GamaLife

Vida Segura 18/25

INFORMATION NOTE ON THE GENERAL TERMS AND CONDITIONS AND SPECIAL TERMS AND CONDITIONS
Vida Segura 18/25

CONTRACT

Vida Segura 18/25 is a life insurance policy entered into between the Policyholder and GamaLife - Companhia de Seguros de Vida, S.A., marketed through NOVO BANCO, S.A. A Policy will be issued for each Policyholder. This document constitutes the Contract entered into between the parties and sets out the agreed Specific Terms and Conditions. The policy may be taken out by an Insured Person, and the Policyholder is responsible for paying the premiums in full. The statements made by the Policyholder and the Insured Person, both in the Subscription Proposal and in the relevant questionnaires required, form the basis of this Contract, which is binding once it comes into force. Any intentionally inaccurate or incomplete statements that affect the risk assessment render the Contract a Voidable Contract; furthermore, in the event of bad faith, the Policyholder shall not be entitled to any refund of premiums. Where the context so permits, the masculine form shall include the feminine, and the singular shall include the plural, and vice versa. The Vida Segura 18/25 policy is governed by the Specific Terms and Conditions, the General Terms and Conditions of Life Insurance, and the Special Terms and Conditions of the respective Complementary Insurances covering Total and Permanent Disability by Accident and Critical Illness Cover.

WHO IS THE POLICYHOLDER?

The Policyholder is the Entity that enters the contractual agreement with the Insurer, and responsible for paying the premium;

WHO IS THE INSURED PERSON?

The Insured Person is the person exposed to the risks which, under the agreed terms, constitute the purpose of this Contract;

WHO IS THE BENEFICIARY?

The Beneficiary is the Entity on whose behalf the Contract is entered into, as identified in the subscription proposal.

WHAT DOES THE PREMIUM CONSIST OF?

The Premium is the amount paid by the Policyholder to the Insurer in return for coverage of the Contract.

WHAT IS THE ACTUARIAL AGE?

Actuarial Age – The Insured Person's birthday closest to the date on which the insurance contract is entered into or renewed, i.e. if, on the date the insurance contract is entered into or renewed, the Insured Person is less than six months away from their next birthday, their actual age in whole years is considered, plus one year.

WHAT ARE THE COVERAGES OF THE CONTRACT?

The Vida Segura 18/25 policy guarantees payment of the Insured Capital assured to the designated Beneficiary/Beneficiaries should any of the following situations occur during the term of the policy, provided that they are included in the Specific Terms and Conditions:

Principal Insurance

» Death of the Insured Person: payment of the Insured Capital to the designated Beneficiary/Beneficiaries.

Complementary Insurances

» Total and Permanent Disability by Accident: provides for the full advance payment of the Insured Capital in the event of the Insured Person suffering Total and Permanent Disability by Accident.

» Critical Illness Cover of the Insured Person: provides for the full advance payment of the Insured Capital in the event of the Insured Person falling ill.

The cover provided for in this Contract shall not be determined or caused by any illness, medical condition or state of health pre-existing at the date of its conclusion; in such cases, the Insurer shall be released from the obligation to pay the Insured Capital.

WHAT CONSTITUTES TOTAL AND PERMANENT DISABILITY BY ACCIDENT?

The Insured Person is deemed to be in a state of Total and Permanent Disability by Accident whenever, as a result of an Accident, they are permanently and irreversibly unable to carry out their profession or any other gainful activity in accordance with their knowledge and skills, and furthermore, have a Degree of Incapacity of 66% in accordance with the "National

Table of Disability due to Work-Related Accidents and Occupational Diseases" officially in force at the time the disability is recognised.

Total and Permanent Disability by Accident (or its degree) must be determined based on objective medical evidence, by a doctor appointed by the Insurer or, in the event of a disagreement with the Insurer, by an Arbitral Tribunal or Judicial Court, whose determination shall take precedence over any opinions or decisions issued by Social Security, the Caixa Geral de Aposentações (General Pension Fund) or any other voluntary or compulsory scheme that replaces or supplements them.

Total and Permanent Disability is only recognised following an assessment by a Medical Board authorised for this purpose confirming that the aforementioned Degree of Incapacity is permanent and irreversible, i.e. it is not subject to future changes, and does not require reassessment after the Medical Board's meeting took place.

If, on the date the Contract comes into effect, the Insured Person is already suffering from some form of disability, only the difference between the existing degree of disability and the new degree of disability will be taken into account.

Total and Permanent Disability must be established within one year of the date of the accident.

The term "Accident" refers to any sudden, unforeseen and abnormal event caused by an external, violent force beyond the Insured Person's will, resulting in bodily injury that can be objectively confirmed by a medical examination.

The following are not considered accidents:

- All illnesses of any kind, unless resulting from a covered accident;
- Injuries which, by their nature, may be treated as an accident, but which are of internal origin and unrelated to a covered accident, such as hernias, lower back pain, sciatica, injuries resulting from "straining", heart attacks regardless of the cause, coronary heart disease, aneurysm rupture, cerebral embolisms, subarachnoid haemorrhages, epileptic seizures and *delirium tremens;* - attempted suicide.

The following are considered accidents:

- After-effects of drowning;
- Injuries sustained whilst rescuing people or property at risk;
- Poisoning and burns resulting from the accidental ingestion of toxic or corrosive substances or the accidental release of gases or vapours.

Exclusion of Accidents occurring prior to the entry into force of the Contract:

a) All cases where the Insured Person is found to have a blood alcohol level equal to or higher than that specified by law for drivers of motor vehicles in Portugal are also excluded.

b) Persons who have voluntarily caused the accident are excluded from insurance cover.

WHAT CONSTITUTES A CRITICAL ILLNESS?

If the Insured Person is diagnosed with one of the Critical Illnesses defined in the following sub-paragraphs, and provided that these are specified in the Special Terms and Conditions, the Insurer guarantees the advance payment of 100% of the Insured Capital under the Principal Insurance, thereby automatically cancelling the relevant Specific Terms and Conditions.

The Critical Illnesses (provided they are contractually agreed) covered under the Contract are:

- Cancer;
- Myocardial infarction;
- Stroke (Cerebrovascular Accident);
- Limb Paralysis;
- Multiple Sclerosis;
- Coma;
- Severe Head Trauma;
- Loss of Limbs.

These are defined as follows:

Cancer (excluding less advanced stages)

Any malignant tumour that has been definitively diagnosed with histological confirmation and is characterised by the uncontrolled growth of malignant cells and invasion of tissue. The diagnosis must be confirmed by a specialist. Unless specifically excluded, Leukaemia, Malignant Lymphoma and Myelodysplastic Syndrome are covered by this definition.

Myocardial Infarction (heart attack).

A myocardial infarction is the death of heart tissue due to prolonged obstruction of blood flow. Under this definition, myocardial infarction is indicated by an increase and/or decrease in cardiac biomarkers (troponin or CK-MB) to levels considered diagnostic of myocardial infarction, together with at least two of the following criteria:

- Symptoms of ischaemia (such as chest pain)
- Changes in the electrocardiogram (ECG) indicative of new ischaemia (new ST-T changes or new left bundle branch block)
- Development of pathological Q waves on the ECG. The diagnosis must be confirmed by a cardiologist.

Stroke (Cerebrovascular Accident) (CVA).

Death of brain tissue due to an acute cerebrovascular event caused by intracranial thrombosis or haemorrhage (including subarachnoid haemorrhage) or embolism of extracranial origin, with:

- Acute onset of new neurological symptoms, and
- New objective neurological deficits on clinical examination.

The neurological deficit must persist for more than three months after the date of diagnosis. The diagnosis must be confirmed by a neurologist and supported by imaging.

Limb Paralysis (total and irreversible).

Total and irreversible loss of muscle function in both limbs, resulting from injury or disease of the spinal cord or brain. A limb is defined as a whole arm or a whole leg. The paralysis must have been present for more than three months, confirmed by a neurologist and supported by clinical and diagnostic findings.

Multiple Sclerosis (resulting in permanent symptoms).

Definitive diagnosis of multiple sclerosis, which must be confirmed by a neurologist and supported by all of the following criteria:

- Current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least six months
- MRI (Magnetic Resonance Imaging) showing at least two demyelinating lesions in the brain or spinal cord, characteristic of multiple sclerosis.

Coma (resulting in permanent symptoms)

A definitive diagnosis of a state of unconsciousness with no reaction or response to external stimuli or internal needs, which:

- This results in a score of 8 or below on the Glasgow Coma Scale for at least 96 hours,
- Requires the use of life-support systems, and
- Results in a persistent neurological deficit[1], which must be assessed at least 30 days after the start of the coma.

The diagnosis must be confirmed by a neurologist.

Severe Head Trauma – traumatic brain injury (resulting in permanent loss of physical abilities).

A definitive diagnosis of a brain function disorder resulting from a head injury. The head injury must result in a total inability to perform, unaided, at least three out of six Activities of Daily Living for a continuous period of at least three months, with no reasonable prospects of recovery.

Activities of Daily Living are:

- Bathing – the ability to bathe in (including getting in and out of) a bath or shower or to wash oneself satisfactorily by other means.
- Dressing and undressing – the ability to put on, take off, fasten and unfasten all items of clothing and, where necessary, any medical devices, prosthetic limbs or other surgical appliances.
- Eating – the ability to eat when food has been prepared and provided.
- Personal hygiene – the ability to maintain a satisfactory standard of personal hygiene by using the toilet or managing bowel and bladder functions.
- Moving between rooms – the ability to go from room to room on a single floor.
- Getting in and out of bed – the ability to get out of bed into a chair or wheelchair in an upright position and back again.

The diagnosis must be confirmed by a neurologist or neurosurgeon and supported by typical imaging (CT or MRI scans of the brain).

Loss of Limbs.

A definitive diagnosis of complete separation of two or more limbs at or above the wrist or ankle joint as a result of an accident or medically necessary amputation. The diagnosis must be confirmed by a specialist.

Complementary Critical Illness Cover can only be taken out at the same time as complementary insurance for Total and Permanent Disability by Accident. Complementary Critical Illness Cover has a 90-day waiting period.

WHAT IS NEEDED TO SUBSCRIBE?

Subscription Age:

- Minimum: 18 years;

- Maximum: 24 years.

- Maximum Age of Permanence: 25 years.

Acceptance is based on the accuracy of the information provided in the Subscription Proposal, as well as in any medical questionnaires, where applicable.

WHAT IS THE TIME LIMIT FOR THE INCONTESTABILITY OF THE CONTRACT?

Two (2) years after the date on which the Contract was signed, the Insurer may not rely on any negligent omissions or inaccuracies provided by the Policyholder or the Insured Person in the Initial Risk Declaration (this does not apply to the complementary cover for Total and Permanent Disability by Accident under the life insurance policy).

WHAT DOES THE INITIAL RISK DECLARATION CONSIST OF?

When applying for the insurance, the Policyholder and the Insured Person must disclose, in all truth and honesty, all facts or circumstances for an accurate risk assessment, or that may influence the acceptance of the application, the proper determination of the applicable premium, or the acceptance of the cover provided.

WHAT HAPPENS IN THE EVENT OF FRAUDULENT OMISSIONS OR INACCURACIES BY THE POLICYHOLDER OR THE INSURED PERSON?

In the event of any fraudulent omissions or inaccuracies in the Initial Risk Declaration made by the Policyholder or the Insured Person, the Insurer shall cancel the Contract by sending a notice to that effect to the Policyholder within three (3) months of becoming aware of the breach. Any claims, whether before the Insurer has become aware of the fraudulent breach or within the period referred to in the preceding paragraph, shall not be covered by the Contract. The Insurer is entitled to the premium due up to the end of the aforementioned period when the fraudulent conduct of the Policyholder/Insured Person is intended to obtain an advantage, until the expiry of the Contract.

WHAT HAPPENS IN THE EVENT OF NEGLIGENT OMISSIONS OR INACCURACIES BY THE POLICYHOLDER OR INSURED PERSON?

If there are any negligent omissions or inaccuracies in the Initial Risk Declaration made by the Policyholder or the Insured Person, the Insurer may:

a) Propose a contractual amendment establishing a time period of at least fourteen (14) days for the Policyholder/Insured Person to provide a statement;

b) Cancel the Contract if it is proven that the Insurer would not, under any circumstances, have entered into the Contract had it been aware of the omitted or inaccurately stated fact.

Under such circumstances, the Contract shall cease to be effective twenty (20) days after the Insurer has sent the proposed amendment, if the Policyholder/Insured Person does not agree to it, or thirty (30) days after the notice of termination has been sent. If the Contract is terminated, the premium will be refunded according to the time period remaining until the expiry date.

In the event of a claim arising prior to the termination or amendment of the Contract, where the claim's occurrence or consequences have been influenced by a fact subject to a negligent omission or inaccuracy, the Insurer shall:

(a) Cover the claim proportionally to the difference between the premium paid and the premium that would have been due if,

at the time the Contract was signed, it has been aware of the omitted or inaccurately stated fact;
(b) Refuse to cover the claim, demonstrating that it would not, under any circumstances, have entered into the Contract had it been aware of the omitted or inaccurately stated fact.

WHEN DOES THE CONTRACT COMMENCE?
This Contract shall commence at midnight on the date specified in the Policy's Specific Terms and Conditions.

WHAT IS THE DURATION OF THE CONTRACT?
The Contract's duration is as stated in the Specific Terms and Conditions. The Contract is entered into for a period of one year, tacitly renewed for additional periods of the same duration, until the end of the policy year in which the Insured Person reaches the maximum age of permanence of the Contract.

WHAT IS NEEDED TO TAKE OUT THIS INSURANCE?
In order to take out this insurance, the Insured Persons and Policyholder must fully complete and sign the Insurance Subscription Proposal, which must include details of their civil and tax identification, as well as the Beneficiary/Beneficiaries, per the guarantees of the Contract.
In order to carry out a comprehensive risk assessment, the Insurer takes into account the analysis of the Questionnaires, the Health Declaration or required medical examinations, as well as the professional and non-professional activities of the Insured Person (or the Insured Persons, in the case of joint life insurance).
After analysing the available information, the Insurer may take one of the following decisions: a) Notify the Insured Person of its acceptance of the insurance policy without reservation, resulting in the immediate issue of the Contract.
b) Propose conditional acceptance, or acceptance subject to premium loading of the Insured Person under the insurance policy and/or with exclusions or limitations on cover.
c) Notify complete rejection of the Insurance Proposal.
The proposal referred to in sub-paragraph (b) or the refusal referred to in sub-paragraph (c) must be notified within 30 days of the date of receipt of all required accompanying documents of the Subscription Proposal or those which the Insurer has requested for its consideration. Whenever the Insurer, in exercising its right, makes a counter-offer subject to the condition set out in sub-paragraph (b), the policy shall only be deemed to be in force once the Policyholder has accepted the counter-offer in writing.

WHAT IF I AM ON SICK LEAVE?
Insured Persons who, at the start of this insurance, are on sick leave will only be covered by the insurance upon their return to work, provided they meet the eligibility criteria set out above.

CAN I MAKE AMENDMENTS TO THE CONTRACT?
Any amendments to the Terms and Conditions of the Contract are subject to mutual agreement between the Policyholder and the Insurer. The Insurer reserves the right, in the event of an increase in the coverage amount, to make acceptance of the amendment conditional upon the Insured Persons passing any medical examinations deemed necessary for this purpose by the Insurer. The costs of these tests shall be borne by the Insurer. Amendments shall take effect on the policy Anniversary Date, provided they are notified in writing and received by the Insurer at least 60 days prior to that date.

WHAT IS THE INSURED CAPITAL AMOUNT?
The Insured Capital is €10,000.

HOW IS THE CONTRACT PREMIUM CALCULATED?
The Contract premium is fixed for the entire term, and amounts to €3.00 per month or €36.00 per year. This amount includes the statutory charges, in particular the INEM levy (National Medical Emergency Institute).

HOW IS THE PREMIUM PAID?
The premium, plus statutory charges, is payable annually by the Policyholder in advance, and will be debited from the Policyholder's bank account held with NOVO BANCO, S.A.
The premium is payable before the end of the policy year in which the Insured Person dies or in which the early compensation is paid,

at the latest by the end of the period specified in the Specific Terms and Conditions or upon reaching the agreed term age.

WHAT HAPPENS IF THE PREMIUM IS NOT PAID?

Any failure to pay the premium within 30 days of the due date shall allow the Insurer, pursuant to the law, to proceed with Policy termination by sending a notice simultaneously – when they are different persons – to the Policyholder and the Insured Person, at least 8 days prior to the effective date.

CAN A POLICY BE REINSTATED?

The Policyholder may reinstate a policy that has been cancelled due to non-payment, under the original terms and conditions, within six (6) months of the termination date, upon payment of outstanding premiums and corresponding default interest. The Insurer reserves the right, in such cases, to make the Policy revalidation conditional upon the Insured Person (or the Insured Persons, in the case of joint life insurance) passing a medical examination. The costs of medical examinations shall be borne by the Policyholder.

CAN THE POLICYHOLDER TERMINATE THE CONTRACT?

The Policyholder is entitled to terminate the Contract on the policy Anniversary Date with at least 30 days' prior notice to the Insurer.

WHO IS THE BENEFICIARY OF THIS CONTRACT?

The Policyholder is entitled to name the Beneficiaries in accordance with the terms of the Contract, and to amend the Beneficiary Clause at any time until the date on which the Beneficiary is entitled to the insured amounts. Such an amendment shall only be valid provided that the Insurer has received the relevant written notification with the Beneficiary's identification details, including their full name, address, and civil and tax identification numbers.

In the event that the Beneficiary's identification details are incorrect or out of date, thereby preventing the Insurer from establishing their identity, payment of the share of the Benefit shall be suspended pending a claim from the person concerned. Any change to the Beneficiary will result in an Additional Endorsement.

WHEN DOES THE INSURANCE COVERAGE END?

a) Following termination by the Insured Person or the Policyholder;

b) When the Insured Person reaches the term age of 25;

c) Due to the voidability of the insurance contract because of false statements, omissions, or inaccurate or incomplete statements regarding the state of health affecting the risk assessment. If liability for these statements is attributed to the Insured Person, cover for that person will be cancelled;

d) Due to the Insured Person's attempted suicide, in relation to the cover for Total and Permanent Disability by Accident;

e) By termination of the Contract due to non-payment of the premium within 30 days of its due date;

f) On the expiry date of the Specific Terms and Conditions;

g) Payment of the Insured Capital in accordance with the Specific Terms and Conditions.

h) If the Policyholder exercises their right of withdrawal.

WHAT ARE THE EXCLUDED RISKS IN THE EVENT OF THE INSURED PERSON'S DEATH?

The death cover provided under this Contract shall apply regardless of the cause of death, except when death is caused by:

a) A criminal act in which the Beneficiary/Insured Person is the material or moral author, or to which they have been an accomplice;

b) Suicide, if it occurs during the first year of the policy or during the first year following any increase in the capital insured;

c) Claims arising as a direct or indirect consequence of an intentional act by the Insured Person or committed with their complicity;

d) Aviation accidents, except when the Insured Person is a passenger on a commercial passenger aircraft duly authorised by IATA (International Air Transport Association);

e) Injuries or harm resulting from active participation in acts of kidnapping, riots, insurrection, uprisings, brawls, terrorism or sabotage, provided that the Insured Person was not acting in self-defence or in an attempt to rescue people or property.

f) Revolution, civil war and war with a foreign country, whether declared or not;

g) Alcoholism and the use of drugs when not medically prescribed;

h) Occurrence of nuclear risks;

i) High-Risk Sports such as car racing, motorcycling, hunting outside the European territory, spearfishing, scuba diving, mountaineering, caving, boxing, any form of martial arts, bungee jumping, motorcycling, caving, piloting non-commercial aircraft and, in general, all types of aerial vehicles, alpinism, exploratory travel, bullfighting, training of wild animals, parachuting, free flight, gliding, hang gliding, microlight aircraft flying, and, in general, any sport or recreational activity of a notoriously dangerous nature, j) Claims arising from competitions, betting or attempts to break records and, in general, all acts of a notoriously dangerous nature that are not justified by any professional necessity or attempt to rescue persons.

1) Accidents suffered by the Insured Person as a result of acts committed by them which are classified as criminal offences under the law, including acts committed under the influence of toxic drugs, narcotic drugs or psychotropic substances not prescribed by a doctor. For the purposes of this provision, the Insured Person shall be deemed to have been under the influence of toxic drugs, narcotic drugs or psychotropic substances whenever any such substance is found in the bloodstream or any bodily fluid used for such tests;

WHAT IF THE INSURED PERSON SUFFERS TOTAL AND PERMANENT DISABILITY BY ACCIDENT?

Excluded Risks in the event of total and permanent disability by accident are the same as those for the Insured Person's death.

WHAT ABOUT CRITICAL ILLNESS COVER?

Excluded risks in the event of critical illness cover are:

Cancer.

a) Any tumour histologically classified as pre-malignant, non-invasive or carcinoma in situ (including ductal and lobular carcinoma in situ of the breast and cervical dysplasia CIN-1, CIN-2 and CIN-3).

b) Any prostate cancer, unless histologically classified as having a Gleason Score greater than 6 or having progressed to at least clinical TNM stage T2N0M0.

c) Chronic Lymphocytic Leukaemia, unless it has progressed to at least Binet Stage.

d) Basal cell carcinoma and squamous cell carcinoma of the skin, and stage IA malignant melanoma (T1aN0M0), unless there is evidence of metastases.

e) Papillary thyroid cancer measuring less than 1 cm in diameter and histologically described as T1N0M0.

f) Papillary microcarcinoma of the bladder, histologically described as Ta.

g) polycythaemia vera and essential thrombocythemia.

h) Monoclonal Gammopathy of Undetermined Significance (MGUS).

i) Gastric MALT Lymphoma, if the condition can be treated with Helicobacter eradication.

j) Gastrointestinal stromal tumour (GIST), stage I and II, according to the AJCC *Cancer Staging Manual,* Seventh Edition (2010).

k) Cutaneous lymphoma, unless the condition requires treatment with chemotherapy or radiotherapy.

l) Microinvasive breast carcinoma (histologically classified as T1mic), unless the condition requires a mastectomy, chemotherapy or radiotherapy.

m) Microinvasive cervical carcinoma (histologically classified as stage IA1), unless the condition requires a hysterectomy, chemotherapy or radiotherapy.

Myocardial infarction.

(a) Acute coronary syndrome (stable or unstable angina).

b) Elevated troponin levels in the absence of obvious ischaemic heart disease (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity).

c) Myocardial infarction with normal coronary arteries or caused by coronary vasospasm, myocardial bypass, or drug abuse.

d) Myocardial infarction occurring within 14 days of coronary angioplasty or coronary artery bypass surgery.

Stroke (Cerebrovascular Accident).

a) Transient ischaemic attack (TIA) and prolonged reversible ischaemic neurological deficit (PRIND).

b) Trauma to brain tissue or blood vessels.

c) Neurological deficits caused by generalised hypoxia, infection, inflammatory disease, migraine or medical intervention.

d) Incidental findings during imaging (CT or MRI) with no clearly related clinical symptoms (silent stroke).

e) Death of tissue in the optic nerve, retina or vestibular system.

Limb Paralysis.

a) Paralysis resulting from physical injury or psychological disorders.

b) Guillain-Barré syndrome.

c) Periodic or hereditary paralysis.

Multiple Sclerosis.

a) Possible multiple sclerosis and isolated syndromes that are neurologically or radiologically suggestive of, but not diagnostic of, multiple sclerosis.

b) Isolated optic neuritis and neuromyelitis optica.

Coma.

a) Clinically induced coma.

b) Any coma resulting from self-inflicted injury, alcohol consumption or drug use.

Severe Head Trauma.

Any severe head trauma caused by self-inflicted injury, alcohol or drug use.

Loss of Limbs.

Loss of limbs due to self-inflicted injury.

WHAT IS THE TERRITORIAL SCOPE OF THE CONTRACT?

The territorial scope of this Contract extends worldwide; however, the cover provided under this Policy may be subject to restrictions in the event of illness or accidents caused by political risks and war risks.

WHAT DO POLITICAL RISKS AND WAR RISKS CONSIST OF?

"Political risks and war risks" are defined as any direct or indirect consequences of riots, revolutions, kidnapping, civil war or war with a foreign country, whether declared or not, insurrection, uprisings, brawls, terrorism or sabotage as defined under Portuguese criminal legislation in force, regardless of where the events take place and who the perpetrators may be.

ARE THERE ANY RESTRICTIONS WHEN THE INSURED PERSON BELONGS TO THE ARMED FORCES?

If the Insured Person has joined, or eventually joins, the armed forces or equivalent (such as paramilitary formations), whether on a voluntary or compulsory basis, and takes part in military operations or hostile situations of any kind, the cover provided under the Contract shall be suspended from the date of the declaration of war or, in the absence thereof, from the start of hostilities until six months after their cessation, except in the case of a special convention and payment of the relevant additional premium.

WHAT IS NEEDED TO PAY OUT THE INSURED AMOUNTS IN THE EVENT OF THE INSURED PERSON'S DEATH?

The documents to be submitted to the Insurer in the event of a claim are as follows:

a) The Insured Person's identification document;

b) The Insured Person's death certificate;

c) Where the death is due to illness, a medical report must be provided detailing its causes and progression, including the dates of diagnosis, tests and treatments;

d) Where death is caused by an accident, the actions of a third party or an unknown cause,

the following must be provided: certified copy of the occurrence report or document describing the accident issued by the competent authority; a copy of the forensic post-mortem report or a document confirming that such a report was not required; and the court's decision (where third parties are involved). Once the claim notification has been made and all supporting documents requested by the Insurer have been submitted, the Insurer undertakes to notify the Insured Person and/or the Beneficiary, within a maximum of thirty (30) days, whether or not the claim is covered under the Contract.

WHAT IF THE INSURED PERSON SUFFERS TOTAL AND PERMANENT DISABILITY BY ACCIDENT?

In the event of disability, the Insured Person must send the Insurer a medical certificate from the attending physician stating the onset, causes, nature and progression of the disability. This certificate, under the responsibility of the Insured Person, must be sent to the Insurer within 60 days of the Total and Permanent Disability by Accident being established. A detailed description of activities carried out by the Insured Person prior to the incapacity must be provided. The event giving rise to the disability (its cause) must occur during the Policy Term and/or during the period in which cover is in force for the Insured Person, and must also be reported to the Insurer within a maximum of 60 days of the cessation of cover. The Insurer reserves the right to request further information and to carry out any investigations deemed necessary to accurately determine the Insured Person's condition, including arranging for the Insured Person to be examined by its own doctors if necessary. In such case, the costs shall be borne by the Insurer. The Insured Person must authorise their attending physician to provide to the Insurer's medical representative, on a confidential basis, all medical information relating to the reported claim. In the absence of an agreement, any of the parties concerned may seek to resolve the dispute by applying to the Medical Board, which shall serve as an Arbitral Tribunal.

WHAT HAPPENS IN THE EVENT OF A CRITICAL ILLNESS OF THE INSURED PERSON?

In the event of a Critical Illness, the Beneficiary named in the Terms and Conditions must send the following to the Insurer: Medical certificate issued by the attending physician, following the detailed and accurate diagnosis of a Critical Illness, describing the medical history and stating the date of the first symptoms. This certificate, under the responsibility of the Policyholder or the Insured Person, must be sent to the Insurer within 60 days of diagnosing the illness.

The event giving rise to the Critical Illness (its cause) must occur during the Policy Term and/or during the period in which cover is in force for the Insured Person, and must also be reported to the Insurer within a maximum of 90 days of the cessation of cover.

Monitoring the Insured Person's state of health: The Insurer may, at any time, carry out any checks deemed necessary on the Insured Person in order to verify their actual state of health or the declared illness. Except in cases of force majeure, any refusal to grant the Insurer free access shall result in the suspension of Cover. The Insured Person must authorise their attending physician to provide to the Insurer's medical representative, on a confidential basis, all medical information relating to the reported claim. Failure by the Beneficiary or the Insured Person to comply with the provisions of the preceding sub-paragraphs, or the provision of false information to the Insurer, shall result in the suspension of the right to the Insured Amounts.

In the event of a Critical Illness, the amount will be paid 30 days after the illness has been definitively diagnosed.

CAN I EXERCISE MY RIGHT OF WITHDRAWAL?

1 - The Policyholder is entitled to freely terminate the Contract, without having to provide any reason, and without entitlement to any claim for compensation or penalty from the Policyholder.

2 - In the case of a Distance Contract relating to a specific financial service to which another distance contract is in any way attached, relating to financial services provided by a provider or by a third party on the basis of an agreement with that provider, the attached Contract shall be deemed automatically and simultaneously terminated, without penalty, provided that the Policyholder exercises the right of termination pursuant to the provisions of the preceding paragraph.

3 - Where the Contract is signed with a duration of one (1) year or more, the Policyholder shall have, for the purposes of the right of withdrawal, a period of thirty (30) days from the date on which they are notified of its signing.
4 - The termination of the Contract, pursuant to the above terms, must be notified to the Insurer in writing, either via hardcopy or another durable medium available and accessible to the Insurer.
5. The exercise of the right of withdrawal extinguishes the obligations and rights arising from the Contract or transaction, effective from the date of its signing. 6 - Where the Insurer has received any sums in payment, it shall be obliged to refund them to the Policyholder within 30 days of receiving notice of the right of withdrawal.
7 - The consumer must return to the provider any sums or goods received from it within 30 days of sending the notice of the right of withdrawal.
8 - The Policyholder is not obliged to pay for the service actually provided before the expiry of the right of withdrawal.
9 - This does not apply if the Policyholder has requested that the Contract start prior to the expiry of the right of withdrawal, in which case the Policyholder is obliged to pay the Insurer, as soon as possible, for the services actually provided, up to a maximum of the proportional value of those services within the scope of the contractually agreed transactions.
10 - The payment referred to in the preceding paragraph may only be demanded if the Insurer proves that it has informed the consumer of the amount payable.

WHAT IS THE DOMICILE ASSOCIATED WITH THIS CONTRACT?

For the purposes of this Contract, the Policyholder's domicile shall be deemed to be that specified in the Specific Terms and Conditions and/or, in the event of a change, any other domicile notified to the Insurer in writing or by any other means leaving a permanent record. Policyholders who take up residence outside Portugal must designate a domicile in the Portuguese territory for the purposes of this Contract.

COMMUNICATIONS OR NOTIFICATIONS

Any communications or notifications provided for in this Policy shall be considered valid and fully effective when done in writing or by any other means that leave a permanent record, sent to the Policyholder's last known address as stated in the Contract, to their email address, or to the Insurer's registered office or email address.

CHANGE OF ADDRESS UNDER THE CONTRACT

Any change to the address, registered office or email address of the Policyholder or the Insured Person must be notified to the Insurer or to NOVO BANCO, S.A., in writing or by any other means that leave a permanent record, within 30 (thirty) days of the change, failing which any communications or notifications sent by the Insurer to the known address or email address shall be deemed valid and effective.
Notwithstanding the above, any update to the Policyholder's contact details associated with the account, namely their domicile and email address, will result in a change to those details held by the Insurer, with the address and email address used for the purposes of the policy's Communications and Notifications being updated with the intermediary NOVO BANCO, S.A.

WHAT HAPPENS IN THE EVENT OF A DISPUTE?

In the event of a dispute between the Policyholder, the Insured Person and/or the Beneficiary with the Insurer with regard to assessing the risks covered by this Contract or determining the compensation amount, the parties may seek to resolve the dispute via the Medical Board, which shall act as an Arbitral Tribunal. The Medical Board shall consist of three doctors, one appointed by each of the parties in addition to a third doctor, who shall chair the board and have a casting vote, by mutual agreement between those appointed by the parties or, failing such agreement, by the National Institute of
Legal Medicine (office in the Insured Person's area of residence).

WHAT IS THE CONTRACT'S LEGAL FRAMEWORK?
This Contract shall be governed by Portuguese law. Any omissions in this Contract shall be governed by applicable legislation. The competent jurisdiction for settling any disputes arising from this Contract shall be that established by law.

WHAT IS THE CONTRACT'S TAX FRAMEWORK?
This Contract shall be governed by Article 12 of the Personal Income Tax Code and sub-sub-paragraph (ii) of sub-paragraph (a) of Article 1(5) of the Stamp Duty Code. The Insurer shall not be held liable for any costs or charges arising from any amendment to that regime.

PROFIT PARTICIPATION
This Policy does not provide for profit participation for the Policyholder or the Insured Persons.

PROTECTION OF COMPUTERISED PERSONAL DATA:
The data collected will be processed and stored electronically and is intended for use in contractual dealings with the Insurer and its Subcontractors. Any omissions, inaccuracies or falsehoods, both with regard to required or optional provision of information, are the responsibility of the Policyholder/Insured Person.

CLARIFICATIONS:
Any clarification requests or complaints must be notified in writing to the Insurer via the branches of NOVO BANCO, S.A.

GENERAL TERMS AND CONDITIONS

ANNUAL RENEWABLE TERM LIFE INSURANCE

ARTICLE 1. DEFINITIONS

1.1. The following definitions shall apply for the purposes of this Contract:

a) Insurer: GamaLife - Companhia de Seguros de Vida, S.A.;

b) Policyholder: the Entity that enters the contractual agreement with the Insurer, and responsible for paying the premium;

c) Insured Person: the person exposed to the risks which, under the agreed terms, constitute the purpose of this Contract;

d) Beneficiary: the Entity on whose behalf the Contract is entered into, as identified in the subscription proposal.

e) Policy: document representing the contract between the Policyholder and the Insurer, which includes the agreed General, Special, and Specific Terms and Conditions;

f) Premium: the amount paid by the Policyholder to the Insurer in return for coverage of the Contract.

g) Subscription proposal: a document to be completed and signed by the Policyholder and the Insured Person, containing the essential information required to for the proposed risk assessment and which, if accepted, will form the basis of the Contract.

h) Actuarial Age – The Insured Person's birthday closest to the date on which the insurance contract is entered into or renewed, i.e. if, on the date the insurance contract is entered into or renewed, the Insured Person is less than six months away from their next birthday, their actual age in whole years is considered, plus one year.

i) 2. Where the context so permits, the masculine form shall include the feminine, and the singular shall include the plural, and vice versa.

ARTICLE 2. CONTRACTUAL GUARANTEES

2.1. The Insurer undertakes, in the event of the Insured Person's death during the policy term, to pay the Insured Capital specified therein to the Beneficiary designated by the Insured Person.

2.2. In addition to Death cover, where expressly provided for in the Policy's Specific Terms and Conditions, complementary coverage may also be provided pursuant to the Special Terms and Conditions annexed to these General Terms and Conditions of the Policy. Complementary Insurances can only be taken out at the same time as the death cover referred to in 2.1. This choice is made at the

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Insured Person's time of subscription, and is specified in the Specific Terms and Conditions.

2.3. The cover provided for in this Contract shall not be determined or caused by any illness, medical condition or state of health pre-existing at the date of its conclusion; in such cases, the Insurer shall be released from the obligation to pay the Insured Capital.

ARTICLE 3. INCONTESTABILITY/ INITIAL RISK DECLARATION

3.1. Incontestability: Two (2) years after the date on which the Contract was signed, the Insurer may not rely on any negligent omissions or inaccuracies provided by the Policyholder or the Insured Person in the Initial Risk Declaration. The provisions of the preceding paragraph apply solely to cover for the risk of death and do not, therefore, apply to the supplementary cover for Total and Permanent Disability by Accident under the life insurance policy.

3.2. Initial Risk Declaration: When applying for the insurance, the Policyholder and the Insured Person must disclose, in all truth and honesty, all facts or circumstances for an accurate risk assessment, or that may influence the acceptance of the application, the proper determination of the applicable premium, or the acceptance of the cover provided. The declaration in question must include the facts and circumstances expressly requested in a questionnaire provided for this purpose by the Insurer. The statements made by the Policyholder and the Insured Person (or by the Insured Persons, in the case of joint life insurance) in the subscription proposal and the relevant questionnaires and/or Health Declaration shall comprise the basis of this Contract, which is binding once it enters into force, notwithstanding the provisions of the Articles below.

ARTICLE 4. FRAUDULENT OMISSIONS OR INACCURACIES BY THE POLICYHOLDER OR THE INSURED PERSON

4.1. In the event of any fraudulent omissions or inaccuracies in the Initial Risk Declaration made by the Policyholder or the Insured Person pursuant to Article 3(2), the Insurer shall cancel the Contract by sending a notice to that effect to the Policyholder within three (3) months of becoming aware of the breach.

4.2. Any claims, whether before the Insurer has become aware of the fraudulent breach or within the period referred to in the preceding paragraph, shall not be covered by the Contract.

4.3. Notwithstanding the provisions of the above paragraphs, the Insurer is entitled to the premium due up to the end of the period referred to in (1) or, when the fraudulent conduct of the Policyholder/Insured Person is intended to obtain an advantage, until the expiry of the Contract.

ARTICLE 5. NEGLIGENT OMISSIONS OR INACCURACIES BY THE POLICYHOLDER OR THE INSURED PERSON

5.1. In the event of any negligent omissions or inaccuracies in the Initial Risk Declaration made by the Policyholder or the Insured Person pursuant to Article 4(1), the Insurer may:

a) Propose a contractual amendment establishing a time period of at least fourteen (14) days for the Policyholder/Insured Person to provide a statement;

b) Cancel the Contract if it is proven that the Insurer would not, under any circumstances, have entered into the Contract had it been aware of the omitted or inaccurately stated fact.

5.2. Pursuant to the preceding paragraph, the Contract shall cease to be effective twenty (20) days after the Insurer has sent the proposed amendment, if the Policyholder/Insured Person does not agree to it, or thirty (30) days after the notice of termination has been sent per sub-paragraph b).

5.3. If the Contract is terminated, the premium will be refunded according to the time period remaining until the expiry date.

5.4. In the event of a claim arising prior to the termination or amendment of the Contract, where the claim's occurrence or consequences have been influenced by a fact subject to a negligent omission or inaccuracy, the Insurer shall:

(a) Cover the claim proportionally to the difference between the premium paid and the premium that would have been due if,

at the time the Contract was signed, it has been aware of the omitted or inaccurately stated fact;

1.1. Refuse to cover the claim, demonstrating that it would not, under any circumstances, have entered into the Contract had it been aware of the omitted or inaccurately stated fact.

ARTICLE 6. COMMENCEMENT, CONTRACT DURATION AND EFFECT OF COVERAGE

1.2. This Contract shall commence at midnight on the date specified in the Policy's Specific Terms and Conditions.

1.3. Cover under this Contract cannot be granted before midnight on the day following that on which the Insured Person meets the eligibility criteria set out in point 5 of these General Terms and Conditions. The Contract's duration is as stated in the Specific Terms and Conditions.

1.4. Notwithstanding the above, cover for the risks insured under this Contract shall only take effect from the moment the relevant premium or the initial instalment of the Contract is paid.

1.5. The Contract is entered into for a period of one year, until the end of the policy year in which the Insured Person(s) reach(es) the maximum age of permanence of the Contract.

ARTICLE 7. INSURANCE ELIGIBILITY AND ACTIVATION CONDITIONS

7.1. In order to take out this insurance, the Insured Persons and Policyholder must fully complete and sign the Insurance Subscription Proposal, which must include details of their civil and tax identification, as well as the Beneficiary, per the guarantees of the Contract.

7.2. Medical examinations must be provided by all persons whose state of health has undergone any significant change due to illness or accident, or any other factor that affects the covered risk assessment.

7.3. Insured Persons who, at the start of this insurance, are on sick leave will only be covered by the insurance upon their return to work, provided they meet the eligibility criteria set out in the other paragraphs of this clause.

7.4. In order to carry out a comprehensive risk assessment, the Insurer takes into account the analysis of the Questionnaires, the Health Declaration or required medical examinations, as well as the professional and non-professional activities of the Insured Person (or the Insured Persons, in the case of joint life insurance). After analysing the available information, the Insurer may take one of the following decisions: a) Notify the Insured Person of its acceptance of the insurance policy without reservation, resulting in the immediate issue of the Contract.

b) Propose conditional acceptance, or acceptance subject to premium loading of the Insured Person under the insurance policy and/or with exclusions or limitations on cover.

c) Notify complete rejection of the Insurance Proposal. The proposal referred to in sub-paragraph (b) or the refusal referred to in sub-paragraph (c) must be notified within 30 days of the date of receipt of all required accompanying documents of the Subscription Proposal or those which the Insurer has requested for its consideration. Whenever the Insurer, in exercising its right, makes a counter-offer subject to the condition set out in sub-paragraph (b), the policy shall only be deemed to be in force once the Policyholder has accepted the counter-offer in writing.

ARTICLE 8. AMENDMENT TO THE CONTRACT

8.1. Any amendments to the Terms and Conditions of the Contract are subject to mutual agreement between the Policyholder and the Insurer.

8.2. The Insurer reserves the right, in the event of an increase in the coverage amount, to make acceptance of the amendment conditional upon the Insured Persons passing any medical examinations deemed necessary for this purpose by the Insurer. The costs of these tests shall be borne by the Insurer.

8.3. Amendments shall take effect on the policy Anniversary Date, provided they are notified in writing and received by the Insurer at least 60 days prior to that date. The anniversary date shall be the date specified in the Policy's Specific Terms and Conditions.

ARTICLE 9. INSURED CAPITAL

The Insured Capital for each Insured Person is €10,000 (ten thousand euros).

ARTICLE 10. CONTRACT PREMIUM

The contract premium is fixed for the entire term, and amounts to €3.00 per month or €36.00 per year. This amount includes the statutory charges, in particular the INEM levy (National Medical Emergency Institute).

ARTICLE 11. PREMIUM PAYMENT

11.1. The Policyholder shall pay the premium, plus any statutory charges, in advance on an annual basis. Pursuant to the Specific Terms and Conditions, the Insurer may allow the annual premium to be paid in monthly instalments.

11.2. The premium, regardless of the Premium Instalment chosen, will be paid by one of the methods agreed with the Policyholder.

11.3. The Policyholder is entitled to change the Premium Instalment on the policy anniversary date. This change must be notified in writing and received by the Insurer at least 60 days before the anniversary date.

11.4. The premium is payable before the end of the policy year in which the Insured Person dies or in which the early compensation is paid, at the latest by the end of the period specified in the Specific Terms and Conditions or upon reaching the agreed term age.

ARTICLE 12. FAILURE TO PAY PREMIUMS 12.1. Any failure to pay the premium within 30 days of the due date shall allow the Insurer, pursuant to the law, to proceed with Policy TERMINATION by sending a notice simultaneously – when they are different persons – to the Policyholder and the Insured Person, at least 8 days prior to the effective date, notwithstanding the provisions of 15.4.

12.2. The exercise of the option granted in the preceding paragraph shall not prejudice the Insurer's right to the premium corresponding to the time period that has elapsed.

ARTICLE 13. POLICY REINSTATEMENT

13.1. The Policyholder may reinstate a policy that has been cancelled due to non-payment, under the original terms and conditions, within six (6) months of the termination date, upon payment of outstanding premiums and corresponding default interest.

13.2. The Insurer reserves the right, in such cases, to make the Policy revalidation conditional upon the Insured Person (or the Insured Persons, in the case of joint life insurance) passing a medical examination.

The costs of medical examinations shall be borne by the Policyholder.

13.3. Any renewal requested after the specified period will result in a new policy, which will be issued in accordance with the officially approved technical guidelines.

ARTICLE 14. RIGHTS AND OBLIGATIONS OF THE POLICYHOLDER AND INSURED PERSON

14.1. It is the Policyholder's responsibility to pay the premium within the time limits set by the Insurer.

14.2. The Policyholder is entitled to terminate the Contract on the policy Anniversary Date, subject to the provisions of 15.5 and 15.6, with at least 30 days' prior notice to the Insurer.

ARTICLE 15. BENEFICIARIES

15.1. The Policyholder is entitled to name the Beneficiaries in accordance with the terms of the Contract, and to amend the Beneficiary Clause at any time until the date on which the Beneficiary is entitled to the insured amounts, notwithstanding the provisions of the following paragraphs. Such an amendment shall only be valid provided that the Insurer has received the relevant written notification with the Beneficiary's identification details, including their full name, address, and civil and tax identification numbers.

In the event that the Beneficiary's identification details are incorrect or out of date, thereby preventing the Insurer from establishing their identity, payment of the share of the Benefit shall be suspended pending a claim from the

person concerned. Any change to the Beneficiary will result in an Additional Endorsement.

15.2. Whenever the Policyholder and the Insured Person are different persons, the Beneficiary Clause may only be changed with the agreement and at the initiative of both.

15.3. The Beneficiary Clause shall be deemed irrevocable once the Beneficiary has accepted the benefit, and the Policyholder shall be prevented from making any changes to the Beneficiary Clause.

15.4. The Policyholder's waiver of the right to amend the Beneficiary Clause, as well as the Beneficiary's acceptance, must be set out in a written document, whose validity is subject to actual notification to the Insurer.

15.5. Given that this is an Irrevocable Beneficiary Clause, the Beneficiary's prior consent will be required in order to terminate the Contract or to exercise any right or power to amend contractual terms affecting the Beneficiary's rights, except in the event of misrepresentation.

15.6. Given that this is an Irrevocable Beneficiary Clause, the Insurer shall notify the Beneficiary and the Policyholder simultaneously of any non-payment of the premium and the resulting consequences.

The policy may be cancelled due to non-payment of the premium, in the event of default by the Policyholder, unless the Beneficiary steps in to fulfil these obligations.

15.7. The Beneficiary shall be entitled to replace of the Policyholder in the event of the latter's death, provided that the Policyholder has previously notified the Insurer in writing and the Insured Person(s) has/have given their written consent.

ARTICLE 16. CESSATION OF COVER

The cover provided under this Contract shall cease to have effect:

a) On the date on which the Contract is terminated pursuant to Article 22;

b) On the date on which the instalments under this Contract are paid;

c) At the end of the policy year in which the Insured Person reaches the age of twenty-five (25).

d) On the date of termination or cancellation of this Contract.

ARTICLE 17. EXCLUDED RISKS

The death cover provided under this Contract shall apply regardless of the cause of death, except when death is caused by:

a) A criminal act in which the Beneficiary/Insured Person is the material or moral author, or to which they have been an accomplice;

b) Suicide, if it occurs during the first year of the policy or during the first year following any increase in the capital insured;

c) Claims arising as a direct or indirect consequence of an intentional act by the Insured Person or committed with their complicity;

d) Aviation accidents, except when the Insured Person is a passenger on a commercial passenger aircraft duly authorised by IATA (International Air Transport Association);

e) Injuries or harm resulting from active participation in acts of kidnapping, riots, insurrection, uprisings, brawls, terrorism or sabotage, provided that the Insured Person was not acting in self-defence or in an attempt to rescue people or property.

f) Revolution, civil war and war with a foreign country, whether declared or not;

g) Alcoholism and the use of drugs when not medically prescribed;

h) Occurrence of nuclear risks;

i) High-Risk Sports such as car racing, motorcycling, hunting outside the European territory, spearfishing, scuba diving,

mountaineering, caving, boxing, any form of martial arts, bungee jumping, motorcycling, caving, piloting non-commercial aircraft and, in general, all types of aerial vehicles, alpinism, exploratory travel, bullfighting, training of wild animals, parachuting, free flight, gliding, hang gliding, microlight aircraft flying, and, in general, any sport or recreational activity of a notoriously dangerous nature.

(j) Claims arising from competitions, betting or attempts to break records and, in general, all acts of a notoriously dangerous nature that are not justified by any professional necessity or attempt to rescue persons.

ARTICLE 18. TERRITORIAL SCOPE

18.1. The territorial scope of this Contract extends worldwide.

18.2. The cover provided under this policy shall be suspended if the Insured Person travels to countries where there are political risks and war risks, in which case cover for these risks shall be subject to the provisions of the following paragraphs.

18.2.1. For the purposes of this policy, "Political risks and war risks" are defined as any direct or indirect consequences of riots, revolutions, kidnapping, civil war or war with a foreign country, whether declared or not, insurrection, uprisings, brawls, terrorism or sabotage as defined under Portuguese criminal legislation in force, regardless of where the events take place and who the perpetrators may be.

18.2.2. If the Insured Person has joined, or eventually joins, the armed forces or equivalent (such as paramilitary formations), whether on a voluntary or compulsory basis, and takes part in military operations or hostile situations of any kind, the cover provided under the Contract shall be suspended from the date on which the Insured Person began participating in that military operation until the end of that participation, except in the case of a special convention and payment of the relevant additional premium.

18.2.3. Similarly, cover for the consequences of political risks or war will not be provided if such events occur in territories or countries where there is a declared state of conflict (civil war or war with a foreign country) or where the competent authorities formally advise against travel to or visits due to political or military activities, except in the case of a special convention and payment of the relevant additional premium. For this purpose, the competent authority is deemed to be the Ministry of Foreign Affairs or a similar authority in the country where the Policyholder has their habitual residence.

18.2.4. If the Insured Person wishes to travel to a country experiencing political instability or war and wishes to maintain the cover provided by this insurance, they must first notify the Insurer of the intended trip and its duration. The Insurer must respond within 30 days to indicate whether it refuses to provide cover or whether it accepts the cover and under what conditions, and any failure by the Insurer to respond shall be deemed as acceptance.

18.2.5. If, following their return, the Insured Person travels to that country or territory again, cover for the consequences associated with political or war risks will not be provided under the Policy whilst those countries or territories remain in a state of war or are not recommended by the competent authorities, except in the case of a special convention and payment of the relevant additional premium.

18.2.6. At the time of signing the Contract, the Policyholder and/or Insured Person must state the maximum duration of the trips they intend to make abroad in the Subscription Proposal.

18.2.7. The Specific Terms and Conditions may extend the cover provided under the Contract to certain countries or regions that fall within the scope of the above points, provided that the Conditions expressly state the terms under which such an extension of cover is accepted by the Insurer.

18.2.8. The Special Terms and Conditions for complementary coverage may specify a more limited territorial scope for such cover.

18.3. The Policyholder is entitled to a partial refund of the premium already paid, calculated on a pro-rata basis, for the period during which cover was suspended. The Insurer shall pay this amount to the Policyholder by crediting a bank account held with NOVO BANCO, S.A.

ARTICLE 19. SETTLEMENT OF INSURED AMOUNTS

19.1. Payment of the Insured Amounts shall be made by bank transfer to the account specified by the Beneficiaries, or at the Insurer's offices in the location where this Contract was issued, after delivery by the Policyholder or Beneficiaries of the Specific Terms and Conditions, the Insured Person's identification document, supporting documents

proving the Beneficiary's status and the Insured Person's Death Certificate. The Insurer may also require a medical certificate stating the causes and progression of the illness that led to the death, as well as request other documents relating to the death, such as police, court or hospital records.

19.2. The Insured Amounts shall be paid to the designated Beneficiary on the date of the Insured Person's death or, if the Insured Person has already died, to their heirs in the order established for legitimate succession under sub-paragraphs (a) to (e) of paragraph 1 of Article 2133 of the Civil Code, provided that the benefit is irrevocable. If no benefit has been claimed and the Beneficiary is not alive on the date of the claim, the Insured Capital will be paid to the Insured Person's heirs in accordance with the above rules.

19.3. If no Beneficiary has been designated, the Insured Amounts will be paid per the following rules:

a) If no Beneficiary has been designated, to the Insured Person's heirs;

b) If the Beneficiary predeceases
the Insured Person, to the Insured Person's heirs;

c) If the Beneficiary predeceases
the Insured Person, provided that the right to revoke the Beneficiary Clause has been waived, to the Beneficiary's heirs.

d) In the event that the Insured Person and the Beneficiary die at the same time, to the Beneficiary's heirs.

19.4. If the Beneficiary is a minor, the Insurance Company will pay the compensation due via a bank deposit by opening an account in the Beneficiary's name.

19.5. Any discrepancies between the age stated in the Subscription Proposal and that shown on the identification document will result in adjustments to the insured amounts, in accordance with the premiums paid, taking into account the exact age and the rates in force on the date the Specific Terms and Conditions were issued.

19.6. In the circumstances in 19.5, the Insurer shall not be obliged to provide cover if it proves that it would never have accepted the application had it been aware of the circumstances at the time of the proposal or upon acceptance thereof. Under such circumstances, the policy shall be deemed voidable, and the Insurer shall be refunded all sums paid. The Insurer shall be obliged to refund to the Policyholder (where the latter is responsible for paying the premium), or to the Policyholder's heirs (should the Policyholder have died), all premiums paid, without interest, less any costs proven to have been incurred.

ARTICLE 20. PROFIT PARTICIPATION

This modality does not provide for profit participation.

ARTICLE 21. TERMINATION OF CONTRACT

**21.1. Subject to the provisions of 15.4 and 15.5, this Contract may be terminated by the Policyholder on the policy anniversary date, by notifying the Insurer in accordance with the
prior notice period of 30 days.**

21.2. The Contract may also be terminated by the Insurer under the conditions set out in 12.1.

ARTICLE 22. RIGHT OF WITHDRAWAL

22.1 The Policyholder is entitled to freely terminate the Contract, without having to provide any reason, and without entitlement to any claim for compensation or penalty from the Policyholder.

22.2 In the case of a Distance Contract relating to a specific financial service to which another distance contract is in any way attached, relating to financial services provided by a provider or by a third party on the basis of an agreement with that provider, the attached Contract shall be deemed automatically and simultaneously terminated, without penalty, provided that the Policyholder exercises the right of termination pursuant to the provisions of the preceding paragraph.

22.3 Where the Contract is signed with a duration of one (1) year or more, the Policyholder shall have, for the purposes of the right of withdrawal, a period of thirty (30) days from the date on which they are notified of its signing.

22.4 The termination of the Contract, pursuant to the above terms, must be notified to the Insurer in writing, either via hardcopy or another durable medium available and accessible to the Insurer.

22.5 The exercise of the right of withdrawal extinguishes the obligations and rights arising from the Contract or

transaction, effective from the date of its signing.

22.6 Where the Insurer has received any sums in payment, it shall be obliged to refund them to the Policyholder within 30 days of receiving notice of the right of withdrawal.

22.7 The consumer must return to the provider any sums or goods received from it within 30 days of sending the notice of the right of withdrawal.

22.8 The Policyholder is not obliged to pay for the service actually provided before the expiry of the right of withdrawal.

22.9 This does not apply if the Policyholder has requested that the Contract start prior to the expiry of the right of withdrawal, in which case the Policyholder is obliged to pay the Insurer, as soon as possible, for the services actually provided, up to a maximum of the proportional value of those services within the scope of the contractually agreed transactions.

22.10 The payment referred to in the preceding paragraph may only be demanded if the Insurer proves that it has informed the consumer of the amount payable.

ARTICLE 23. RIGHT OF TERMINATION

The Right of Termination may be exercised pursuant to the law in force.

ARTICLE 24. DOMICILE AND COMMUNICATIONS AND NOTIFICATIONS BETWEEN THE PARTIES

24.1. For the purposes of this Contract, the Policyholder's domicile shall be deemed to be that specified in the Specific Terms and Conditions. A Policyholder who establishes their residence outside Portugal must designate a domicile within Portugal for the purposes of this Contract.

24.2. Any communications or notifications provided for in this Policy shall be considered valid and fully effective when done in writing or by any other means that leave a permanent record, sent to the Policyholder's last known address as stated in the Contract, to their email address, or to the Insurer's registered office or email address.

24.3. Any change to the address, registered office or email address of the Policyholder or the Insured Person must be notified to the Insurer or to NOVO BANCO, S.A., via registered letter with acknowledgement of receipt, within 30 (thirty) days of the change, failing which any communications or notifications sent by the Insurer to the known address or email address shall be deemed valid and effective.

24.4. Notwithstanding the provisions of the preceding paragraph, any update to the Policyholder's contact details associated with the account specified for the purposes of Article 5 (Payment of Premiums), namely their domicile, shall entail a change to those details held by the Insurer, with the policy address becoming the updated domicile held by the intermediary NOVO BANCO, S.A.

ARTICLE 25. PREVENTING AND COMBATING MONEY LAUNDERING AND THE FINANCING OF TERRORISM

To comply with its legal obligations to prevent and combat money laundering and the financing of terrorism, GamaLife is lawfully entitled to refuse the proposed insurance contract or any requested contractual transaction, as well as to terminate the contract effective immediately, whenever it becomes aware or suspects that it may be linked to offences involving money laundering or the financing of terrorism. The contract, or any transaction relating to it, will be rejected if the Insurer is not provided with all the information required by law regarding the identification of the Policyholder, Insured Persons and Beneficial Owners, as well as the source and destination of the relevant funds.

ARTICLE 26. ARBITRATION

26.1. In the event of a dispute between the Policyholder, the Insured Person and/or the Beneficiary with the Insurer with regard to assessing the risks covered by this Contract or determining the compensation amount, the parties may seek to resolve the dispute via the Medical Board, which shall act as an Arbitral Tribunal.

26.2. The Medical Board shall consist of three doctors, one appointed by each of the parties in addition to a

third doctor, who shall chair the board and have a casting vote, by mutual agreement between those appointed by the parties or, failing such agreement, by the National Institute of Legal Medicine (office in the Insured Person's area of residence).

26.3. The Arbitral Tribunal shall operate in accordance with Law No. 63/2011 of 14 December, and the arbitrators appointed by the parties must be medical practitioners.

26.4. Where a Medical Board is required, the Insurer and the Policyholder or the Insured Person shall bear the fees and expenses of the doctor/arbitrator appointed by them, whilst those of the Chair shall be borne equally by both parties. In the absence of the Policyholder or the Insured Person, the costs that would otherwise be their responsibility shall be borne by the Beneficiaries by way of deduction from the amounts payable.

ARTICLE 27. LEGISLATION AND JURISDICTION

27.1. This Contract shall be governed by Portuguese law.

27.2. Any omissions in this Contract shall be governed by applicable legislation.

27.3. The competent jurisdiction for settling any disputes arising from this Contract shall be that established by law.

SPECIAL TERMS AND CONDITIONS

INSURANCE FOR TOTAL AND PERMANENT DISABILITY BY ACCIDENT COMPLEMENTARY TO THE ANNUAL RENEWABLE TERM LIFE INSURANCE

In addition to the Principal Insurance (Death Cover), as agreed and expressly stated in the Specific Terms and Conditions, the risk defined below may be covered in accordance with the relevant Articles.

The Supplementary Cover for Total and Permanent Disability by Accident comprises an integral part of the Principal Insurance, without which it cannot exist, whereby this cover shall be governed by the GENERAL TERMS AND CONDITIONS of the Principal Insurance and, by secondary application, by these Special Terms and Conditions.

ARTICLE 1. GUARANTEES

If an Insured Person becomes totally and permanently disabled as a result of an accident, this Supplementary Cover will guarantee the advance payment of the sum assured under the Principal Insurance, pursuant to Article 9 of the relevant General Terms and Conditions. The guarantees under the Supplementary Cover for Total and Permanent Disability shall apply if the disability occurs before the Contract's expiry date or before the end of the policy year in which the Insured Person reaches the age of 25.

Payment of the aforementioned capital amount will result in the termination of the relevant Contract.

ARTICLE 2. DEFINITION OF TOTAL AND PERMANENT DISABILITY BY ACCIDENT (TPD/A)

2.1. The Insured Person is deemed to be in a state of Total and Permanent Disability by Accident whenever, as a result of an Accident, they are permanently and irreversibly unable to carry out their profession or any other gainful activity in accordance with their knowledge and skills, and furthermore, have a Degree of Incapacity of 66% in accordance with the "National Table of Incapacity for Work Accidents and Occupational Diseases" officially in force at the time the disability is recognised.

2.2. Total and Permanent Disability by Accident (or its degree) must be determined based on objective medical evidence, by a doctor appointed by the Insurer or, in the event of a disagreement with the Insurer, by an Arbitral Tribunal or Judicial Court, whose determination shall take precedence over any opinions or decisions issued by Social Security, the Caixa Geral de Aposentações (General Pension Fund) or any other voluntary or compulsory scheme that replaces or supplements them.

Total and Permanent Disability is only recognised following an assessment by a Medical Board authorised for this purpose confirming that the aforementioned Degree of Incapacity is permanent and irreversible, i.e. it is not subject to future changes, and does not require reassessment after the Medical Board's meeting took place.

2.3. If, on the date the Contract comes into effect, the Insured Person is already suffering from some form of disability, only the difference between the existing degree of disability and the new degree of disability will be taken into account.

2.4. Total and Permanent Disability must be established within one year of the date of the accident.

2.5. The term "Accident" refers to any sudden, unforeseen and abnormal event caused by an external, violent force beyond the Insured Person's will, resulting in bodily injury that can be objectively confirmed by a medical examination.

2.5.1. The following are not considered accidents:

- All illnesses of any kind, unless resulting from a covered accident;

- Injuries which, by their nature, may be treated as an accident, but which are of internal origin and unrelated to a covered accident, such as hernias, lower back pain, sciatica, injuries resulting from "straining", heart attacks regardless of the cause, coronary heart disease, aneurysm rupture, cerebral embolisms, subarachnoid haemorrhages, epileptic seizures and *delirium tremens;*

- Attempted suicide.

2.5.2. The following are considered accidents:

- After-effects of drowning;
- Injuries sustained whilst rescuing people or property at risk;
- Poisoning and burns resulting from the accidental ingestion of toxic or corrosive substances or the accidental release of gases or vapours.

2.6. Exclusion of Accidents occurring prior to the entry into force of the Contract:

a) All cases where the Insured Person is found to have a blood alcohol level equal to or higher than that specified by law for drivers of motor vehicles in Portugal are also excluded.

b) Persons who have voluntarily caused the accident are excluded from insurance cover.

ARTICLE 3. ENFORCEABILITY OF INSURED AMOUNTS

Once the claim notification has been made and all supporting documents requested by the Insurer have been submitted, the Insurer undertakes to notify the Insured Person and/or the Beneficiary, within a maximum of thirty (30) days, whether or not the claim is covered under the Contract.

ARTICLE 4. - JUSTIFICATION AND RECOGNITION OF RIGHT TO INSURED AMOUNTS

a) **In the event of disability, the Insured Person must send the Insurer a medical certificate from the attending physician stating the onset, causes, nature and progression of the disability. This certificate, under the responsibility of the Insured Person, must be sent to the Insurer within 60 days of the Total and Permanent Disability by Accident being established. A detailed description of activities carried out by the Insured Person prior to the incapacity must be provided.**

b) **The event giving rise to the disability (its cause) must occur during the Policy Term and/or during the period in which cover is in force for the Insured Person, and must also be reported to the Insurer within a maximum of 60 days of the cessation of cover, where this occurs pursuant to sub-paragraphs (a), (e) and (f) of Article 5. of these Special Terms and Conditions.**

c) The Insurer reserves the right to request further information and to carry out any investigations deemed necessary to accurately determine the Insured Person's condition, including arranging for the Insured Person to be examined by its own doctors if necessary. In such case, the costs shall be borne by the Insurer. The Insured Person must authorise their attending physician to provide to the Insurer's medical representative, on a confidential basis, all medical information relating to the reported claim.

d) Failure by the Beneficiary or the Insured Person to comply with the provisions of the preceding sub-paragraphs, or the provision of false information to the Insurer, shall result in the suspension or loss of the right to the Insured Amounts.

e) The Insurer shall notify the Policyholder and/or the Insured Person whether or not it accepts their claim after receiving the documents referred to in sub-paragraphs (a) and (c) within the legal time limits established for this purpose.

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f) In the absence of an agreement, any of the parties concerned may seek to resolve the dispute by applying to the Medical Board, which shall serve as an Arbitral Tribunal. The Medical Board shall consist of three doctors, one appointed by each of the parties and a third, who shall chair the board and have a casting vote, by mutual agreement between those appointed by the parties or, in the absence of such agreement, by the National Institute of Legal Medicine (office in the Insured Person's area of residence). The Arbitral Tribunal shall operate in accordance with Law No 63/2011 of 14 December, although the arbitrators appointed by the parties must be medical doctors. Where a Medical Board acts as an Arbitral Tribunal, the Insurer and the Policyholder or the Insured Person shall bear the fees and expenses of the doctor/arbitrator appointed by them, whilst those of the Chair shall be borne equally by both parties. In the absence of the Policyholder or the Insured Person, the costs that would otherwise be their responsibility shall be borne by the Beneficiaries by way of deduction from the amounts payable.

g) The Insurer must be paid for any premiums and additional premiums for the Principal Insurance, as well as any premiums relating to the Supplementary Cover for total and permanent disability by accident, which may fall due during the course of the discussions. If the decision is to recognise the existence of total and permanent disability by accident, the Insurer shall refund the sums received and, where applicable, pay the amounts due plus interest at 3% per annum, calculated from the end of the time period specified in (3).

h) If the disability resulting from illness or accident is aggravated by, or arises from, a physical condition from which the Insured Person was already suffering at the time of taking out the insurance, the Insurer's liability shall not exceed that which it would have had if the illness or accident occurred to a healthy person, notwithstanding the potential voidability of the life insurance policy due to false statements regarding the Insured Person's state of health, should such statements be found to be true.

i) The degree of disability attributable to physical conditions from which the Insured Person was already suffering at the time of taking out the insurance shall not be taken into account when determining the degree of disability to be awarded under this cover.

ARTICLE 5. END OF COVERAGE

For each Insured Person, this cover shall cease to apply:

a) Upon termination of the Policy or the Principal Insurance Contract;

b) If the Insured Person attempts suicide;

c) If the Insured Person causes or exacerbates their disability in any way;

d) If the Insured Person is called up to take part in military operations, policing operations or operations to suppress acts of terrorism;

e) At the Term Age of coverage as defined in the Policy's Specific Terms and Conditions;

f) At the end of the policy year in which the Insured Person reaches the age of twenty-five (25).

ARTICLE 6. EXCLUDED RISKS

Excluded Risks from the Supplementary Cover for Total and Permanent Disability by Accident are the same as those set out in the General Terms and Conditions of the Annual Renewable Term Life Insurance, namely:

a) A criminal act in which the Beneficiary/Insured Person is the material or moral author, or to which they have been an accomplice;

b) Suicide, if it occurs during the first year of the policy or during the first year following any increase in the capital insured;

c) Claims arising as a direct or indirect consequence of an intentional act by the Insured Person or committed with their complicity;

d) Aviation accidents, except when the Insured Person is a passenger on a commercial passenger aircraft duly authorised by IATA (International Air Transport Association);

e) Injuries or harm resulting from active participation in acts of kidnapping, riots, insurrection, uprisings, brawls, terrorism or sabotage, provided that the Insured Person was not acting in self-defence or in an attempt to rescue people or property.

f) Revolution, civil war and war with a foreign country, whether declared or not;

g) Alcoholism and the use of drugs when not medically prescribed;

h) Occurrence of nuclear risks;

i) High-Risk Sports such as car racing, motorcycling, hunting outside the European territory, spearfishing, scuba diving,
mountaineering, caving, boxing, any form of martial arts, bungee jumping, motorcycling, caving, piloting non-commercial aircraft and, in general, all types of aerial vehicles, alpinism, exploratory travel, bullfighting, training of wild animals, parachuting, free flight, gliding, hang gliding, microlight aircraft flying, and, in general, any sport or recreational activity of a notoriously dangerous nature.
j) Claims arising from competitions, betting or attempts to break records and, in general, all acts of a notoriously dangerous nature that are not justified by any professional necessity or attempt to rescue persons.
l) Accidents suffered by the Insured Person as a result of acts committed by them which are classified as criminal offences under the law, including acts committed under the influence of toxic drugs, narcotic drugs or psychotropic substances not prescribed by a doctor. For the purposes of this provision, the Insured Person shall be deemed to have been under the influence of toxic drugs, narcotic drugs or psychotropic substances whenever any such substance is found in the bloodstream or any bodily fluid used for such tests;

ARTICLE 7. FINAL PROVISIONS
In all cases not provided for in these **SPECIAL TERMS AND CONDITIONS,** the GENERAL TERMS AND CONDITIONS of the Principal Insurance and/or the legislation in force shall apply.

SPECIAL TERMS AND CONDITIONS
COMPLEMENTARY CRITICAL ILLNESS INSURANCE UNDER ANNUAL RENEWABLE TERM LIFE INSURANCE

In addition to the Principal Insurance (Death Cover), as agreed and expressly stated in the Specific Terms and Conditions, the risk defined below may be covered in accordance with the relevant Articles.
The Complementary Critical Illness Cover can only be taken out at the same time as the Supplementary Cover for "Total and Permanent Disability by Accident", forming a single package with the Principal Insurance, without which it cannot exist. This cover is governed by the General Terms and Conditions of the Principal Insurance - Annual Renewable Group Term Life Insurance and by these Special Terms and Conditions.
ARTICLE 1. GUARANTEES
If the Insured Person is diagnosed with one of the Critical Illnesses defined in the following sub-paragraphs, and provided that these are specified in the Specific Terms and Conditions, the Insurer guarantees the advance payment of 100% of the Insured Capital under the Principal Insurance, thereby automatically cancelling the relevant Contract.
The guarantees under the Complementary Critical Illness Cover shall apply if the Critical Illness occurs before the Contract's expiry date or before the end of the policy year in which the Insured Person reaches the age of 25.

ARTICLE 2. DEFINITION OF CRITICAL ILLNESSES.
2.1. Cancer (excluding less advanced stages) Any malignant tumour that has been definitively diagnosed with histological confirmation and is characterised by the uncontrolled growth of malignant cells and invasion of tissue. The diagnosis must be confirmed by a specialist.
Unless specifically excluded, Leukaemia, Malignant Lymphoma and Myelodysplastic Syndrome are covered by this definition.
For the above definition, the following are not covered:
- Any tumour histologically classified as pre-malignant, non-invasive or carcinoma in situ (including ductal and lobular carcinoma in situ of the breast and cervical dysplasia CIN-1, CIN-2 and CIN-3);
- Any prostate cancer, unless histologically classified as having a Gleason Score greater than 6 or having progressed to at least clinical TNM stage T2N0M0;
- Chronic Lymphocytic Leukaemia, unless it has progressed to at least Binet Stage;

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- Basal cell carcinoma and squamous cell carcinoma of the skin, and stage IA malignant melanoma (T1aN0M0), unless there is evidence of metastases;

- Papillary thyroid cancer measuring less than 1 cm in diameter and histologically described as T1N0M0;

- Papillary microcarcinoma of the bladder, histologically described as Ta;

- Polycythaemia vera and essential thrombocythemia;

Monoclonal Gammopathy of Undetermined Significance (MGUS);

- Gastric MALT Lymphoma, if the condition can be treated with Helicobacter eradication;

- Gastrointestinal stromal tumour (GIST), stage I and II, according to the AJCC Cancer Staging Manual, Seventh Edition (2010);

- Cutaneous lymphoma, unless the condition requires treatment with chemotherapy or radiotherapy;

Microinvasive breast carcinoma (histologically classified as T1mic), unless the condition requires a mastectomy, chemotherapy or radiotherapy;

- Microinvasive cervical carcinoma (histologically classified as stage IA1), unless the condition requires a hysterectomy, chemotherapy or radiotherapy.

2.2. Myocardial Infarction (heart attack).

A myocardial infarction is the death of heart tissue due to prolonged obstruction of blood flow. Under this definition, myocardial infarction is indicated by an increase and/or decrease in cardiac biomarkers (troponin or CK-MB) to levels considered diagnostic of myocardial infarction, together with at least two of the following criteria:

- Symptoms of ischaemia (such as chest pain)
- Changes in the electrocardiogram (ECG) indicative of new ischaemia (new ST-T changes or new left bundle branch block)
- Development of pathological Q waves on the ECG

The diagnosis must be confirmed by a cardiologist.

For the above definition, the following are not covered: - Acute coronary syndrome (stable or unstable angina)

- Elevated troponin levels in the absence of obvious ischaemic heart disease (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity)

- Myocardial infarction with normal coronary arteries or caused by coronary vasospasm, myocardial bypass, or drug abuse

- Myocardial infarction occurring within 14 days of coronary angioplasty or coronary artery bypass

2.3. Stroke (Cerebrovascular Accident) (CVA).

Death of brain tissue due to an acute cerebrovascular event caused by intracranial thrombosis or haemorrhage (including subarachnoid haemorrhage) or embolism of extracranial origin, with:

- Acute onset of new neurological symptoms, and
- New objective[1] neurological deficits on clinical examination.

The neurological deficit must persist for more than three months after the date of diagnosis. The diagnosis must be confirmed by a neurologist and supported by imaging.

For the above definition, the following are not covered:

- Transient ischaemic attack (TIA) and prolonged reversible ischaemic neurological deficit (PRIND);

- Trauma to brain tissue or blood vessels;

- Neurological deficits caused by generalised hypoxia, infection, inflammatory disease, migraine or medical intervention;

- Incidental findings during imaging (CT or MRI) with no clearly related clinical symptoms (silent stroke);

- Death of tissue in the optic nerve, retina or vestibular system.

Note: (1) For the above definition, the following are not covered:

a. **An abnormality observed on CT or MRI scans or other imaging techniques without any defined associated clinical symptoms**
b. **Neurological signs that occur without any symptomatic abnormalities, e.g. rapid reflexes without other symptoms**

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c. Symptoms of psychological or psychiatric origin

2.4. Limb Paralysis (total and irreversible).

Total and irreversible loss of muscle function in both limbs, resulting from injury or disease of the spinal cord or brain. A limb is defined as a whole arm or a whole leg. The paralysis must have been present for more than three months, confirmed by a neurologist and supported by clinical and diagnostic findings.

For the above definition, the following are not covered: - Paralysis resulting from physical injury or psychological disorders

- Guillain-Barré syndrome

- Periodic or hereditary paralysis

2.5. Multiple Sclerosis (resulting in permanent symptoms).

Definitive diagnosis of multiple sclerosis, which must be confirmed by a neurologist and supported by all of the following criteria:

- Current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least six months
- MRI (Magnetic Resonance Imaging) showing at least two demyelinating lesions in the brain or spinal cord, characteristic of multiple sclerosis.

For the above definition, the following are not covered: - Possible multiple sclerosis and isolated syndromes that are neurologically or radiologically suggestive of, but not diagnostic of, multiple sclerosis - Isolated optic neuritis and neuromyelitis optica 2.6. Coma (resulting in permanent symptoms)

A definitive diagnosis of a state of unconsciousness with no reaction or response to external stimuli or internal needs, which:

- This results in a score of 8 or below on the Glasgow Coma Scale for at least 96 hours,
- Requires the use of life-support systems, and
- Results in a persistent neurological deficit[1], which must be assessed at least 30 days after the start of the coma.

The diagnosis must be confirmed by a neurologist.

For the above definition, the following are not covered:

- Clinically induced coma

- Any coma resulting from self-inflicted injury, alcohol consumption or drug use.

2.7. Severe Head Trauma – traumatic brain injury (resulting in permanent loss of physical abilities).

A definitive diagnosis of a brain function disorder resulting from a head injury. The head injury must result in a total inability to perform, unaided, at least three out of six Activities of Daily Living for a continuous period of at least three months, with no reasonable prospects of recovery.

Activities of Daily Living are:

- Bathing – the ability to bathe in (including getting in and out of) a bath or shower or to wash oneself satisfactorily by other means.
- Dressing and undressing – the ability to put on, take off, fasten and unfasten all items of clothing and, where necessary, any medical devices, prosthetic limbs or other surgical appliances.
- Eating – the ability to eat when food has been prepared and provided.
- Personal hygiene – the ability to maintain a satisfactory standard of personal hygiene by using the toilet or managing bowel and bladder functions.
- Moving between rooms – the ability to go from room to room on a single floor.
- Getting in and out of bed – the ability to get out of bed into a chair or wheelchair in an upright position and back again.

The diagnosis must be confirmed by a neurologist or neurosurgeon and supported by typical imaging (CT or MRI scans of the brain).

For the above definition, the following are not covered:

- Any severe head trauma caused by self-inflicted injury, alcohol or drug use.

2.8. Loss of Limbs.

A definitive diagnosis of complete separation of two or more limbs at or above the wrist or ankle joint as a result of an accident or medically necessary amputation. The diagnosis must be confirmed by a specialist.

For the above definition, the following are not covered: - Loss of limbs due to self-inflicted injury.

ARTICLE 3. WAITING PERIOD

The payment of capital in the event of a Critical Illness will only be made if the illness manifests itself three months after the issue date of the Specific Terms and Conditions.

ARTICLE 4. JUSTIFICATION AND RECOGNITION OF RIGHT TO INSURED AMOUNTS

4.1. In the event of a Critical Illness, the Beneficiary named in the Terms and Conditions must send the following to the Insurer: Medical certificate issued by the attending physician, after the detailed and accurate diagnosis of a Critical Illness, describing the medical history and stating the date of the first symptoms. This certificate, under the responsibility of the Policyholder or the Insured Person, must be sent to the Insurer within 60 days of diagnosing the illness.

4.2. The event giving rise to the Critical Illness (its cause) must occur during the Policy Term and/or during the period in which cover is in force for the Insured Person, and must also be reported to the Insurer within a maximum of 90 days of the cessation of cover.

4.3. Monitoring the Insured Person's state of health: The Insurer may, at any time, carry out any checks deemed necessary on the Insured Person in order to verify their actual state of health or the declared illness. Except in cases of force majeure, any refusal to grant the Insurer free access shall result in the suspension of Cover. The Insured Person must authorise their attending physician to provide to the Insurer's medical representative, on a confidential basis, all medical information relating to the reported claim.

4.4. Failure by the Beneficiary or the Insured Person to comply with the provisions of the preceding sub-paragraphs, or the provision of false information to the Insurer, shall result in the suspension of the right to the Insured Amounts.

4.5. In the event of a Critical Illness, the amount will be paid 30 days after the illness has been definitively diagnosed.

4.6. In the absence of an agreement between the parties, the Insured Person undertakes to accept the decision of the Medical Board, comprising the doctor appointed by him/her, the doctor appointed by the Insurer and a third doctor chosen by both or, in the absence of agreement on such appointment, by a person appointed by the President of the Court of Appeal for the competent jurisdiction. The costs of the third doctor's fees shall be borne in equal parts by the Insurer and the Policyholder or the Insured Person, or, in their absence, by the Beneficiaries, by way of deduction from the amounts payable.

4.7. In the absence of an agreement, any of the parties concerned may seek to resolve the dispute by applying to the Medical Board, which shall serve as an Arbitral Tribunal. The Medical Board shall consist of three doctors, one appointed by each of the parties and a third, who shall chair the board and have a casting vote, by mutual agreement between those appointed by the parties or, in the absence of such agreement, by the National Institute of Legal Medicine (office in the Insured Person's area of residence). The Arbitral Tribunal shall operate in accordance with Law No 63/2011 of 14 December (or any other legislation that may replace it), although the arbitrators appointed by the parties must be medical doctors.

Where a Medical Board acts as an Arbitral Tribunal, the Insurer and the Policyholder or the Insured Person shall bear the fees and expenses of the doctor/arbitrator appointed by them, whilst those of the Chair shall be borne equally by both parties. In the absence of the Policyholder or the Insured Person, the costs that would otherwise be their responsibility shall be borne by the Beneficiaries by way of deduction from the amounts payable.

4.8. The Insurer must be paid for any premiums and additional premiums for the Principal Insurance, as well as any premiums relating to this Supplementary Cover, which may fall due during the course of the discussions. If the decision is to recognise the existence of a Critical Illness, the Insurer shall refund the sums received and shall pay, where applicable, the amounts due together with interest at the rate of 3% per annum, calculated from the end of the period specified in Article 3.

Until the disputes have been resolved, the premiums and additional premiums for the Principal Insurance, as well as any premiums relating to the Complementary Critical Illness Cover that may fall due during the course of the discussions, must be paid to the

Insurer. If the decision goes against the Insurer, the Insurer shall refund the sums received.

ARTICLE 5. END OF COVERAGE

5.1. The cover provided under the Contract ceases for each Insured Person upon cancellation of the Policy.

5.2. At the end of the policy year in which the Insured Person reaches the age of twenty-five (25).

ARTICLE 6EXCLUDED RISKS

The excluded risks from the Complementary Critical Illness Cover are set out in Article 2 of these Special Terms and Conditions.

ARTICLE 7. FINAL PROVISIONS

In all cases not provided for in these Special Terms and Conditions, the General Terms and Conditions of the Principal Insurance and/or the legislation in force shall apply.

Done at: O2-10-2025 (Segue21 5.O)