed with him, irrespective of what the Insurer agrees to pay.

39. 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. On the basis of that report, the Insurer shall notify the Insured or those entitled under him of its decision together with the findings of the Medical Committee.

40. 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 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.