GamaLife

Vida Segura Plus

INFORMATION NOTE ON THE GENERAL TERMS AND CONDITIONS AND SPECIAL TERMS AND CONDITIONS
- Vida Segura Plus -

CONTRACT
Vida Segura Plus 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 render the Contract a Voidable Contract; furthermore, in the event of bad faith, the Insured Person 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 Plus 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 Plus 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, up to a maximum of €150,000.

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 disability 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.

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 by Accident 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 by Accident 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, up to a maximum of €150,000.00, thereby automatically cancelling the relevant Specific Terms and Conditions.

The Critical Illnesses (provided they are contractually agreed) covered under the Contract are: Stroke (Cerebrovascular Accident); Aplastic Anaemia; Cancer; Coronary artery bypass surgery (two or more arteries); Surgery for aortic disease; Heart valve surgery; Coma; Alzheimer's disease (before the age of 65); Parkinson's disease (before the age of 65); Terminal Liver Disease; Motor Neurone Disease; End-stage lung disease; Acute Viral Encephalitis; Myocardial Infarction; Multiple Sclerosis (MS); Fulminant Viral Hepatitis; Kidney Failure – End-Stage Renal Disease; Bacterial Meningitis; Limb Paralysis; Loss of Hearing; Loss of Speech; Loss of Limbs; Loss of Vision; Severe Burns; Major Organ Transplant; Severe Head Trauma; HIV (Human Immunodeficiency Virus) contracted in the course of practising a regulated profession).

These are defined as follows:

Stroke (Cerebrovascular Accident) (CVA).

CVA - resulting in permanent symptoms. 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:

a) Sudden onset of new neurological symptoms, and b) Recent objective neurological deficits on clinical examination.

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

Aplastic Anaemia.

Aplastic Anaemia - with severe failure of the bone marrow. A definitive diagnosis of aplastic anaemia results in bone marrow failure, characterised by anaemia, neutropenia and thrombocytopenia. Treatment of the condition must involve blood transfusions and at least one of the following treatments: a) Bone marrow stimulants;

b) Immunosuppressants;

c) Bone marrow transplant.

The diagnosis must be confirmed by a haematologist and substantiated by bone marrow histology.

Cancer.

Cancer – excluding early 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 expressly excluded, leukaemia, malignant lymphoma and myelodysplastic syndrome.

Coronary artery bypass surgery (two or more arteries).

Coronary artery bypass surgery - for the treatment of multivessel coronary artery disease. The performance of heart surgery to correct stenosis or blockage of two or more coronary arteries using coronary artery bypass grafting (CABG - *Coronary Artery Bypass Graft)).* Heart surgery involving a full sternotomy (vertical incision of the sternum) and minimally invasive procedures (partial sternotomy or thoracotomy) are covered. The need for such surgery must be demonstrated by coronary angiography and confirmed by a cardiologist or a cardiothoracic surgeon.

Aortic surgery.

Aortic surgery - including minimally invasive procedures. Surgery to treat aortic stenosis, obstruction, aneurysm or dissection. Minimally invasive procedures, such as endovascular surgery, are covered by this definition. The decision to perform aortic surgery must be confirmed by a cardiothoracic surgeon and supported by imaging results.

Heart valve surgery.

Heart valve surgery - including minimally invasive and catheter-based procedures. Surgery to replace or repair abnormalities in one or more heart valves. The following procedures are covered by this definition: a) Replacement or repair of a heart valve involving a full sternotomy (vertical incision of the sternum), a partial sternotomy or a thoracotomy;

b) Ross procedure;

c) Balloon valvuloplasty;

d) Transcatheter aortic valve implantation (TAVI)

The need for such surgery must be confirmed by a cardiologist or a cardiothoracic surgeon and supported by an echocardiogram or the results of a cardiac catheterisation.

Coma.

Coma - resulting in persistent symptoms. Definitive diagnosis of a state of unconsciousness with no reaction or response to external stimuli or internal needs, which:

a) Results in a score of 8 or below on the Glasgow Coma Scale, persisting continuously for at least 96 hours;

b) Requires the use of life-support systems, and

c) Results in a persistent neurological deficit, which must be assessed at least 30 days after the start of the coma.

d) The diagnosis must be confirmed by a neurologist.

Alzheimer's disease (before the age of 65).

Alzheimer's disease (before the age of 65) - requiring constant supervision.

Definitive diagnosis of Alzheimer's disease, as evidenced by all of the following characteristics: a) A decline in cognitive ability involving impairment of memory and

executive functions (sequencing, organising, abstracting and planning), resulting in a significant reduction in mental and social functioning;

b) Changes in personality;

c) A gradual onset and continuous decline in cognitive function;

d) No disturbance of consciousness;

e) Typical neuropsychological and neuroradiological findings (e.g. CT scan/MRI).

The condition must require constant supervision (24 hours a day, for those under 65). The diagnosis and the need for supervision must be confirmed by a neurologist.

Parkinson's disease (before the age of 65).

Idiopathic Parkinson's disease (before the age of 65) - resulting in the permanent loss of physical capabilities. Definitive diagnosis of primary idiopathic Parkinson's disease, evidenced by at least two of the following clinical manifestations: a) Muscle rigidity;

b) Tremor; and

c) Bradykinesia (abnormal slowness of movement; slowness of physical and mental responses).

Idiopathic Parkinson's disease (before the age of 65) must result in a total inability to perform, independently, at least 3 of the 6 activities of daily living for a continuous period of at least 3 months, regardless of pharmacological treatment.

Activities of Daily Living are:

a) Hygiene: the ability to wash oneself in a bath or shower (including getting in and out of the bath or shower) or to wash oneself satisfactorily by other means;

b) Dressing and undressing: the ability to put on and take off clothing, taking into account the clothes usually worn, including putting on prostheses and orthoses;

c) Eating/drinking: the ability to eat and drink when food (solid or liquid) has been prepared and made available, including the ability to sip through a straw or use other adapted utensils;

d) Maintaining personal hygiene: the ability to maintain a reasonable standard of hygiene, using the toilet and controlling bowel and bladder function;

e) Mobility: the ability to move around within one's home, on level surfaces.

f) Getting in and out of bed: the ability to move from bed to a chair in an upright position or a wheelchair, and vice versa.

The diagnosis must be confirmed by a neurologist.

The implantation of a neuro-stimulator to control symptoms through deep brain stimulation is, irrespective of activities of daily living, covered by this definition. The implant must be deemed medically necessary by a neurologist or neurosurgeon.

Terminal liver disease.

Terminal liver disease - *Child-Pugh* Classification of B or C. Definitive diagnosis of severe liver disease, proven by a *Child-Pugh* classification score of at least 7 points (*Child-Pugh* Classification of B or C). The score must be calculated using all of the following variables:

a) Total bilirubin levels;

b) Serum albumin levels;

c) Severity of ascites;

d) INR values;

e) Hepatic encephalopathy.

The diagnosis must be confirmed by a gastroenterologist and supported by imaging and laboratory test results.

Motor Neurone Disease.

Motor Neurone Disease - resulting in a permanent loss of physical capabilities. Definitive diagnosis of one of the following motor neuron diseases:

a) Amyotrophic Lateral Sclerosis (ALS or *Lou Gehrig's Syndrome;*

b) Primary Lateral Sclerosis (PLS);

c) Progressive Muscular Atrophy (PMA);

d) Progressive Bulbar Palsy.

The condition must result in a permanent inability to perform at least 3 of the 6 Activities of Daily Living independently for a continuous period of at least 3 months, with no prospect of recovery. Activities of Daily Living are:

Hygiene: the ability to wash oneself in a bath or shower (including getting in and out of the

bath or shower) or to wash oneself satisfactorily by other means;

b) Dressing and undressing: the ability to put on and take off clothing, taking into account the clothes usually worn, including putting on prostheses and orthoses;

c) Eating/drinking: the ability to eat and drink when food (solid or liquid) has been prepared and made available, including the ability to sip through a straw or use other adapted utensils;

d) Maintaining personal hygiene: the ability to maintain a reasonable standard of hygiene, using the toilet and controlling bowel and bladder function;

e) Mobility: the ability to move around within one's home, on level surfaces;

f) Getting in and out of bed: the ability to move from bed to a chair in an upright position or a wheelchair, and vice versa.

The diagnosis must be confirmed by a neurologist and supported by nerve conduction studies (NCS) and electromyography (EMG).

Chronic Pulmonary Disease.

Chronic Pulmonary Disease - resulting in chronic respiratory failure. Definitive diagnosis of a terminal lung disease resulting in chronic respiratory failure, confirmed by all of the following criteria:

a) FEV1 (forced expiratory volume in one second) less than 40% of the predicted value on two occasions at least one month apart;

b) Oxygen therapy for at least 16 hours a day for a minimum period of three months;

c) Persistent reduction in partial pressure of oxygen (PaO_2) to below 55 mmHg (7.3 kPa) on arterial blood gas analysis, measured without the administration of oxygen.

The diagnosis must be confirmed by a specialist.

Acute Viral Encephalitis.

Acute Viral Encephalitis - resulting in persistent symptoms. Definitive diagnosis of acute viral encephalitis, resulting in a persistent neurological deficit documented for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a neurologist and based on typical clinical symptoms, cerebrospinal fluid analysis or brain biopsy results.

Myocardial Infarction.

Myocardial Infarction. Death of heart tissue caused by prolonged obstruction of blood flow. The myocardial infarction must be confirmed by an increase and/or decrease in cardiac enzymes (troponin or CK-MB) to levels considered diagnostic of myocardial infarction, in conjunction with at least two of the following criteria:

a) Symptoms of ischaemia (such as chest pain);

b) Recent electrocardiographic (ECG) changes indicative of ischaemia (recent ST-T segment changes or recent left bundle branch block);

c) Development of pathological Q waves on the ECG. The diagnosis must be confirmed by a cardiologist.

Multiple Sclerosis.

Multiple sclerosis – with persistent symptoms. A definitive diagnosis of multiple sclerosis must be confirmed by a neurologist and meet all of the following criteria:

a) Current clinical impairment of motor or sensory function, which has remained constant for a continuous period of at least 6 months;

b) MRI (Magnetic Resonance Imaging) showing at least two demyelinating lesions in the brain or spinal cord, characteristic of multiple sclerosis.

Fulminant Viral Hepatitis.

Fulminant Viral Hepatitis - resulting in acute liver failure. Definitive diagnosis of fulminant viral hepatitis, as evidenced by all of the following criteria:

a) Serological findings typical of acute viral hepatitis;

b) Development of hepatic encephalopathy;

c) Reduction in liver size;

d) Increased bilirubin levels;

e) Coagulopathy according to a *International Normalized Ratio* (INR) above 1.5;

f) Development of liver failure within 7 days of the onset of symptoms;

g) No history of liver disease.

The diagnosis must be confirmed by a gastroenterologist.

End-Stage Renal Disease.

End-Stage Renal Disease - requiring permanent dialysis. Chronic and irreversible failure of both kidneys, resulting in the need for regular haemodialysis or peritoneal dialysis, or if a kidney transplant has been performed. Dialysis must be medically necessary and confirmed by a nephrologist.

Bacterial Meningitis.

Bacterial meningitis - resulting in persistent symptoms. Definitive diagnosis of bacterial meningitis resulting in a persistent neurological deficit confirmed for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a neurologist and supported by the growth of pathogenic bacteria in a cerebrospinal fluid culture.

Limb Paralysis.

Limb Paralysis - total and irreversible. Total and irreversible loss of muscle function in all of any two limbs, as a result of injury or disease of the brain or spinal cord. “Limb” is defined as the entire upper or lower limb. The paralysis must have been present for more than three months, must be confirmed by a neurologist, and must be substantiated by clinical and diagnostic findings.

Loss of Hearing.

Deafness - permanent and irreversible. Definitive diagnosis of permanent and loss of hearing in both ears, resulting from illness or accidental injury. The diagnosis must be confirmed by an otorhinolaryngologist and substantiated by an average hearing threshold of over 90 dB at 500, 1000 and 2000 hertz in the better ear, as determined by a pure-tone audiogram.

Loss of Speech.

Loss of Speech - permanent and irreversible. Definitive diagnosis of total and irreversible loss of the ability to speak, resulting from physical injury or illness. This situation must have persisted for an uninterrupted period of at least six months. The diagnosis must be confirmed by an otorhinolaryngologist.

Loss of Limbs.

Loss of Limbs. Definitive diagnosis of the complete separation of two or more limbs, at or above the wrist or ankle joint, as a result of an accidental or medically necessary amputation. The diagnosis must be confirmed by a specialist.

Loss of Vision.

Loss of vision – irreversible. Loss of depth perception in both eyes resulting from any disease or injury that cannot be corrected by refractive correction, medication or surgery. Loss of depth perception is confirmed by a visual acuity of 3/60 or worse (0.05 or worse on the decimal scale) in the better eye after correction, or a visual field of less than 10° in diameter in the better eye after correction. The diagnosis must be confirmed by an ophthalmologist.

Severe Burns.

Third-degree burns - covering 20% of the body surface area. Burns involving the destruction of the skin across its entire depth down to the underlying tissue (third-degree burns) and covering at least 20% of the body surface area, as determined using the ‘Rule of Nines’ method or the *Lund and Browder” Chart.* The diagnosis must be confirmed by a specialist.

Major Organ Transplant.

Primary organ, composite tissue or bone marrow transplant. Organ transplant in which the Insured Person is the recipient of an allograft or autologous graft of one or more of the following organs: a) Heart;

b) Kidney;

c) Liver (including partial liver resection and liver transplantation from a living donor);

d) Lung (including lobe transplantation from a living donor or single-lung transplantation);

e) Bone marrow (allogeneic haematopoietic stem cell transplant preceded by total bone marrow ablation);

f) Small intestine;

g) Pancreas.

Total or partial transplants of the face, arm, hand and leg (composite tissue allografts) are also covered by this definition. The condition giving rise to the transplant must be deemed

untreatable by any other means, and must be confirmed by a specialist.

Severe Head Trauma.

Severe head trauma – resulting in permanent loss of physical capabilities. Definitive diagnosis of impaired brain function resulting from traumatic brain injury. The head injury must result in a total inability to perform at least 3 out of 6 Activities of Daily Living independently for an uninterrupted period of at least 3 months, with no reasonable prospects of recovery.

Activities of Daily Living are:

a) Hygiene: the ability to wash oneself in a bath or shower (including getting in and out of the bath or shower) or to wash oneself satisfactorily by other means;

b) Dressing and undressing: the ability to put on and take off clothing, taking into account the clothes usually worn, including putting on prostheses and orthoses;

c) Eating/drinking: the ability to eat and drink when food (solid or liquid) has been prepared and made available, including the ability to sip through a straw or use other adapted utensils;

d) Maintaining personal hygiene: the ability to maintain a reasonable standard of hygiene, using the toilet and controlling bowel and bladder function;

e) Mobility: the ability to move around within one's home, on level surfaces.

f) Getting in and out of bed: the ability to move from bed to a chair in an upright position or a wheelchair, and vice versa.

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

HIV – Human Immunodeficiency Virus infection contracted in the course of professional duties.

HIV infection contracted in the course of a professional activity.

Definitive diagnosis of Human Immunodeficiency Virus (HIV) infection resulting from an incident occurring whilst carrying out any of the following professional activities:

a) Doctor or dentist;
b) Nurse or midwife;
c) Doctor's or dentist's assistant;
d) Laboratory technician or laboratoryassistant;
e) Member of the fire brigade;
f) Members of the ambulance service;
g) Hospital staff member or hospital maintenance worker;
h) Police;
i) Prison guards.

HIV infection must be confirmed by all of the following criteria:

a) The incident must have occurred after the policy came into effect;

b) The incident must be reported, investigated and documented in accordance with the current guidelines issued by the relevant authorities (e.g. occupational medicine);

c) Negative HIV test result, carried out within five days of the incident;

d) HIV seroconversion must occur within 12 months of the incident;

e) The incident that caused the infection must have taken place within the country.

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: 64 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

complementary Total and Permanent Disability by Accident cover of the life insurance).

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 be due if, at the time of signing the Contract, the Insurance Company had 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 determined by the Policyholder and is set out in the relevant Specific Terms and Conditions.
The Insured Capital is updated annually, in the Policy Year of the Specific Terms and Conditions, in accordance with the Consumer Price Index (year-on-year rate of change in November of the year preceding the update).
The Insured Person's Critical Illness Cover has a maximum Insured Capital amount of €150,000.

HOW IS THE CONTRACT PREMIUM CALCULATED?
In each Policy Year, the premium is calculated based on the actuarial age of the Insured Person(s) on that date, and the Insured Capital. This amount is subject to 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. This modality allows the Policyholder to pay the premium on a monthly basis. **The minimum monthly premium is €3.00.** 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:

- **» Death: 70 years;**
- **»Total and Permanent Disability by Accident and Critical Illnesses: 65 years. This Complementary Coverage ends when the Insured Person reaches the Term Age.**

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, 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.

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:

Stroke (Cerebrovascular Accident) (CVA).

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

b) Traumatic injury to brain tissue or blood vessels;

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

d) Insignificant findings on imaging tests (CT or MRI) with no clearly related clinical symptoms (silent stroke);

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

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

a) or having progressed to at least clinical TNM stage T2N0M0 (TNM classification);

c) Chronic lymphocytic leukaemia, unless it has progressed to stage B of the Binet classification;

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

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

f) Microscopic papillary carcinoma of the bladder, histologically classified as Ta;

g) Polycythaemia vera and essential thrombocythemia;

h) Monoclonal gammopathy of undetermined significance;

i) Gastric MALT lymphoma, if treatable by eradicating Helicobacter pylori;

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

k) Cutaneous lymphoma, unless it requires treatment with chemotherapy or radiotherapy;

l) Micro-invasive breast carcinoma (histologically classified as T1mic), unless it requires a mastectomy, chemotherapy or radiotherapy;

m) Micro-invasive cervical carcinoma (histologically classified as stage IA1), unless it requires a hysterectomy, chemotherapy or radiotherapy;

n) Borderline tumours or tumours with a low risk of malignancy (FIGO stages I and II).

Coronary artery bypass surgery (two or more arteries).

a) Coronary artery bypass surgery to treat stenosis or occlusion of a coronary artery;

b) Coronary angioplasty or stent placement.

Aortic surgery.

a) Surgery on any part of the thoracic or abdominal aorta (including bypass surgery using aortofemoral or aorto-iliac grafts);

b) Aortic surgery related to a hereditary connective tissue disorder (e.g. *Marfan syndrome, Ehlers-Danloss syndrome);*

c) Surgery following a traumatic injury to the aorta.

Heart valve surgery.

Transcatheter mitral valve clipping.

Coma.

a) Medically induced coma.

b) Any coma resulting from self-inflicted injuries, alcohol or drug abuse.

Alzheimer's disease (before the age of 65).

Other forms of brain dementia caused by systemic disorders or psychiatric conditions.

Parkinson's disease (before the age of 65).

a) Secondary parkinsonism (including toxin- or drug-induced parkinsonism);

b) Essential tremor; and

c) Parkinsonism associated with other conditions or neurodegenerative diseases.

Terminal liver disease.

Severe liver disease caused by alcohol consumption or drug use (including hepatitis B or C and infections acquired through intravenous drug use).

Motor Neurone Disease.

a) Multifocal motor neuropathy (MMN) and myositis;

b) Post-polio syndrome;

c) Muscle atrophy of the spine;

d) Polymyositis and dermatomyositis.

Acute Viral Encephalitis.

a) Encephalitis in the presence of HIV;

b) Encephalitis caused by a bacterial or protozoal infection;

c) Myalgic or paraneoplastic encephalomyelitis.

Myocardial Infarction.

a) Acute coronary syndrome (stable or unstable angina pectoris);

b) Elevated troponin levels in the absence of ischaemic heart disease (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, toxicity due to the use of narcotics);

c) Myocardial infarction with normal coronary arteries or caused by coronary vasospasm, coronary artery bypass graft *(myocardial bridging)* or abuse of narcotic drugs;

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

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.

Fulminant Viral Hepatitis.

a) All non-viral causes of acute liver failure (including paracetamol or aflatoxin poisoning);

b) Fulminant viral hepatitis associated with intravenous drug use.

End-Stage Renal Disease.

Reversible acute kidney failure managed with temporary renal dialysis.

Bacterial Meningitis.

Aseptic, viral, parasitic or non-infectious meningitis.

Limb Paralysis.

a) Paralysis resulting from self-harm or psychological disorders;

b) Guillain-Barré syndrome;

c) Intermittent or hereditary paralysis.

Loss of Speech.

Loss of speech resulting from psychiatric disorders.

Loss of Limbs.

Loss of limbs due to self-inflicted injury.

Severe Burns.

a) Third-degree burns due to self-inflicted injury;

b) Any first- or second- degree burn.

Major Organ Transplant.

a) Transplant of other organs, body parts or tissues (including corneas and skin);

b) Transplantation of other cells (including islet cells and other stem cells, except haematopoietic stem cells).

Severe Head Trauma.

Any head trauma resulting from self-inflicted injury, alcohol or drug use.

HIV – Human Immunodeficiency Virus infection contracted in the course of professional duties.

HIV infection resulting from any other means of transmission, including sexual activity or drug abuse.

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, 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, 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.

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. A Policyholder who establishes their residence outside Portugal must designate a domicile within Portugal 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 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).

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 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 AND 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 be due if, at the time of signing the Contract, the Insurance Company had 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.

ARTICLE 6. COMMENCEMENT, CONTRACT DURATION AND EFFECT OF COVERAGE

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

6.2. 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.

6.3. 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.

6.4. 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

9.1. The Insured Capital for each Insured Person is set out in the relevant Specific Terms and Conditions.

9.2. The method for calculating the premium, as well as the relationship between the respective premium and the Insured Capital, comprises part of the pre-contractual information obligations and is set out in the relevant Information Note.

9.3. The Insured Capital is updated annually, in the Policy Year of the Specific Terms and Conditions, in accordance with the Consumer Price Index (year-on-year rate of change in November of the year preceding the update).

ARTICLE 10. CONTRACT PREMIUM

10.1. Premiums are calculated on the basis of the Insured Person's actuarial age and the Insured Capital, in accordance with the Insurer's current rates for the contractually agreed modality, plus any statutory charges.

10.2. In the case of annual renewable insurance, premiums will be calculated on the Policy's anniversary date.

10.3. The method for calculating the premium, as well as the relationship between the premium and the Insured Capital, comprises part of the pre-contractual information and is set out in the relevant Information Note.

10.4. The amount of the initial premium is as stated in the Specific Terms and Conditions.

10.5. The premiums due shall be calculated in accordance with the Insurer's current rates for the contractually agreed modality.

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, provided that the Policyholder pays the associated Premium Instalment fee.

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 has given their written consent.

ARTICLE 16. CESSATION OF COVER

16.1. 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 seventy (70), or any other age differing from this one, provided that this is specified in the Policy's Specific Terms and Conditions;

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

16.2. When two Insured Persons are covered under this Contract (in the case of joint life insurance), the death or disability of either one shall also result in the automatic termination of the 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, 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 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 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).

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. 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 by Accident 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 by Accident 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. <u>The following are not considered accidents</u>:

- 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. <u>The following are considered accidents</u>:

- 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.

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) In the case of joint life insurance, this cover shall cease for the first Insured Person who reaches the age of 65, or any lower age as defined in the policy's Specific Terms and Conditions, whilst remaining in force for the other Insured Person until they reach the specified term age.

ARTICLE 6. EXCLUDED RISKS The Excluded Risks of 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, 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;

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 Complementary Absolute and Definitive Disability Insurance, 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 65.

ARTICLE 2. DEFINITION OF CRITICAL ILLNESSES

2.1. Stroke (Cerebrovascular Accident) (CVA).

CVA - resulting in permanent symptoms.

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

a) Sudden onset of new neurological symptoms, and b) Recent objective neurological deficits on clinical examination.

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

The following are excluded:

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

c) Traumatic injury to brain tissue or blood vessels;

d) Neurological deficits caused by generalised hypoxia, infection, inflammatory disease, migraine or intervention;

e) Insignificant findings on imaging tests (CT or MRI) with no clearly related clinical symptoms (silent stroke);

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

2.2. Aplastic Anaemia.

Aplastic Anaemia - with severe failure of the bone marrow.

A definitive diagnosis of aplastic anaemia results in bone marrow failure, characterised by anaemia, neutropenia and thrombocytopenia. Treatment of the condition must involve blood transfusions and at least one of the following treatments: a) Bone marrow stimulants;

b) Immunosuppressants;

c) Bone marrow transplant.

The diagnosis must be confirmed by a haematologist and substantiated by bone marrow histology.

2.3. Cancer.

Cancer – excluding early 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 expressly excluded, leukaemia, malignant lymphoma and myelodysplastic syndrome. **The following are excluded:**

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 (TNM classification);

c) Chronic lymphocytic leukaemia, unless it has progressed to stage B of the Binet classification;

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

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

f) Microscopic papillary carcinoma of the bladder, histologically described as such;

g) Polycythaemia vera and essential thrombocythemia;

h) Monoclonal Gammopathy of Undetermined Significance (MGUS);

i) Gastric MALT lymphoma, if treatable by eradicating *Helicobacter pylori;*

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

k) Cutaneous lymphoma, unless it requires treatment with chemotherapy or radiotherapy;

l) Micro-invasive breast carcinoma (histologically classified as T1mic), unless it requires a mastectomy, chemotherapy or radiotherapy;

m) Micro-invasive cervical carcinoma (histologically classified as stage lA1), unless it requires a hysterectomy, chemotherapy or radiotherapy;

n) Borderline tumours or tumours with a low risk of malignancy (FIGO stages I and II).

2.4. Coronary artery bypass surgery (two or more arteries).

Coronary artery bypass surgery - for the treatment of multivessel coronary artery disease.

The performance of heart surgery to correct stenosis or blockage of two or more coronary arteries using coronary artery bypass grafting (CABG - *Coronary Artery Bypass Graft)).* Heart surgery involving a full sternotomy (vertical incision of the sternum) and minimally invasive procedures (partial sternotomy or thoracotomy) are covered. The need for such surgery must be demonstrated by coronary angiography and confirmed by a cardiologist or a cardiothoracic surgeon. **The following are excluded:**

a) Coronary artery bypass surgery to treat stenosis or occlusion of a coronary artery;

b) Coronary angioplasty or stent placement.

2.5. Aortic surgery.

Aortic surgery - including minimally invasive procedures.

Surgery to treat aortic stenosis, obstruction, aneurysm or dissection. Minimally invasive procedures, such as endovascular surgery, are covered by this definition. The decision to perform aortic surgery must be confirmed by a cardiothoracic surgeon and supported by imaging results. **The following are excluded:**

a) Surgery on any part of the thoracic or abdominal aorta (including bypass surgery using aortofemoral or aorto-iliac grafts);

b) Aortic surgery related to a hereditary connective tissue disorder (e.g. Marfan syndrome, Ehlers-Danloss syndrome);

c) Surgery following a traumatic injury to the aorta.

2.6. Heart valve surgery.

Heart valve surgery - including minimally invasive and catheter-based procedures.

Surgery to replace or repair abnormalities in one or more heart valves. The following procedures are covered by this definition:

a) Heart valve replacement or repair involving full sternotomy (vertical division of the sternum), partial sternotomy or thoracotomy;

b) Ross procedure;

c) Balloon valvuloplasty;

d) Transcatheter aortic valve implantation (TAVI). The need for such surgery must be confirmed by a cardiologist or a cardiothoracic surgeon and supported by an echocardiogram or the results of a cardiac catheterisation.

The following are excluded:

Transcatheter mitral valve clipping

2.7. Coma.

Coma - resulting in persistent symptoms.

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

a) results in a score of 8 or below on the Glasgow Coma Scale, persisting continuously for at least 96 hours;

b) requires the use of life-support systems, and

c) results in a persistent neurological deficit, which must be assessed at least 30 days after the start of the coma.

The diagnosis must be confirmed by a neurologist.

The following are excluded:

a) Medically induced coma.

b) Any coma resulting from self-inflicted injuries, alcohol or drug abuse.

2.8. Alzheimer's disease (before the age of 65).

Alzheimer's disease (before the age of 65) - requiring constant supervision.

Definitive diagnosis of Alzheimer's disease, as evidenced by all of the following characteristics: a) A decline in cognitive ability involving impairment of memory and executive functions (sequencing, organising, abstracting and planning), resulting in a significant reduction in mental and social functioning;

b) Changes in personality;

c) A gradual onset and continuous decline in cognitive function;

d) No disturbance of consciousness;

e) Typical neuropsychological and neuroradiological findings (e.g. CT scan/MRI).

The condition must require constant supervision (24 hours a day, for those under 65). The diagnosis and the need for supervision must be confirmed by a neurologist.

The following are excluded:

Other forms of brain dementia caused by systemic disorders or psychiatric conditions.

2.9. Parkinson's disease (before the age of 65).

Idiopathic Parkinson's disease (before the age of 65) - resulting in the permanent loss of physical capabilities.

Definitive diagnosis of primary idiopathic Parkinson's disease, evidenced by at least two of the following clinical manifestations: a) Muscle rigidity;

b) Tremor; and

c) Bradykinesia (abnormal slowness of movement; slowness of physical and mental responses).

Idiopathic Parkinson's disease (before the age of 65) must result in a total inability to perform, independently, at least 3 of the 6 activities of daily living for a continuous period of at least 3 months, regardless of pharmacological treatment.

Activities of Daily Living are:

a) Hygiene: the ability to wash oneself in a bath or shower (including getting in and out of the bath or shower) or to wash oneself satisfactorily by other means;

b) Dressing and undressing: the ability to put on and take off clothing, taking into account the clothes usually worn, including putting on prostheses and orthoses;

c) Eating/drinking: the ability to eat and drink when food (solid or liquid) has been prepared and made available, including the ability to sip through a straw or use other adapted utensils;

d) Maintaining personal hygiene: the ability to maintain a reasonable standard of hygiene, using the toilet and controlling bowel and bladder function;

e) Mobility: the ability to move around within one’s home, on level surfaces.

f) Getting in and out of bed: the ability to move from bed to a chair in an upright position or a wheelchair, and vice versa.

The diagnosis must be confirmed by a neurologist.

The implantation of a neuro-stimulator to control symptoms through deep brain stimulation is,

irrespective of activities of daily living, covered by this definition.
The implant must be deemed medically necessary by a neurologist or neurosurgeon.
The following are excluded:
a) Secondary parkinsonism (including toxin- or drug-induced parkinsonism);
b) Essential tremor; and
c) Parkinsonism associated with other conditions or neurodegenerative diseases.

2.10. Terminal liver disease.
Terminal liver disease - *Child-Pugh* Classification of B or C.
Definitive diagnosis of severe liver disease, proven by a *Child-Pugh* classification score of at least 7 points (*Child-Pugh* Classification of B or C). The score must be calculated using all of the following variables: a) Total bilirubin levels;
b) Serum albumin levels;
c) Severity of ascites;
d) INR values;
e) Hepatic encephalopathy.
The diagnosis must be confirmed by a gastroenterologist and supported by imaging and laboratory test results.
The following are excluded:
Severe liver disease caused by alcohol consumption or drug use (including hepatitis B or C and infections acquired through intravenous drug use).

2.11. Motor Neurone Disease.
Motor Neurone Disease - resulting in a permanent loss of physical capabilities.
Definitive diagnosis of one of the following motor neuron diseases:
a) Amyotrophic Lateral Sclerosis (ALS or *Lou Gehrig's Syndrome;*
b) Primary Lateral Sclerosis (PLS);
c) Progressive Muscular Atrophy (PMA);
d) Progressive Bulbar Palsy.
The condition must result in a permanent inability to perform at least 3 of the 6 Activities of Daily Living independently for a continuous period of at least 3 months, with no prospect of recovery.
Activities of Daily Living are:
a) Hygiene: the ability to wash oneself in a bath or shower (including getting in and out of the bath or shower) or to wash oneself satisfactorily by other means;
b) Dressing and undressing: the ability to put on and take off clothing, taking into account the clothes usually worn, including putting on prostheses and orthoses;
c) Eating/drinking: the ability to eat and drink when food (solid or liquid) has been prepared and made available, including the ability to sip through a straw or use other adapted utensils;
d) Maintaining personal hygiene: the ability to maintain a reasonable standard of hygiene, using the toilet and controlling bowel and bladder function;
e) Mobility: the ability to move around within one's home, on level surfaces;
f) Getting in and out of bed: the ability to move from bed to a chair in an upright position or a wheelchair, and vice versa.
The diagnosis must be confirmed by a neurologist and supported by nerve conduction studies (NCS) and electromyography (EMG).
The following are excluded:
a) Multifocal motor neuropathy (MMN) and myositis;
b) Post-polio syndrome;
c) Muscle atrophy of the spine;
d) Polymyositis and dermatomyositis.

2.12. Chronic Pulmonary Disease.
Chronic Pulmonary Disease - resulting in chronic respiratory failure.
Definitive diagnosis of a terminal lung disease resulting in chronic respiratory failure, confirmed by all of the following criteria:
a) FEV1 (forced expiratory volume in one second) less than 40% of the predicted value on two occasions at least one month apart;
b) Oxygen therapy for at least 16 hours a day for a minimum period of three months;
c) Persistent reduction in partial pressure of oxygen (PaO_2) to below 55 mmHg (7.3 kPa) on arterial blood gas analysis, measured without the administration of oxygen.
The diagnosis must be confirmed by a specialist.

2.13. Acute Viral Encephalitis.

Acute Viral Encephalitis - resulting in persistent symptoms Definitive diagnosis of acute viral encephalitis, resulting in a persistent neurological deficit documented for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a neurologist and based on typical clinical symptoms, cerebrospinal fluid analysis or brain biopsy results.

The following are excluded:

a) Encephalitis in the presence of HIV;

b) Encephalitis caused by a bacterial or protozoal infection;

c) Myalgic or paraneoplastic encephalomyelitis.

2.14. Myocardial Infarction.

Myocardial Infarction.

Death of heart tissue caused by prolonged obstruction of blood flow. The myocardial infarction must be confirmed by an increase and/or decrease in cardiac enzymes (troponin or CK-MB) to levels considered diagnostic of myocardial infarction, in conjunction with at least two of the following criteria:

a) Symptoms of ischaemia (such as chest pain);

b) Recent electrocardiographic (ECG) changes indicative of ischaemia (recent ST-T segment changes or recent left bundle branch block);

c) Development of pathological Q waves on the ECG. The diagnosis must be confirmed by a cardiologist.

The following are excluded:

a) Acute coronary syndrome (stable or unstable angina pectoris);

b) Elevated troponin levels in the absence of ischaemic heart disease (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, toxicity due to the use of narcotics);

c) Myocardial infarction with normal coronary arteries or caused by coronary vasospasm, coronary artery bypass graft *(myocardial bridging)* or abuse of narcotic drugs;

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

2.15. Multiple Sclerosis.

Multiple sclerosis – with persistent symptoms.

A definitive diagnosis of multiple sclerosis must be confirmed by a neurologist and meet all of the following criteria:

a) Current clinical impairment of motor or sensory function, which has remained constant for a continuous period of at least 6 months;

b) MRI (Magnetic Resonance Imaging) showing at least two demyelinating lesions in the brain or spinal cord, characteristic of multiple sclerosis.

The following are excluded:

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.

2.16. Fulminant Viral Hepatitis.

Fulminant Viral Hepatitis - resulting in acute liver failure.

Definitive diagnosis of fulminant viral hepatitis, as evidenced by all of the following criteria:

a) Serological findings typical of acute viral hepatitis;

b) Development of hepatic encephalopathy;

c) Reduction in liver size;

d) Increased bilirubin levels;

e) Coagulopathy according to a International Normalized Ratio (INR) above 1.5;

f) Development of liver failure within 7 days of the onset of symptoms;

g) No history of liver disease.

The diagnosis must be confirmed by a gastroenterologist.

The following are excluded:

a) All non-viral causes of acute liver failure (including paracetamol or aflatoxin poisoning

b) Fulminant viral hepatitis associated with intravenous drug use.

2.17. End-Stage Renal Disease.

End-Stage Renal Disease - requiring permanent dialysis.

Chronic and irreversible failure of both kidneys, resulting in the need for regular haemodialysis or peritoneal dialysis, or if a kidney transplant has been performed. Dialysis must be medically necessary and confirmed by a nephrologist.

The following are excluded: Reversible acute kidney failure managed with temporary renal dialysis.

2.18. Bacterial Meningitis.

Bacterial meningitis - resulting in persistent symptoms.

Definitive diagnosis of bacterial meningitis resulting in a persistent neurological deficit confirmed for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a neurologist and supported by the growth of pathogenic bacteria in a cerebrospinal fluid culture.

The following are excluded: Aseptic, viral, parasitic or non-infectious meningitis.

2.19. Limb Paralysis.

Limb Paralysis - total and irreversible.

Total and irreversible loss of muscle function in all of any two limbs, as a result of injury or disease of the brain or spinal cord. “Limb” is defined as the entire upper or lower limb. The paralysis must have been present for more than three months, must be confirmed by a neurologist, and must be substantiated by clinical and diagnostic findings.

The following are excluded:

a) Paralysis resulting from self-harm or psychological disorders;

b) Guillain-Barré syndrome;

c) Intermittent or hereditary paralysis.

2.20. Loss of Hearing.

Deafness - permanent and irreversible.

Definitive diagnosis of permanent and loss of hearing in both ears, resulting from illness or accidental injury. The diagnosis must be confirmed by an otorhinolaryngologist and substantiated by an average hearing threshold of over 90 dB at 500, 1000 and 2000 hertz in the better ear, as determined by a pure-tone audiogram.

2.21. Loss of Speech.

Loss of Speech - permanent and irreversible.

Definitive diagnosis of total and irreversible loss of the ability to speak, resulting from physical injury or illness. This situation must have persisted for an uninterrupted period of at least six months. The diagnosis must be confirmed by an otorhinolaryngologist.

The following are excluded: Loss of speech resulting from psychiatric disorders.

2.22. Loss of Limbs.

Loss of Limbs.

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

The following are excluded: Loss of limbs due to self-inflicted injury.

2.23. Loss of Vision.

Loss of vision – irreversible.

Loss of depth perception in both eyes resulting from any disease or injury that cannot be corrected by refractive correction, medication or surgery. Loss of depth perception is confirmed by a visual acuity of 3/60 or worse (0.05 or worse on the decimal scale) in the better eye after correction, or a visual field of less than 10° in diameter in the better eye after correction. The diagnosis must be confirmed by an ophthalmologist.

2.24. Severe Burns.

Third-degree burns - covering 20% of the body surface area.

Burns involving the destruction of the skin across its entire depth down to the underlying tissue (third-degree burns) and covering at least 20% of the body surface area, as determined using the ‘Rule of Nines’ method or the Lund and Browder Chart". The diagnosis must be confirmed by a specialist.

2.25. Major Organ Transplant.

Primary organ, composite tissue or bone marrow transplant.

Organ transplant in which the Insured Person is the recipient of an allograft or autologous graft of one or more of the following organs:

a) Heart;

b) Kidney;

c) Liver (including partial liver resection and liver transplantation from a living donor);
d) Lung (including lobe transplantation from a living donor or single-lung transplantation);
e) Bone marrow (allogeneic haematopoietic stem cell transplant preceded by total bone marrow ablation);
f) Small intestine;
g) Pancreas.
Total or partial transplants of the face, arm, hand and leg (composite tissue allografts) are also covered by this definition. The condition giving rise to the transplant must be deemed untreatable by any other means, and must be confirmed by a specialist.
The following are excluded:
a) Transplant of other organs, body parts or tissues (including corneas and skin);
b) Transplantation of other cells (including islet cells and other stem cells, except haematopoietic stem cells)

2.26. Severe Head Trauma.
Severe head trauma – resulting in the permanent loss of physical capabilities.
Definitive diagnosis of impaired brain function resulting from traumatic brain injury. The head injury must result in a total inability to perform at least 3 out of 6 Activities of Daily Living independently for an uninterrupted period of at least 3 months, with no reasonable prospects of recovery.
Activities of Daily Living are:
a) Hygiene: the ability to wash oneself in a bath or shower (including getting in and out of the bath or shower) or to wash oneself satisfactorily by other means;
b) Dressing and undressing: the ability to put on and take off clothing, taking into account the clothes usually worn, including putting on prostheses and orthoses;
c) Eating/drinking: the ability to eat and drink when food (solid or liquid) has been prepared and made available, including the ability to sip through a straw or use other adapted utensils;
d) Maintaining personal hygiene: the ability to maintain a reasonable standard of hygiene, using the toilet and controlling bowel and bladder function;
e) Mobility: the ability to move around within one's home, on level surfaces.
f) Getting in and out of bed: the ability to move from bed to a chair in an upright position or a wheelchair, and vice versa.
The diagnosis must be confirmed by a neurologist or a neurosurgeon and supported by the results of imaging tests (CT or MRI scans of the brain).
The following are excluded: Any head trauma resulting from self-inflicted injury, alcohol or drug use.

2.27. HIV – Human Immunodeficiency Virus infection contracted in the course of professional duties.
HIV infection contracted in the course of a professional activity.
Definitive diagnosis of Human Immunodeficiency Virus (HIV) infection resulting from an incident occurring whilst carrying out any of the following professional activities: a) Doctor or dentist;
b) Nurse or midwife;
c) Doctor's or dentist's assistant;
d) Laboratory technician or laboratory assistant;
e) Member of the fire brigade;
f) Members of the ambulance service;
g) Hospital staff member or hospital maintenance worker;
h) Police;
i) Prison guards.
HIV infection must be confirmed by all of the following criteria:
a) The incident must have occurred after the policy came into effect;
b) The incident must be reported, investigated and documented in accordance with the current guidelines issued by the relevant authorities (e.g. occupational medicine);
c) Negative HIV test result, carried out within five days of the incident;
d) HIV seroconversion must occur within 12 months of the incident;

e) The incident that caused the infection must have taken place within the country

The following are excluded: HIV infection resulting from any other means of transmission, including sexual activity or drug abuse.

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. If the Contract is for one Insured Person, this Complementary Critical Illness Cover shall cease when the Insured Person reaches the term age agreed for this coverage.

5.3. This cover shall cease when the Insured Person reaches the age of 65 or any other age below this, as defined in the Policy's Specific Terms and Conditions.

ARTICLE 6. EXCLUDED 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.