Personal Life Plan Agreement

Individuals

William Russell

For members with a personal life plan whose period of cover starts on or after **01 January 2021**

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Welcome to William Russell

Thank **you** for choosing a personal life plan. **We** want to provide **you** with an insurance policy **you** can rely on, so it is important that **you** fully understand the scope of the cover **we** provide. This **agreement** explains what is and what is not covered by **your plan**, and how **your claims** will be administered.

By taking out a personal life **plan** from William Russell **you** have become a member of the **William Russell Association for Health, Financial Protection and Well-Being (WRA)**, and **you** are eligible for cover under the **WRA's** contract of insurance with **us**.

Please take time to read this **agreement** along with **your Certificate of Insurance** and **application form**. Together, these documents describe **your** cover under the contract of insurance between the **WRA** and **us**.

Certain words **we** use within this **agreement** have a special meaning to which **we** would like to draw **your** attention. For example: -

- '**We**, **us**, **our**' – means William Russell Europe SRL, on behalf of the **insurer**
- 'Life benefit' – means the amount for which you have insured your life, as shown on your **Certificate of Insurance**.

These words appear in **bold** type, and **we** provide their precise meanings in the *Definitions* section of this **agreement**.

All web addresses in this **agreement** are live. Simply click on a link and **you** will be taken directly to **our** website. **We** are, of course, always at the end of a telephone to answer queries or deal with **your claim**. **You** can find **our** contact details below.

William Russell

William Russell Europe SRL is the administrator of your plan. William Russell Europe SRL is registered in Belgium with the Financial Services and Markets Authority (FSMA), as mandated underwriter, acting on behalf of AWP Health &Life SA (part of the Allianz group of companies).

Allianz

Allianz (AWP Health & Life SA, registered address at Eurosquare 2, 7 rue Dora Maar, 93400 Saint Ouen, France) is the **insurer** of **your plan**.

Your right to cancel within 30 days

If **you** decide **your plan** does not meet **your** needs, **you** will need to send **us** the following email if **you** wish to cancel **your plan** within 30 days. Provided **we** receive **your** instruction within 30 days of **your** plan start date, and provided **you** have made no **claims**, **we** will refund **your premium** in full.

*I, **[Enter Full Name & Address]**, withdraw from membership to the plan number **[Enter Plan Number]** subscribed to by **[Enter Full Name]** with AWP Health & Life SA, in accordance with Article L.132-5-1 of the French Insurance Code.*

I hereby certify that, on the date of this email, I am not aware of any claim invoking the policy coverage since the policy was concluded.

If **we** receive **your** instruction to cancel **your plan** more than 30 days after **your date of entry**, the terms of **our** cancellation policy will apply.

Contact details

If you have an enquiry about your plan or insurance	**Phone**	+44 1276 486 455
	Fax	+44 1276 486 466
	Email	enquiries@william-russell.com
If you need to make a claim	**Phone**	+44 1276 486 460
	Fax	+44 1276 486 466
	Email	claims@william-russell.com
If you'd like to write to us	**William Russell Europe SRL** Place Marcel Broodthaers, 8 1060 Saint-Gilles Brussels, Belgium	

General conditions

This **agreement**, together with **your application form** and **your Certificate of Insurance** determine the terms and conditions of **your** cover under the **master policy.**

Eligibility for cover

To be eligible for cover under the personal life **plan**:

- **you** must not be living in any of the following countries: Iran, North Korea, Libya, South Sudan, Syria, Yemen or Switzerland.
- **you** must be at least 18 years of age, on the date that **your** plan commences
- **you** must not be more than 69 years of age
- **your** occupation must be 100% office-based (if **your** occupation is not 100% office-based, **you** must provide **us** with a full job description)

Maximum life benefit

The maximum amount payable for the **life benefit** is 20 times **your gross annual earnings** at the time **you** made **your** application, less the benefit payable under any other life insurance policy that **you** held at the time **you** made **your** application, subject to a maximum benefit of US$2,000,000 or £1,500,000 or €1,700,000.

In the event of a claim, **we** may require proof that **your gross annual earnings** were equal to or more than one twentieth of **your life benefit** and **your** other life insurance cover combined at the time **you** made **your** application.

If **you** are a **houseperson**, student, retired person or voluntary worker, at the time **you** made **your** application, the maximum amount payable under the **life benefit** is US$160,000 or £120,000 or €136,000.

Maximum accident benefit

The maximum amount payable under the **accident benefit** is US$500,000 or £375,000 or €500,000. The amount payable under the **accident benefit** cannot exceed the amount of **your life benefit**.

When your plan ceases

Your plan will automatically cease:

- on the date of **your** death
- upon payment of the **terminal illness** benefit
- at the end of the annual **period of cover** during which **you** reach **your** 70th birthday
- if **you** take up residence in any of the following countries: Iran, North Korea, Libya, South Sudan, Syria, Yemen
- at the **renewal date** immediately following the date of **your** becoming a resident of Switzerland, regadless of whether Switzerland is **your country of nationality**
- at the **renewal date** immediately following the date of **your** return to live in the USA, if **your country of nationality** is the USA.

If **your** plan ceases because **we** have paid the **terminal illness** benefit or the **life benefit**, **we** will not refund the unused **premium** for the remainder of the **period of cover**. If **your** plan ceases and **we** have not paid the **terminal illness** benefit or the **life benefit**, **we** will refund the unused **premium** for the remainder of the **period of cover**.

When we have the right to cancel your plan

We have the right to cancel **your** plan immediately if:

- **you** do not pay **your** renewal **premium** within 30 days of **your renewal date**
- **you** do not pay **your** monthly or quarterly or semi-annual **premium** within 30 days of its **due date**
- **you** cease to be a member of the **William Russell Association for Health, Financial Protection and Well-Being.**
- **you** or any person acting on **your** behalf has made any threatening or abusive comment or used any unacceptable language towards **us**, any member of **our** staff, or any service provider acting on **our** behalf, whether verbally or in writing
- **you** have misled **us**, or attempted to mislead **us**, whether intentionally or carelessly, at any time by providing **us** with false information or by working with another party to provide false information to **us**.

If **we** cancel **your** plan for any of the above reasons, **we** may also report the matter to the relevant authorities (if appropriate).

If **your** death, **terminal illness** diagnosis or **accidental bodily injury** occurs after **your** plan has ceased, no benefit will be payable, even if the death, **terminal illness** or **accidental bodily injury** arises from an injury or illness that existed whilst **your** plan was in force.

You may cancel **your** plan by instructing **us** in writing. **Your** plan will be cancelled upon receipt by **us** of **your** instruction to do so.

Limitations on actions

The provisions relating to the statute of limitations on actions arising from the insurance contract are established by Articles L.114-1 - L.114-3 of the French Insurance Code indicated hereafter: -

Article L. 114-1 of the French Insurance Code

All actions arising from an insurance contract are limited to two years after the incident giving rise thereto. However, this statute of limitations only applies: -

1° In case of concealment, omission, false or inaccurate declaration of the risk involved, from the day on which the **insurer** had knowledge thereof;

2° In the event of a **claim** of damages, from the day on which the Parties involved became aware thereof, if they prove that they were unaware of it until then.

When the action of the Insured Party against the **Insurer** is due to the action of a third party, the statute of limitations only starts to run from the day on which the third party initiated legal proceedings against the Insured Party or was compensated by him.

The limitation is extended to ten years in life insurance contracts when the beneficiary is a person distinct from the policyholder and, in accident insurance contracts affecting people, when the beneficiaries are the beneficiaries of the deceased insured party.

For life insurance contracts, notwithstanding the provisions of Item 2, the actions of beneficiaries are limited to thirty years after the death of the Insured Party.

Article L. 114-2 of the French Insurance Code

The running of the statute of limitations is interrupted by one of the ordinary causes of interruption and by the appointment of experts following an incident. The interruption of the statute of limitations of the action can furthermore result from the sending of a registered letter with return receipt requested sent by the **Insurer** to the Insured Party regarding the action for the payment of the **premium** and by the Insured Party to the **Insurer** for the payment of the compensation.

Article L. 114-3 of the French Insurance Code

As an exception to article 2254 of the French Civil Code, the Parties to the insurance contract cannot, even by joint agreement, modify the duration of the statute of limitations, nor add to the causes of its suspension or interruption.

Additional information

The ordinary causes of interruption of the statute of limitations are mentioned in Article 2240 and in accordance with the Civil Code; among the latter include notably: the questioning of one of the joint debtors by a judicial action or by an act of compulsory execution or the acknowledgement by the debtor of the right of the person against whom he applied the statute of limitations. For the exhaustive list of the ordinary causes of interruption of the statute of limitations refer to the aforementioned articles of the Civil Code herein above.

Your obligations

Full disclosure about your medical history

You must disclose on **your application form** all **pre-existing medical conditions**.

Your completed, signed and dated **application form** is an integral and crucial part of **your agreement** with **us** and the cover **we** provide.

If a claim is submitted in respect of death, **terminal illness** or **accidental bodily injury** which is caused by or related to a **pre-existing medical condition** or **related condition** which **you** omitted to tell **us** about on **your application form**, or **you** omitted to tell **us** everything about, **we** will refuse to pay that claim.

If **your application form** omitted facts, or contained materially incorrect or incomplete facts, **we** have the right to declare **your** plan void. Alternatively **we** may impose **special terms** on **your** plan which will apply with effect from **your date of entry**.

A change in your state of health between you signing the application form and paying your premium

If, after completing, signing and dating **your application form** any changes occurred in the facts **you** gave **us**, such as a change in **your** state of health, **you** must tell **us** by email to enquiries@william-russell.com about the change and **we** reserve the right to decline **your** application or to accept **your** application with **special terms**.

A change in your occupation

You must inform **us** immediately by email to enquiries@william-russell.com, if **you** change **your** occupation or the tasks and duties within that occupation. If **you** change **your** occupation **we** may cancel **your** plan, increase **your premium**, reduce **your** benefit or make **your** plan subject to **special terms**.

A change in your address, country of residence or email address

You must inform **us** immediately, by email to enquiries@william-russell.com if **you** change **your** address and/or **country of residence**. If **you** change **your country of residence we** may cancel **your** plan, increase **your premium**, reduce **your** benefit or make **your** plan subject to **special terms**.

You must tell **us**, in writing, if **you** change **your** email address as **we** will email **you** with **our** renewal terms and renewal **premium** invoice prior to **your renewal date** or **we** may need to contact **you**.

If you participate in hazardous activities

You must inform **us**, by email to enquiries@william-russell.com of **your** intention to participate in any **hazardous activities**.

If **you** participate in **hazardous activities we** may cancel **your** plan, increase **your premium**, reduce **your** benefit or make **your** plan subject to **special terms**.

If you return home

If **you** are an expatriate and **you** return to **your country of nationality you** may continue to renew **your** plan provided that the local laws in **your country of nationality** permit **you** to do so, and provided that **we** are permitted to offer cover in that country. **We** reserve the right to refuse to offer cover in certain countries.

If **you** become a resident of Switzerland (whatever **your country of nationality**) **your** plan will automatically cease at the **renewal date** immediately following the date of **your** becoming a resident of Switzerland.

If **you** return home to the USA and **your country of nationality** is the USA, **your** plan will automatically terminate on the **renewal date** following **your** permanent return to the USA.

Administration of your plan

Claiming your reimbursement of medical fees

To obtain reimbursement of the cost of any medical examination or tests **we** have specifically requested, please complete a reimbursement form and return this to **us**, together with a copy of the receipted bills for the examination or tests **you** have had.

Medicals can be completed by a doctor of **your** choice providing they hold recognised qualifications and all information must be in English.

Provided **we** receive **your** fully completed Reimbursement of Medical Fees form and a copy of the receipted bills within two months of **your** plan going into force (or **your** increased cover going into force if **your** application is for an increase in benefits on an existing plan), **we** will reimburse **you**, up to a maximum amount of US$750 or £563 or €638, depending upon the currency of **your** plan. Medical fees will be refunded in **your** plan currency.

We will only pay a reasonable and customary charge which means that if the cost of **your** medical examination and/or medical tests is more than **we** would reasonably have expected to pay in **your** location, **we** will only pay the amount which is customarily charged and **you** will have to pay the rest.

Provided **you** have given **us** full and complete instructions as to where to send the reimbursement, it will be made by **us** direct to **your** bank account at the end of the month following the month **your** plan goes into force. If **you** pay **your premiums** semi-annually, quarterly or monthly, reimbursement will be made direct to **your** bank account after **your** plan has been in force for a full 6-month period.

If **you** decide not to accept any offer **we** may make to commence cover (or to increase cover if **your** application is for an increase in benefits under an existing plan) **we** will not reimburse **your** medical fees, even if the reason **you** do not proceed is because **we** have accepted **your** application subject to **special terms** and/or a **premium** loading. However, if **we** decline to offer cover to **you** (or to offer an increase in **your** benefit if **your** application is for an increase in benefit) due to medical reasons, **we** will reimburse **your** medical fees in accordance with the above limits.

If **you** cancel **your** plan within 12 months of commencing **your** plan or increasing **your** benefit, **we** shall deduct from **your premium** refund any reimbursement **we** have made to **you** in respect of **your** medical fees.

We will not reimburse any bills received by **us** more than 2 months after **your** plan commences, or more than 2 months after any increase in cover becomes effective if the bills relate to an increase in cover.

Payment of premiums

Premiums may be paid annually, semi-annually, quarterly or monthly.

Annual **premiums** may be paid by a credit or debit card that is acceptable to **us**, or by banker's draft or cheque drawn on a British bank, by bank transfer direct to **our** bank account, or, if **you** pay **your premiums** in Sterling from a UK bank account, by direct debit.

Semi-annual, quarterly or monthly **premiums** must be paid by a credit or debit card acceptable to **us**, and **we** will make automatic withdrawals from **your** card as appropriate until **we** are instructed to stop. Please note that if the card **you** instruct **us** to withdraw **your premiums** from expires during **your period of cover** it is **your** responsibility to supply **us** with new card details. If **you** pay **your premiums** in Sterling from a UK bank account **we** can also accept payment by direct debit. **Your** plan will automatically cease if **we** are unable to withdraw **your premiums** within 30 days of the date on which they fall due.

Your premiums must be paid to **us** in the currency of **your** plan.

Unpaid or late premiums

We will automatically cancel **your** plan if **you** fail to pay an annual, semi-annual, quarterly or monthly **premium** by its **due date**, or if **we** are unable to collect **your premium** from **your** credit/debit card or direct debit by its **due date**. However, **we** may allow **your** plan to continue without **you** having to complete a new **application form** and health declaration if **you** pay the outstanding **premium** within 30 days of its **due date**.

If **your premium** is not received by **us** within 30 days of its **due date you** will have to re-apply for a new plan and **we** will require a new **application form** and new medical evidence which must be provided at **your** own expense. If **you** are accepted for cover, the **pre-existing medical condition** exclusion will apply from **your date of entry** to **your** new plan and **you** will be charged at the **premium** rates prevailing when **we** decide to commence **your** new plan. **We** may accept **your** new application with or without **special terms** or **we** may refuse to accept **your** application at **our** sole and complete discretion and without **us** having to give any reason for **our** decision.

Insurance premium tax

If **your country of residence** is a country where **we** are obliged to collect **insurance premium tax you** must pay to **us** the amount of any **insurance premium tax** due.

Renewing your plan

Once **your** plan has commenced **you** may continue to renew **your** plan each year subject to the **agreement** in force at the time of each subsequent **renewal date**.

We will not cancel **your** plan unless **we** are entitled to do so under **our** cancellation policy (please see the **When your plan ceases** section on Page 4).

Maximum ages for renewing your plan

You cannot renew **your** plan once **you** reach the age of 70 years.

Age-related premiums

Our premiums are age-related and will increase as **you** get older. The **premiums** are subject to change and cannot be guaranteed for the future.

Applying for an increase in benefit

You may apply for an increase in benefit at any time by completing a new **application form**. Upon receipt of **your** application for an increase in benefit **we** will advise **you** of **our** medical requirements to underwrite the increase in benefit **you** require. Any increase in benefit must be within the maximum benefit limits stated in this **agreement**.

When **we** have received sufficient information about **your** health, **your** occupation and **your hazardous activities we** will assess **your** application for additional benefit.

If **your** state of health has changed since **your** original application, **we** may impose a medical **premium** loading, and/or a specific medical exclusion in respect of the additional benefit. **We** may also decline to accept **your** application for additional benefit at **our** discretion.

If **you** have changed **your** occupation and/or location, or **you** have taken up a previously undeclared **hazardous activity**, **we** may impose a **premium** loading and/or exclusion in respect of **your** whole plan (and not just the amount of the increase).

If **we** decide to accept **your** application for an increase in benefit, **we** will issue a **premium** invoice that will state the terms upon which **your** application for the additional benefit has been accepted, and the **premium** required to put **your** additional cover into force.

Please note that, in some circumstances, after **you** have been accepted for an increase in benefit, it may be necessary to provide **you** with a separate plan, which may have different renewal and **premium due dates**. This will be communicated to **you** if this is required.

You must pay this additional **premium** within 30 days of the date of **our** invoice. Provided **we** receive payment of **your** invoice within 30 days, **we** will commence **your** additional benefit from the date of **our** invoice, subject to there having been no change in **your** state of health.

If **we** have not received payment within 30 days, **your** application for additional benefit will be cancelled and **you** will have to re-apply for the additional benefit.

Your life benefit and **accident benefit** may be increased up to age 69 (subject to the maximum benefit limits stated in this **agreement**).

Applying for a reduction in benefit

You may apply to reduce **your** benefit 6-months after **your date of entry**, by sending **your** instructions by email to enquiries@william-russell.com.

Appointing a beneficiary

If **you** did not nominate a beneficiary when **you** applied for your plan, **you** can appoint a beneficiary at any time. Email **us** at enquiries@william-russell.com and **we** will send **you** the necessary form(s).

If **you** have not appointed a beneficiary at the time of **your** death, the beneficiary of **your** plan shall be:

- **your** spouse*; failing him/her
- **your** legally declared child(ren) in equal shares; failing him/her/them
- **your** estate.

If **you** do not appoint a beneficiary for the event of **terminal illness**, the benefit will be paid to **you**.

*Please note that in the event of a claim, a partner may not have the same rights as attributed to a spouse. If **you** wish the benefit to be paid to **your** partner, **you** must name **your** partner as beneficiary.

Cancelling your plan

You may cancel **your** plan after it has been in force for a full 6-month period. After that, upon receipt of **your** written instruction that **you** wish to cancel **your** plan you may be entitled to a **pro rata refund** of **your premium**. If **you** decide to cancel **your** plan within the first 12 months, (or within 12 months of an increase in benefit), **we** will deduct the amount of any medical fees reimbursement **we** have made to **you** from **your premium** refund.

No **premium** refund is due if a claim has been made.

If you are not satisfied with your plan, you can instruct us to cancel from the date the plan commenced. **We** will refund **your** premium in full, provided that we receive **your** instruction within 30 days of **your** plan commencing, and that no claims have been made.

The personal life plan is not an investment plan and does not acquire a cash or surrender value.

Your life benefit

When we pay your life benefit

In the event of **your** death, **we** will pay the **life benefit** stated on **your Certificate of Insurance**, provided that:

- **your life benefit** does not exceed 20 times **your gross annual earnings** at the time that **you** applied for **your** plan
- **your** plan was in full force at the time of **your** death
- **your** death was not caused directly or indirectly by any risk excluded in this **agreement**, or by any **special terms** stated on **your Certificate of Insurance**.

In the event of a **terminal illness we** will pay the **life benefit** stated on **your Certificate of Insurance**, provided that:

- **your terminal illness** is expected (by **your** consultant and by **our Chief Medical Officer**) to lead to **your** death within 12 months or before the first **renewal date** following **your** 70th birthday, whichever is the earlier date
- **your life benefit** does not exceed 20 times **your gross annual earnings** at the time that **you** applied for **your** plan
- **your** plan is in full force at the time **you** notify us that **your** consultant has confirmed that **your** condition is terminal
- **your** terminal illness is not caused directly or indirectly by any risk excluded in this **agreement**, or by any **special terms** stated on **your Certificate of Insurance**.

Please note that the decision of **our Chief Medical Officer** is final.

Making a claim for your life benefit

To substantiate a claim for **your life benefit** following **your** death, the following documents must be submitted to **us** as soon as reasonably possible:

- an official death certificate confirming the cause of death and stating the date of death
- an official document which confirms **your** date of birth
- in the event of death due to an accident, a medical or official certificate stating the cause and circumstances of death, all other reports including police reports, ambulance reports and the reports of any eye-witnesses and such other documents as **we** may reasonably require to establish the cause of death and the circumstances surrounding the death
- proof of **your gross annual earnings** at the time **you** made **your** application (if this was not provided at application stage)
- identification for any named beneficiaries showing date of birth, proof of life, proof of address and full bank details
- any other medical reports or proof that **we** may reasonably require in order to assess **your** claim.

To substantiate a claim for **your life benefit** as a result of **terminal illness**, the following documents must be submitted to **us** as soon as reasonably possible:

- an official document that confirms **your** date of birth
- a claim form completed by **you** or **your** next of kin (if **you** are unable to complete it **yourself**)
- proof of **your gross annual earnings** at the time **you** made **your** application (if this was not provided at application stage)
- identification (if applicable) for any named beneficiaries showing date of birth, proof of life, proof of address, and full bank details
- a medical report that gives full details about the onset, progression, and prognosis of **your terminal illness**, including full details of treatments **you** are receiving
- any other medical reports or proof that **we** may reasonably require in order to assess **your** claim.

The optional accident benefit

When we pay your accident benefit

The **accident benefit** becomes payable if **you** die as a consequence of an **accidental bodily injury** that is suffered during the **period of cover**, provided that:

- **your** plan was in full force at the time of **you** sustained the **accidental bodily injury**
- **your** death arises within one year of the date on which **you** sustained the **accidental bodily injury**
- the **accidental bodily injury** is not caused directly or indirectly by any risk excluded in this **agreement** or by any **special terms** stated on **your Certificate of Insurance**.

A percentage of the **accident benefit** becomes payable if **you** suffer an **accidental bodily injury** that results in any disability stated on the **compensation schedule** (below), provided that:

- **your** plan was in full force at the time of **you** sustained the **accidental bodily injury**
- **your accidental bodily injury** occurs prior to **your renewal date** following **your** 70th birthday
- the **accidental bodily injury** is not caused directly or indirectly by any risk excluded in this **agreement** or by any **special terms** stated on **your Certificate of Insurance**.

If **you** suffer from several disabilities as a consequence of **your accidental bodily injury**, the **accident benefit we** pay will be calculated by adding together the various benefit amounts stated in the **compensation schedule**. The total **accident benefit** payable will be limited to the **accident benefit** stated on **your Certificate of Insurance**.

Ankylosis of the fingers (other than the thumb and forefinger) and of the toes (other than the big toe) will entitle **you** to 50% of the compensation that would be due for the loss of the said members.

Permanent disabilities that are not specified in the **compensation schedule** will be compensated in accordance with their severity, which will adjudged in the light of similar disabilities specified in the **compensation schedule**. **Your** occupation will not be taken into consideration.

The **compensation schedule** assumes that **your** right hand is **your** dominant hand. If **your** left hand is **your** dominant hand, the percentages stated in the 'Left' and 'Right' columns of the **compensation schedule** for the various disabilities specified under the heading, 'Upper limbs', will be transposed.

Compensation schedule for the accident benefit

This is the schedule of disabilities eligible for benefit as a percentage of the **accident benefit** stated on **your Certificate of Insurance**.

Compensation schedule	% of accident benefit payable
Disabilities for which 100% of the accident benefit is payable	
Loss of life	100%
Total and irrecoverable loss of sight in both eyes	100%
Loss of, or loss of use of, both arms or both hands	100%
Complete and permanent deafness of both ears	100%
Removal of lower jaw	100%
Permanent loss of speech	100%
Loss of, or loss of use of, one arm and one leg	100%
Loss of, or loss of use of, one arm and one foot	100%
Loss of, or loss of use of, one hand and one leg	100%
Loss of, or loss of use of, one hand and one foot	100%
Loss of, or loss of use of, both legs	100%
Loss of, or loss of use of, both feet	100%

Compensation schedule	% of accident benefit payable	
Head		
Loss of osseous substance of the skull in all its thickness:		
• surface of at least 6 sq. cm	40%	
• surface of 3 to 6 sq. cm	20%	
• surface of less than 3 sq. cm	10%	
Partial removal of the lower jaw, rising section in its entirety or half of the maxillary bone	40%	
Total and irrecoverable loss of sight in one eye	40%	
Complete and permanent deafness in one ear	30%	
Upper limbs	**Right**	**Left**
Loss of, or loss of use of, one arm or one hand	60%	50%
Considerable loss of osseous substance of the arm (definite & incurable lesion)	50%	40%
Total paralysis of the upper limb (incurable lesion of the nerves)	65%	55%
Total paralysis of the circumflex nerve	20%	15%
Shoulder ankylosis	40%	30%
Elbow ankylosis:		
• in a favourable position (15 degrees round the right angle)	25%	20%
• in an unfavourable position	40%	30%
Extensive loss of osseous substance of the two bones of the forearm (definite and incurable lesion)	40%	30%
Total paralysis of the median nerve	45%	35%
Total paralysis of the radian nerve at the torsion cradle	40%	35%
Total paralysis of the forearm radian nerve	30%	25%
Total paralysis of the hand radial nerve	20%	15%
Total paralysis of the cubital nerve	30%	25%
Ankylosis of the wrist in favourable position (straight and pronation)	20%	15%
Ankylosis of the wrist in unfavourable position (flexion or strained extension of supine position)	30%	25%
Total loss of thumb	20%	15%
Partial loss of thumb (ungual phalanx)	10%	5%
Total ankylosis of thumb	20%	15%
Total amputation of forefinger	15%	10%
Amputation of two phalanges of forefinger	10%	8%
Amputation of the ungual phalanx of forefinger	5%	3%
Simultaneous amputation of thumb and forefinger	35%	25%
Amputation of thumb and finger other than forefinger	25%	20%
Amputation of two fingers other than thumb and forefinger	12%	8%
Amputation of three fingers other than thumb and forefinger	20%	15%

Compensation schedule	% of accident benefit payable	
Upper limbs (continued)	**Right**	**Left**
Amputation of four fingers including thumb	45%	40%
Amputation of four fingers excluding thumb	40%	35%
Amputation of the medial finger	10%	8%
Amputation of the finger other than thumb, forefinger and median	7%	3%
Lower limbs		
Amputation at the thigh (upper half)	60%	
Amputation at the thigh (lower half and leg)	50%	
Total loss of foot (tiblo-tarsal disarticulation)	45%	
Partial loss of foot (sub ankle bone disarticulation)	40%	
Partial loss of foot (medio-tarsal disarticulation)	35%	
Partial loss of foot (tarso-metatarsal disarticulation)	30%	
Total paralysis of lower limb (incurable nerve lesion)	60%	
Complete paralysis of the external poplitic sciatic nerve	30%	
Complete paralysis of the internal poplitic sciatic nerve	20%	
Complete paralysis of two nerves (poplitic sciatic external and internal)	40%	
Ankylosis of the hip	40%	
Ankylosis of the knee	20%	
Loss of osseous substance from the thigh or bones of the leg (incurable condition)	60%	
Loss of osseous of the knee-pan with considerable separation of the fragments and considerable difficulty of movements in stretching the leg	40%	
Loss of osseous substance of the knee-pan while the movements are preserved	20%	
Shortening of the lower limb:		
• by at least 5 cm	30%	
• by 3-5 cm	20%	
• by 1-3 cm	10%	
Total amputation of all toes on one foot	25%	
Amputation of four toes (including the big toe)	20%	
Amputation of four toes (excluding the big toe)	10%	
Amputation of the big toe	10%	
Amputation of two toes (excluding the big toe)	5%	
Amputation of one toe (excluding the big toe)	3%	

Making a claim for your accident benefit

To substantiate a claim for **accident benefit**, the following documents must be submitted to **us** as soon as reasonably possible:

- an official document which confirms **your** date of birth
- a medical or official certificate stating the cause and circumstances of the accident, including police reports, ambulance reports and eye-witness statements
- a detailed medical report describing the injuries sustained
- proof of **your gross annual earnings** at the time **you** made **your** application (if this was not provided at application stage)
- in the event of death, an official death certificate confirming the cause of death and stating the date of death
- any other documentation or proof that **we** may reasonably require in order to assess **your** claim

All documentation and medical reports submitted in connection with a claim must be furnished at **your** own expense.

What you're not covered for

What your plan does not cover

No benefit will be paid if **your** death, **terminal illness** or **accidental bodily injury** arises from any of the following:

- any items specifically excluded on **your Certificate of Insurance**
- a **pre-existing medical condition** or **related condition**, unless **you** have told **us** about it and **we** have agreed to accept cover for it
- **your** active participation in war, warlike activities or terrorist activities
- **your** gross negligence and deliberate exposure to exceptional danger (except in the attempt to save a human life)
- **your** participation in any kind of **professional sport** or **professional racing** (including training or practicing for any kind of **professional sport** or **professional racing**)
- **your** participation in an activity that is illegal in the country in which it is performed
- suicide, or the consequences of attempted suicide or intentionally self-inflicted injuries, whether sane or insane. This exclusion only applies to the first year of **your** plan. If **you** subsequently apply to increase **your life benefit**, this 1-year exclusion shall apply from the date of the increase, but only for the amount of the increase. Each increase in **your life benefit** will be treated separately.
- war, terrorism, kidnap, murder, assault of any kind, or any other act of violence, sustained whilst **you** are in a country or region that the British Foreign, Commonwealth & Development Office ("FCDO") has advised its citizens to leave, or has advised against all travel to, or has advised against all but essential travel to due to security reasons (whether **your** presence in that country or region is permanent or temporary.
- any cause whatsoever, if sustained whilst you are in Iran, Libya, North Korea, South Sudan, Syria, or Yemen (whether **your** presence in the country is permanent or temporary).

No benefit will be paid for any death or **accidental bodily injury** that has not been reported to **us** within 12 months of the death or **accident bodily injury** occuring.

No benefit will be paid upon **your** death if the **life benefit** has already been paid following **your** diagnosis with a **terminal illness**.

You can check the current advice offered by the FCDO about a particular country or region at the following web address: gov.uk/foreign-travel-advice.

Additional exclusions applying to the accident benefit only

Additional exclusions apply in respect of the **accident benefit**. No benefit will be paid if death or **accidental bodily injury** is caused by:

- war, warlike activities, military action, acts of foreign hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection, usurped power, mutiny, riot, strike, martial law, state of siege, attempted overthrow of government, any acts of terrorism, murder, attempted murder, kidnap (including attempted kidnap or attempted rescue from kidnapping), or assault of any kind, anywhere in the world. This exclusion will apply irrespective of whether **you** are an active participant in any of the above activities or merely an innocent bystander
- any illness or disease
- food poisoning and bacterial infections (except infection which occurs through accidental cut or wound injury)
- intentional inhalation of gas, or intentional ingestion of poisons or drugs
- intentionally contracted infection by bacteria or virus
- **you** being under the influence of alcohol or drugs
- an accident whilst participating in a **hazardous activity** unless **you** have made a full declaration of how often **you** intend to participate in that particular activity and **we** have agreed to cover **you** in writing, and **you** have paid any additional **premium** required by **us** to cover the increased risk.

No benefit will be paid if accidental bodily injury is caused by:

- the consequences of attempted suicide or intentionally self-inflicted injuries, whether sane or insane.

How to make a complaint

At William Russell, each one of **our** customers is important to **us**. **We** believe that **you** have the right to professional customer service of the highest quality at all times. If you think **we** have fallen short of this standard, please follow the procedures outlined below.

If **you** are not happy with the service **you** have received, **you** may write to **us** at any time at the following address: -

William Russell Europe SRL
Place Marcel Broodthaers, 8
1060 Saint-Gilles
Brussels, Belgium

Phone +44 1276 486 455
Fax +44 1276 486 466
Email enquiries@william-russell.com

We will investigate **your** complaint and send a response to you within 4 weeks of the receipt of **your** complaint. William Russell Europe SRL acts as mandated underwriter on behalf of the **insurer** of **your** plan in respect of policy administration and **claims** handling. If **your** complaint relates to a decision we have made on behalf of **our** insurer (e.g., a decision regarding a claim **you** have made), **you** can write to the **insurer** at any stage in the process.

AWP Health & Life SA
Customer Relationships
Eurosquare, 2
7 rue Dora Maar
93400 Saint Ouen
France

Email client.care@allianzworldwidecare.com

AWP Health & Life SA is a signatory to the French Insurance Mediation charter. In the event of a persistent and definitive disagreement, the **plan holder** has the option, after the exhaustion of all domestic remedies referred to above, to call for the French Insurance Mediator without prejudice to possibilities of legal action.

La Médiation de l'assurance
TSA 50 110
75441 Paris Cedex 09
France

Web mediation-assurance.org

If **your** complaint relates to a service provided by William Russell Europe SRL and **you** have not received a response from **us** within 4 weeks of **our** receipt of **your** initial complaint, or **you** are dissatisfied with the final response **you** have received from **us**, **you** may write to the Belgian Ombudsman des assurances.

L'Ombudsman des assurances
Square de Meeûs, 35
1000 Brussels, Belgium

Phone +32 (0)2 547 58 71
Fax +32 (0)2 547 59 75
Email info@ombudsman.as
Web ombudsman.as

Arbitration and applicable law

All disputes arising out of or in connection with the present contract shall be finally settled under the Rules of Arbitration of the International Chamber of Commerce of Paris by one or more arbitrators appointed in accordance with the said rules, and shall take place in Paris. The arbitration shall be conducted in English and French law shall apply. A sole arbitrator shall be appointed by the International Chamber of Commerce of Paris unless the parties to the dispute agree otherwise.

How we process your information

We think it is important for all **our** customers to be made aware of what information **we**, as a data controller, hold about them and to have the reassurance of knowing that **we** will process their personal information fairly and securely. The following statements refer to the personal information of **yourself** and all other **insured persons** on **your plan**.

The information we collect

We collect information **you** give **us** as part of **your application**, and in correspondence with **us** by phone, email, post or other means of communication. This information may include sensitive personal information, such as details of **your** physical and mental health.

In addition, **we** may receive information about **you** from third parties, such as those who provide services on **our** behalf.

Failing to provide the personal information **we** require in order to underwrite and administer **your** plan, or to process **your claims**, could result in **your claims** being rejected or not being fully paid, or **your plan** being cancelled.

How we use your personal information

We will only collect information that is necessary to provide **you** with the services **we** offer. These include:

- Underwriting and administration of **your plan**
- Processing **claims**
- **Our** business processes, such as auditing, business planning, and accounting
- Compliance with legal and regulatory obligations
- Research or statistical analysis to help **us** improve **our** services
- Communicating with **you**

By taking out a **plan** with **us**, you agree to **us** processing **your** personal information and sensitive personal information for the above purposes.

Who we may share information with

We may disclose **your** personal information to selected third parties for the listed purposes above, including:

- Our providers of payment services
- Organisation (such as regulatory authorities) where **we** have a duty to disclose or share **your** personal information to comply with legal obligations
- Providers of research, marketing, and analysis services
- The **insurers** or reinsurers of your plan
- **Your** insurance adviser (if **you** have appointed one)

Your information may be disclosed to other parties (such as other insurance companies) with a view to preventing fraudulent or improper **claims**.

Processing claims

In the event of a **claim**, **we** may have to give some information to those involved in **your treatment** or care, or to **your** representative (if **you** have chosen one). This will be done confidentially.

How we keep, store, and dispose of your personal information

We hold **you** information in various forms, including electronic databases, computerised files, and paper files. Information may be held for a period after **your plan** ends with a view to preventing or detecting fraud, or as **we** are required to under Belgian, French or UK law. When **we** dispose of **your** information, **we** will do so securely. **We** may continue to keep non-personally identifiable information for the purposes of research and statistical analysis to improve the services **we** offer.

Where we store your personal information

The information **we** collect from **you** may be transferred to and stored at a destination outside the European Economic Area (EEA). It may also be processed by staff operating outside of the EEA who work for **us** or for one of **our** suppliers. By submitting **your** personal information, **you** agree to this transfer, storing, and processing. **We** will take all steps necessary to ensure that **your** information is treated securely and in accordance with this data protection notice.

Marketing

You have the right to ask **us** not to process **your** information for marketing purposes. **We** will always inform **you** (before collecting **your** information) if **we** intend to use **your** information for such purposes. **You** can withdraw **your** consent for **us** to use **your** information in this way at anytime by sending **us** an email at marketing@william-russell.com.

Obtaining a copy of the information we hold about you

You have a right to request a copy of the information **we** hold about **you**. **You** also have a right to restrict or object to how **we** use **your** information, or to request that any inaccurate information be corrected. To exercise any of these rights, please contact:

The Data Protection Officer
William Russell Europe SRL
8, Place Marcel Broodthaers
1060 Saint-Gilles
Brussels, Belgium

Phone +44 1276 486 455
Fax +44 1276 486 466
Email enquiries@william-russell.com

Where information has been supplied by a **medical practitioner**, **you** should be aware that **we** need their consent before **we** can supply this to **you**, or alternatively **you** can request such information direct from the **medical practitioner**.

If **you** believe **we** are not processing **your** personal data in accordance with the law, you can complain to: -

The Data Protection Authority
Rue de la Presse-Drukpersstraat 35
1000 Brussels, Belgium

You can view **our** full privacy policy at william-russell.com/privacy.

Definitions

This section explains what **we** mean by certain emboldened words and phrases bolded in this **agreement**.

Acceptance terms

Acceptance terms state the terms upon which **we** are prepared to accept **your** application, and the **premium** required to put **your** plan into force.

Accident benefit

The amount specified as the **accident benefit** on **your Certificate of Insurance**.

Accidental bodily injury

A physical injury sustained due solely and directly to an external, violent and visible cause, including continuous or repeated exposure to conditions which were neither expected nor intended.

Agreement

The contents of this document, read in conjunction with **your** completed and signed **application form** and **your Certificate of Insurance**. Together, these items make up **your** agreement and determine the terms and conditions of **your** cover under the **master policy.**

Application form

The **application form you** have completed and signed.

Certificate of Insurance

The confirmation of insurance cover issued by **us**. **Your Certificate of Insurance** confirms the plan **you** have bought, its currency, **your period of cover**, **your** insured benefit, any **special terms** relating to **your** plan, **your country of residence**, and **your country of nationality**. If there are any changes to the details on **your Certificate of Insurance we** will issue **you** with a new **Certificate of Insurance** confirming the changes.

Compensation schedule

The schedule of disabilities eligible for benefit as a percentage of the **accident benefit** stated on **your Certificate of Insurance**.

Country of nationality

Your country of origin for which **you** hold a passport. If **you** hold more than one passport, **your country of nationality** means the country that **you** have declared as **your country of nationality** on **your application form**.

Country of residence

The country in which **you** are habitually resident.

Date of entry

The date on which **your** plan first commenced.

Gross annual earnings (if you are an employee)

The basic annual salary (including **contractual bonuses** and maternity or paternity pay) **you** are earning (before the deduction of income tax). It does not include any dividends, over-time, non-contractual discretionary bonuses, or benefits in kind such as (but not limited to) a car, and living accommodation.

If **you** are an employee, but **your** earnings are based directly on **your** sales performance, **we** will take into account 50% of **your** commission earnings over the 12 month period leading up to the date upon which **you** apply.

If **your** commission earnings fluctuate, **we** will take an average of **your** commission earnings during the period of 36 months immediately preceding the date upon which **you** apply.

Gross annual earnings (if you are self-employed)

Your gross personal income from **your** business during the 12 months immediately preceding the date upon which **you** apply, excluding income **you** receive from dividends, savings, investments or gifts.

If **your** earnings fluctuate, **we** will take an average of **your gross annual earnings** during the period of 36 months immediately preceding the date upon which **you** apply.

Hazardous activities

Activities that increase the risk of death or **accidental bodily injury**. They include (but are not limited to): -

Off-piste or freestyle skiing/snowboarding; scuba diving; rock climbing; mountaineering, pot-holing or caving; hang-gliding or parachuting (including tandem); bungee jumping; kite surfing or windsurfing; hunting or competitive horse-riding; driving or riding a motorised vehicle in any kind of race or competition; riding or riding pillion a motorcycle, motor scooter, moped or quad bike; flying other than as a passenger in a commercial aeroplane; competitive and/or offshore sailing; contact sport.

Any other activity that puts employees in a similar degree of danger as those activities listed above will be considered as a **hazardous activity**. If **you** are in any doubt as to whether an activity is considered to be hazardous or not, please contact **us** for clarification.

Houseperson

A person who is not in any form of paid employment, including self-employment.

Insurance premium tax

Any tax due to any government or government authorised body in **your country of residence**.

Insurer

The insurance company that provides the insurance cover for **your plan**. The **insurer** is Allianz (AWP Health & Life SA).

Life benefit

The amount specified as the **life benefit** on **your Certificate of Insurance**.

Master policy

The contract of insurance issued by us to the **William Russell Association for Health, Financial Protection and Well-Being**, for the benefit of its members.

Period of cover

The period stated as the **period of cover** on **your Certificate of Insurance**.

Pre-existing medical condition

Any disease, illness or injury, whether the condition has been diagnosed or not before **your date of entry**, for which:

- **you** have received medication, advice or **treatment**; or
- **you** have experienced symptoms

Premium

The amount(s) **you** are required to pay **us** either annually, semi-annually, quarterly or monthly for this insurance plan.

Premium due date

The date on which **your premium** is due to be paid by **you**.

Pro rata refund

In the event of a **pro rata refund** the amount refunded, (using an annually paid plan as an example), will be the annual **premium** paid divided by 12 and multiplied by the number of whole calendar months remaining in the **period of cover**. If the plan is cancelled part way through a month, an additional amount, equal to one twelfth of the annual **premium** paid, multiplied by the proportion of days in the calendar month of cancellation will also be paid.

For example, if the annual **premium** is $3,000, the **period of cover** is 01 January to 31 December 2020, and the plan ceases on 27 September 2020, the **pro rata refund** will be $775, as:

- ($3,000 / 12) x 3 = $750 for the three whole months without cover (October, November and December); added to -
- ($3,000 / 12) x 0.1 = $25 for the three days in September without cover (the 0.1 calculated in this example by dividing 3 (the days in September without cover, i.e. the 28th, 29th and 30th) by the total number of days in September (30)).

Appropriate calculation methods using the same principle as the above example will be used if the **premium** frequency is not annual.

Professional racing

Any racing where an employee is being paid to participate, whether by sponsorship, prize money, appearance fees, bonuses, regular income or any other means.

Professional sport

Any sport where an employee is being paid to participate, whether by sponsorship, prize money, appearance fees, bonuses, regular income or any other means.

Related condition

Any disease, illness or injury that is caused by a **pre-existing medical condition** or results from the same underlying cause as a **pre-existing medical condition**.

Renewal date

Renewal date is normally the anniversary of **your** original **date of entry** to **your** plan.

Special terms

Exclusions or conditions that **we** may apply to **your** plan in addition to the terms, conditions and exclusions explained in this booklet. Any **special terms** that apply to **your** plan will be stated on **our Acceptance Terms** invoice and on **your Certificate of Insurance**.

Terminal illness

An illness that has no known cure or has progressed to a point where it cannot be cured, and, in the opinion of **your** hospital consultant and **our** Chief Medical Officer, is expected to lead to death within 12 months.

Us, we, our

William Russell Europe SRL, on behalf of the **insurer.**

William Russell Association for Health, Financial Protection and Wellbeing (WRA)

The not-for-profit association registered in Belgium as the **William Russell Association for Health, Financial Protection and Well-Being.**

You, your

The plan holder as named on **your Certificate of Insurance**.

We're here to help

Call us on
+44 1276 486 455

Visit
william-russell.com

William Russell Europe SRL is registered in Belgium with the Financial Services & Markets Authority, no. 0731.975.658 RPM, as a limited liability company with share capital of €30,000. Mandated underwriter for AWP Health & Life SA. Legal disclosures.
The UK branch of William Russell Europe SRL is registered at William Russell House, The Square, Lightwater, Surrey, GU18 5SS, UK. Deemed authorised and regulated by the Financial Conduct Authority (FCA), reference no. 847808. Details of the Temporary Permissions Regime, which allows EEA-based firms to operate in the UK for a limited period while seeking full authorisation, are available on the FCA's website.

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