Insurance terms and conditions for travel health insurance for language pupils and students from HanseMerkur Reiseversicherung AG VB-KV 2014/III College (CC14/III)

A: General section (applicable to all the Care College / Care College USA tariffs referred to in Section B)

§ 1 Insurable persons and insurability

Unless otherwise agreed, the following applies:

1. The insured persons are those referred to by name in the insurance certificate, for whom the agreed premium has been paid.
2. The following are insurable: trainees, participants in working holiday programmes and persons who can be shown to be temporarily abroad to take further education courses at state or private institutions certified for the purpose, so long as they belong to one of the following groups of people:
   a. Persons with foreign nationality and permanent residence abroad immediately before the trip, during a stay in the Federal Republic of Germany or another member state of the EU, EEA or the Schengen agreement;
   b. Persons with German, Austrian or other nationality and permanent residence in the Federal Republic of Germany or Austria, during a stay abroad;
   c. Persons with German or Austrian nationality, who can show permanent residence abroad for at least two years immediately before the trip, during a stay in the Federal Republic of Germany or another member state of the EU, EEA or the Schengen agreement.
3. Not eligible for insurance coverage and excluded from cover despite payment of the premium are those persons who
   a. other than the prioritised regulation for children insured after birth (cf. § 2 (11) of these conditions), if the insurance begins before age 12 (12th birthday) is reached;
   b. at the start of insurance or at the start of follow-on insurance (extension of the insurance cover by conclusion of an immediately following insurance contract) have reached age 36 (36th birthday);
   c. are subject to legally mandatory health and/or care insurance in the country of destination;
   d. will be engaged in competitive sports or a paid sporting activity during the trip;
   e. have entered illegally;
   f. are in permanent need of care. Persons in need of care are those persons who largely require external assistance to complete everyday tasks;
   g. have, during the period of their residence permits of limited duration in the Federal Republic of Germany, concluded one or several successive travel and health insurance contracts, the total insurance duration of which has exceeded five years at the time when the application to HanseMerkur or Care Concept AG is made. This also applies if there have been several successive contracts with different insurance companies;
   h. are staying in the destination country without the main reason for insurability, other than the prioritised regulation for children insured after birth (cf. § 2 (11) of these conditions).
4. The main reason for the stay in the destination country during the insured period must be education, further education or carrying out a working holiday programme. HanseMerkur must be immediately informed in writing of any change in the main reason for the stay in the Federal Republic of Germany or another member state of the EU, EEA or Schengen Agreement or abroad (e.g. the conclusion of the study or school visit), the adoption of the nationality of the destination country, the award of a permanent right to remain or the refusal of a residence permit in the Federal Republic of Germany or another member state of the EU, EEA or Schengen Agreement or abroad as well the adoption of permanent residence in Germany or Austria or abroad.

§ 2 Conclusion and termination of the insurance contract, insurance of children after birth

Unless otherwise agreed, the following applies:

1. The application to conclude an insurance policy must be made before starting the foreign trip or within one year after entry to the Federal Republic of Germany or another member state of the EU, EEA or Schengen Agreement. What is decisive is the receipt of the insurance application by HanseMerkur AG. The date of entry to the Federal Republic of Germany or another member state of the EU, EEA or Schengen Agreement or the crossing of a border to another country must be proven on request.
2. The contract is concluded when HanseMerkur has received the correctly-completed HanseMerkur application form for this and has accepted the application by sending the insurance certificate. The application is only correctly completed when it contains all the requested information in unambiguous and complete form.
3. Persons who do not meet the requirements for insurability pursuant to § 1 (3) of these Terms and Conditions shall not be eligible to conclude the insurance contract, even through payment of the premium. If a premium is nevertheless paid for a person who is ineligible for insurance coverage, this amount shall be available to the sender after deducting the costs incurred by HanseMerkur AG.
4. The insurance policy must cover the entire duration of the trip.
5. The longest possible insurance duration is 4 years.
6. If the stay is extended within the maximum period, a separate follow-up contract for the further, not originally insured, foreign stay can be concluded, if the following preconditions are satisfied:
   a. The application for extension of insurance protection (follow-up contract) must be made on the form foreseen for this by HanseMerkur and it must be submitted before the expiry of the original insurance contract with HanseMerkur.
   b. HanseMerkur must explicitly agree to the follow-up contract. If a premium is paid for a contract that is not explicitly accepted, the person who has paid it will be entitled to a refund.
   c. For persons with a limited permit to stay in the Federal Republic of Germany, an extension of the insurance cover (follow-up contract) is only possible if, taking into account all previously existing health insurance contracts with insurance cover for the Federal Republic of Germany, a maximum insurance period of five years is not exceeded. HanseMerkur AG must be informed by the policyholder of all previously existing health insurance contracts which have applied during the temporary stay.
7. In the event of extensions to the insurance cover by a follow-up contract:
   a. there is restricted insurance cover for the insurance events, illnesses, ailments and their consequences that arose before the start of the extension, in accordance with § 9.
   b. § 6 (2), § 7 I (2), § 8 (1) (a and k) apply correspondingly. In addition, the special waiting period in accordance with § 7 II (3) should be noted.
8. A change between the Care College Basic, Care College Comfort and Care College Premium tariffs during the contract period is not possible. If a change in tariffs is required due to an official requirement for a residence permit, the insurance cover can be continued in a new contract with a different tariff. The condition for this is that the remaining contract period from the previous contract is not exceeded. Rights and obligations from the previous contract are then transferred to the follow-up contract. The contractual provisions that apply when newly concluding insurance cover shall apply to the additional benefits under the newly selected tariff schedule. In the event that an extension to the insurance cover by a follow-up contract is requested at the same time, clause 7 applies correspondingly. This switch cannot be done retroactively.
9. The insurance contract ends
   a. at the agreed point in time;
   b. with the death of the policyholder or with his relocation from the Federal Republic of Germany or Austria. The insured persons shall however have the right to continue the insurance contract by naming a future policyholder. The statement must be submitted within two months of the policyholder's death or relocation from the country;
   c. with the termination of the temporary stay of the insured person abroad;
   d. if the preconditions for a temporary stay abroad and no longer met; because the insured person has decided to take up permanent residency abroad or because the insured person has permanently returned to the home country;
   e. if one of the requirements for the eligibility of the insured person for insurance coverage no longer applies;
   f. for insured persons with limited right to stay in the Federal Republic of Germany after a total insurance period of five years for all travel health insurance policies concluded after entry to the Federal Republic of Germany, even if several successive follow-up contracts have been concluded with different insurers.
10. In the event that any insured person receives unlimited leave to remain and takes up permanent residence in the Federal Republic of Germany, he has the right to further insurance at the Basic or Standard tariff from
    HanseMerkur Krankenversicherung AG
    Siegfried-Wedells-Platz 1
    20354 Hamburg
11. Coverage of children born while under insurance coverage
    Insurance coverage for newly-born children begins on the date of birth with no risk premiums and waiting periods if it can be demonstrated that the child was registered for insurance with HanseMerkur AG, represented by Care Concept AG, no later than two months after the date of birth, with retrospective effect.
    a. The precondition for this insurance coverage for newly-born children is that
       aa. the contract for the insured parent has on the date of birth applied for at least three months without interruption;
       bb. the requested insurance coverage is not higher or more comprehensive than the coverage of the insured parent;
       cc. there is no other insurance cover.
    b. Adoption shall be treated in the same way as birth, insofar as the child is still a minor at the time of adoption. In the event that there is an increased risk,

a surcharge of up to 100% in addition to the premium rate can be agreed.

c. If the registration for insurance coverage is made more than two months after the birth, or if higher or more comprehensive insurance coverage is requested, the insurance of the child shall be subject to a separate risk assessment by HanseMerkur, represented by Care Concept AG. In this case, the insurance coverage will only go into effect upon acceptance of the insurance contract. The provisions of these paragraphs under clauses 1 to 10 apply correspondingly.

§ 3 Termination

1. Ordinary termination
   The insurance relationship may – if it was concluded for a period exceeding one year – may terminated by the policyholder at the end of the first year or each succeeding year, at three months' notice.
   The termination may be limited to individual insured persons or tariffs. If you give notice for individual insured persons, it is only valid if you prove that the insured persons affected have been made aware of the statement of termination. The statement of termination must be given in writing (e.g. by sending an email, fax or letters etc.). If the policyholder and the insured person are not the same, termination by the policyholder shall only go into effect if the insured persons affected by the statement of termination have been notified, and the policyholder correspondingly demonstrates this. The insured person affected shall however have the right to continue the insurance contract by naming a future policyholder. The statement concerning said continued coverage must be submitted within two months of receipt of the notice of termination.
   The insurer waives its right to ordinary termination.
2. Termination for cause
   The provisions of law on termination for cause are unaffected, both for the policyholder and the insurer.

§ 4 Premium

1. Payment of the first or one-off premium
   a. The first or one-off premium is due when the contract starts.
   b. If the first or one-off premium is not paid on time, HanseMerkur AG is entitled to withdraw from the contract as long as payment has not been made, unless the policyholder is not responsible for the non-payment.
   c. If the first or one-off premium has not been paid when an insured event occurs, HanseMerkur AG is not obliged to provide coverage, unless the policyholder is not responsible for the non-payment.
2. Payment of renewal premiums:
   a. If the renewal premium is not paid on time, HanseMerkur AG will send the policyholder a request for payment and will set a time limit of two weeks for payment.
   b. If an insured event occurs after the deadline has expired, and if the policyholder is then in default of the premium, the interest or the costs, HanseMerkur AG shall not be obliged to provide coverage.
   c. HanseMerkur links the payment deadline of two weeks with the termination of the contract upon the expiration of the payment deadline. The termination will take effect upon expiration of the payment deadline if the policyholder is still in default of payment at this time.
   d. The termination shall become ineffective if the policyholder makes the payment within one month after the termination takes effect. Letter b is not affected by this. The same shall apply in the event that the insured person specifies a new policyholder within two months after being notified of the termination and the outstanding amount is paid by the new policyholder. Letter b is not affected by this.
3. Details concerning the payment of premiums
   a. Payment of the initial or the renewal premium may optionally be made using the SEPA direct debit scheme, by bank transfer, by credit card payment, or by PayPal.
   b. If the insurer deducts the premium from a bank or credit card account using the SEPA direct debit scheme, the payment shall be considered to have been made on time if the premium can be collected on the date of debit, and the policyholder or, in the case that the policyholder is not the owner of the account, the policyholder and/or the owner of the account does / do not dispute the withdrawal.
   If the premium cannot be collected for a reason beyond the control of the policyholder, the payment shall still be deemed to be on time if payment is made immediately upon receipt of a payment request from the insurance company in writing (e.g. by email, fax or post).

§ 5 Right to premium adjustment

1. Within the context of contractual benefits, the benefits provided by the insurer may change, for example as a result of increasing medical treatment expenses or an increased use of medical services. Accordingly, the insurer shall compare the required insurance benefits with the insurance benefits calculated using the technical basis for calculation. If this comparison results in a deviation that exceeds 5%, the insurer may review the premiums and, if necessary, adjust them. Under these same conditions, an agreed additional premium may be added, and the maximum amount for benefits and daily allowances according to the tariff may be increased.
2. These adjustments in accordance with paragraph 1 shall go into effect at the start of the second month following notification of the policyholder.
3. If the insurer increases the premiums in accordance with paragraph 1, the policyholder may terminate the insurance relationship with respect to the affected insured person within one month of receipt of the notice adjusting the date on which the change shall go into effect.

§ 6 Scope, start, duration and end of the insurance cover

Unless otherwise agreed, the following applies:

1. Scope of cover
   a. Under these provisions, HanseMerkur AG offers insurance cover to insured persons who are only temporarily staying abroad during a trip.
   b. "Abroad" in terms of these conditions means, with the exception of the countries of the North American free trade area NAFTA (USA, Canada, Mexico and the territory of the country of the insured person and/or the insured person has permanent residence:
      - for persons of foreign nationality and permanent residence abroad: the Federal Republic of Germany or another member state of the EU, EEA or the Schengen agreement;
      - for persons of German or Austrian nationality and permanent residence in the Federal Republic of Germany or Austria as well as for nationals of European Union countries with permanent residence in the Federal Republic of Germany or Austria: all countries and areas outside the Federal Republic of Germany and Austria;
      - for persons of other nationalities if they have had permanent residence in the Federal Republic of Germany or Austria for at least the last two years: all countries and areas outside the Federal Republic of Germany and Austria.
   c. The insurance cover is also valid if the foreign stay is in more than one host country and the change between the host countries relates to the education and further education courses.
   d. There is no insurance cover if the insured event arises in the home country of the insured person. "The home country" in terms of these contractual provisions is the country in which the person is permanently resident and/or the country of the insured person's nationality.
   e. The extent of insurance cover is shown by the insurance certificate, any separate written agreements, these insurance terms and conditions (general and specific sections) and the legal regulations of the Federal Republic of Germany.
   f. In derogation of b and d, insurance cover is available in the home country of the insured person as well as in third countries under the following preconditions:
      - For insurance contracts made for part of the year with a duration of up to 4 months, insurance cover also includes a temporary holiday visit to the home country of the insured person as well as in third countries for up to 14 days for all home and third country visits during the duration of the contract.
      - For insurance contracts made during the year with a duration of more than 4 and less than 12 months, insurance cover also includes a temporary holiday visit to the home country of the insured person as well as in third countries for up to 28 days for all home and third country visits during the duration of the contract.
      - For several successive contracts made for part of the year, the insurance cover for holiday visits to the home country and third countries is limited to 42 days for all home and third country visits during one insurance year.
      - For insurance contracts made for at least one year, insurance cover includes a temporary holiday visit to the home country of the insured person as well as in third countries for up to 42 days for all home and third country visits during one insurance year. From the second insurance year, insurance cover is provided for holiday stays in the home country or third countries for 21 days respectively for each half insurance year started, though no more than 42 days for all home and third country visits during one insurance year.

An insurance year is considered to be a period of twelve months calculated from the start of insurance, including all immediately succeeding contracts.
The dates of entry to the home country and of departure from the home country are each counted as full days of home country stay.
The start and end of each trip to the home country or a third country during the contract term must be reported

by the policyholder in writing (e.g. by email, fax or letter etc.) before departure and in the event of a claim must be proved on request to HanseMerkur AG or Care Concept AG. Please note in particular § 10 (4).
If the trip is not reported before the start, only 50% of the maximum reimbursable costs according to the tariff will be paid in the event of an insured event.
"The home country" in terms of these insurance terms and conditions is the country of the insured person's nationality and/or the country in which the person is permanently resident.

2. Start
Insurance coverage commences on the date specified in the insurance certificate (commencement of insurance), however it shall not start
   a. before the insurance contract is concluded;
   b. before entry into the Federal Republic of Germany or Austria or the crossing of the foreign border;
   c. if the premium has not been paid;
   d. prior to the expiration of any waiting periods.

3. End
Insurance cover also ends for insured events that are not yet concluded
   a. at the agreed point in time;
   b. for insured persons of German or Austrian nationality, at the latest when the foreign stay ends;
   c. for insured persons who are nationals of a third country, at the latest when the stay in the Federal Republic of Germany or Austria ends;
   d. at the end of the insurance contract;
   e. if the requirements of temporary residence in the Federal Republic of Germany, Austria or abroad are no longer met or an unlimited right to remain is issued for the destination country;
   f. if the insured person no longer meets the eligibility criteria. The criteria are in particular no longer met if the relevant person has acquired citizenship in the destination country or has transferred permanent residence to the destination country with no intention to return;
   g. at the latest after a total insurance period of five years for all travel health insurance policies concluded after entry to the Federal Republic of Germany, even if several successive follow-up contracts have been concluded with different insurers;
   h. after expiry of the agreed insurance duration for holiday stays in the home country, though at the latest after the 42nd day for all holidays stays in the home country within one insurance year.

4. Follow-up liability
The regulation of follow-up liability can be found in the respective tariffs in part B of these provisions.

§ 7 Subject matter of the insurance coverage and the extent of the benefits

Unless otherwise agreed, the following applies:

I. General

1. HanseMerkur AG will provide compensation for treatment costs incurred for acute insured events that occur while travelling abroad after the waiting period. The provisions concerning the waiting period are shown in § 7 II.
2. An insured event is the medically necessary treatment of an insured person due to illness or accident. The insured event starts with the treatment and ends once it is medically established that no further treatment is needed. If the treatment needs to be extended to the consequences of an illness or accident which are not causally linked to treatment up to that point, a new insured event shall be considered to have occurred. The following are also considered insured events:
   a. Examinations and medically necessary treatment due to pregnancy insofar as the pregnancy did not already occur prior to the commencement of the insurance cover or, respectively, when the application to extend the insurance cover (follow-up contract) was made;
   b. childbirth;
   c. death.
3. The scope of the insurance cover is set out in the insurance certificate, any separate written agreements, these general insurance terms and conditions and the statutory provisions of the Federal Republic of Germany.
4. In the Federal Republic of Germany, the insured person is free to choose any recognised locally-established physicians and dentists. Within the scope of the contract, the costs for treatment provided by the practitioner shall be covered insofar as this treatment can be billed in accordance with the current official rate for physicians and dentists. Outside the Federal Republic of Germany, the insured person is free to choose between recognised and accredited physicians and dentists in the country of destination, provided these charge fees are based on the relevant official, applicable fee schedule for physicians and dentists, if available, or based on fees generally charged for similar medical care in the local area.
5. Medications, dressings, remedies and medical devices must be prescribed by the practitioners specified in clause 4 and in addition, medications must be dispensed by a pharmacy. Nutritional products and tonics (e.g. vitamin and nutritional supplements), mineral water, disinfectants, cosmetic preparations, diet and baby food are not considered to be medications, even if these have been prescribed by a physician.
6. In the case of medically necessary inpatient treatment in hospital, the insured person is free to choose from among the public and private hospitals that are under continuous medical management, have adequate diagnostic and therapeutic facilities, keep medical records and do not provide health spa or sanatorium treatments or accept convalescents. Insurance coverage exists for the general care class (shared room) without optional services (private medical treatment). Plan benefits shall only be provided for medically necessary, in-patient treatment at medical facilities that provide health spa or, respectively, sanatorium treatments or that accept convalescents, but that otherwise meet the requirements of clause 1, if no other hospital as specified in clause 1 is reasonably close, or if HanseMerkur AG has agreed in writing to assume the costs prior to the start of treatment.
7. HanseMerkur AG will pay within the limits of the contract for diagnostic and treatment methods and medications that are generally recognised by conventional medicine. In addition, HanseMerkur AG will pay for methods and medications that have proved equally promising in practice, or that are used because no conventional methods or medications are available; HanseMerkur AG may, however, reduce its payments to the amount that would have been incurred had the available conventional methods or medications been used.
8. HanseMerkur AG will cover the expense for repatriation of mortal remains and funeral expenses in the amount specified in the contract if the death of an insured person occurs as a result of an event that falls within the obligation to provide cover under this contract.

II. Waiting periods

1. The general waiting period is 31 days. It begins upon the commencement of insurance. The waiting period does not apply
   a. if the insured person demonstrates that they have entered the insured country of destination within 31 days prior to the application or, respectively, the insurance was concluded prior to the start of the trip abroad. What is decisive is the receipt of the application by HanseMerkur AG or Care Concept AG;
   b. in the event of accidents that occur after the commencement of insurance.
2. Prior insurance that has existed until the start of the current insurance, with no gap, since entry to the Federal Republic of Germany or Austria or respectively since crossing a border to go abroad can be counted towards the waiting period. Restrictions on coverage pursuant to § 8 shall continue to apply without limitations.
3. The special waiting period for childbirth and dental prostheses is eight months. It is calculated from the start of insurance and in the event of extension of insurance cover by a follow-on insurance from the start of the extension.

III. Treatment expenses

The costs that can be reimbursed can be found in the respective tariffs in part B of these provisions.

IV. Repatriation, repatriation of mortal remains / funeral expenses

The costs that can be reimbursed can be found in the respective tariffs in part B of these provisions.

§ 8 Restrictions on the obligation to provide coverage

1. Unless the selected rate or the contractual agreements determine otherwise, no cover is provided for:
   a. Illnesses or the consequences of accidents, the treatment of which is the sole reason or one of the reasons for travel abroad;
   b. treatment whereby it was clear at the start of the trip that such treatment would be necessary if the trip was undertaken as planned;
   c. such illnesses, including their consequences, or consequences of accidents and deaths which were caused by nuclear energy, acts of war or active participation in civil unrest and were not explicitly included in the insurance cover;
   d. spa and sanatorium treatment and rehabilitation measures (for a follow-up treatment, § 7 I (6) subparagraph 3 applies);
   e. addiction treatment, including withdrawal;
   f. out-patient treatment in a spa or health resort. The restriction does not apply if the treatment is necessary because of an accident occurring at the site. The restriction does not apply for illnesses if the insured person was only visiting the spa or health resort briefly and was not staying for the purposes of treatment;
   g. Treatments provided by a spouse, parents or children. Documented material costs shall be reimbursed in accordance with collectively agreed rates;
   h. Treatments provided by the policyholder or by persons with whom the insured person lives within their own family or the home being visited. Documented material costs shall be reimbursed in accordance with collectively agreed rates;
   i. treatment or accommodation caused by infirmity, a need for care or custody;

j. psychoanalytical and psychotherapeutic treatment;
k. pregnancies and the consequences thereof that existed upon the commencement of insurance or the application for an extension to the insurance. We are required to continue to provide cover, however, for unforeseen complications that arise during the contractual period if the pregnant individual has not exceeded the 36th week of pregnancy upon the commencement of insurance or when applying for an extension of the insurance;
l. immunisation measures;
m. aids that did not become necessary for the first time due to an accident within the insured period;
n. Treatment for sterility, including artificial insemination, associated preliminary diagnostics and subsequent treatments, as well as for disorders of and/or damage to the reproductive organs;
o. treatment for HIV infections and their consequences. In derogation thereof, these costs will be covered to the extent of the contract up to EUR 25,000 over the entire contract period, if the infection can be shown to have been identified for the first time after the commencement of insurance or the application for an extension to the insurance;
p. Screening examinations;
q. Dental prostheses, pivot teeth, bridges, crowns and orthodontic treatment, implants, occlusal splints and gnathological measures;
r. suicide, suicide attempts and the consequences thereof;
s. organ donations and the consequences thereof.

2. HanseMerkur AG shall be released from its obligation to provide benefits if:
   a. the policyholder or, respectively, the insured person intentionally causes the insured event;
   b. the policyholder or the insured person attempts to make fraudulent representations to HanseMerkur AG as to the circumstances which are material to the grounds for providing cover and the amount of insurance benefits.
3. If a medical treatment exceeds the medically necessary level, HanseMerkur AG can reduce the benefits to a reasonable level.
4. If the insured person is entitled to benefits from a statutory accident or pension insurance, statutory healthcare or accident assistance, HanseMerkur may deduct the statutory benefits from the insurance benefits.

§ 9 Pre-existing medical conditions

Unless otherwise stated in these conditions or e.g. in the tariff provisions, the following applies:

1. The following are included in insurance cover:
   - Illnesses,
   - Consequences of accidents,
   - Ailments

   including the resulting symptoms – even if they were known before insurance cover was applied for.
   However, there is no obligation to pay benefits if the occurrence of the insured event was known at the time of application for the insurance contract or the application for an extension of insurance cover by a separate follow-on contract.
2. If a prior illness, consequences of accidents and/or ailments covered by § 9 (1) lead to an insured event, the following applies:
   the policyholder is responsible for a deductible of EUR 5,000 for each insured person and insurance year started for the costs to be reimbursed for treatment of prior illnesses, consequences of accidents and/or ailments existing at the time of application for the insurance contract or the application for an extension of insurance cover, as well as the resulting ailments and consequences. An insurance year is considered to be a period of twelve months calculated from the start of insurance. This deductible is not reduced in the case of a shorter period of insurance. The benefits from HanseMerkur AG for this purpose are limited to EUR 30,000 for each insured person during the total contract period.
3. The provisions of
   - § 2 (6) Conclusion of a separate follow-on contract
   - § 6 (2) Commencement of insurance cover
   - § 6 (3) End of insurance cover
   - § 7 I (2) Definition of insured event
   - § 7 II Waiting periods
   - § 8 Restrictions on the obligation to provide cover

   are unaffected.

§ 10 Obligations and consequences of breaches of obligation

1. After the occurrence of the insured event, policyholders and insured persons are obligated
   a. to keep the claim as low as possible and to avoid anything that could lead to an unnecessary increase in costs;
   b. to report the claim to HanseMerkur AG promptly and no later than upon completion of the trip;
   c. to permit HanseMerkur AG to conduct any reasonable investigation into the cause and extent of their obligation to pay compensation and to provide HanseMerkur AG with any relevant information, original receipts and the death certificate in cases of death;
   d. to contact HanseMerkur AG in the event of in-patient treatment and before the start of extensive diagnostic and therapeutic measures.
2. Upon request by HanseMerkur AG, the insured person shall be required to undergo an examination by a physician contracted by HanseMerkur AG.
3. The original bills must be submitted to
   Care Concept AG
   Postfach 30 02 62
   53182 Bonn, Germany
4. HanseMerkur AG shall only be required to make payment (cf. § 10 (6)) if the following evidence, which shall become the property of HanseMerkur AG, is provided:
   a. Original receipts in the currency of the country of destination, which must contain the name of the person treated, the designation of the illness and information on the services of the physician of record. If other insurance cover for treatment costs is available and if this is used first, then copies of invoices noting the reimbursement are sufficient as proof;
   b. prescriptions, lab and x-ray invoices, which must be submitted with the physician's invoice and invoices for medications and medical devices together with the medical prescription;
   c. an official death certificate and a physician's certificate on the cause of death, if costs of repatriation of mortal remains or burial are to be paid;
   d. proof of the start and end of each stay in the Federal Republic of Germany and Austria upon request by HanseMerkur AG;
   e. proof of the start and end of each stay in the home country or a third country upon request by HanseMerkur AG;
   f. proof that the requirements for insurability pursuant to § 1 (2) have been met, and a valid residence permit for the stay in the country of destination upon request or no later than in the event of a claim;
   g. upon request by HanseMerkur AG, proof of all health insurance covering the destination country taken out during the stay in the destination country.
5. Within the context of the investigation of claims, it may be necessary for HanseMerkur AG to obtain personal health information to the extent permitted by law. If the policyholder or the insured person fails to provide consent to the collection of said data, and as a result, HanseMerkur AG is subsequently unable to determine the amount and the scope of the obligation to provide coverage, this will delay the maturity of the claim. The same applies if the institutions or persons queried have not been released by the policyholder from their obligation to maintain confidentiality vis-à-vis HanseMerkur AG.
6. Consequences of breaches of obligation
   If the policyholder or the insured person deliberately breach one of the contractually agreed obligations, HanseMerkur AG is not obliged to pay benefits. In the case of a grossly negligent breach of duty to comply with these obligations, HanseMerkur AG will be entitled to reduce the insurance benefits of the policyholder / the insured person, depending on the severity of the breach and the degree of fault. The burden of proving that gross negligence did not occur shall be borne by the policyholder.

§ 11 Payment of insurance benefits

1. One month after the damage has been reported, the minimum amount which is payable under the circumstances can be claimed as partial payment. This time limit shall be suspended for as long as the verification of the claim by HanseMerkur AG is impeded by the policyholder or the insured person.
2. Any costs incurred in a foreign currency shall be converted into the currency applicable in the Federal Republic of Germany at the exchange rate applicable on the day when HanseMerkur AG receives the relevant receipts. For traded currencies, the latest official Frankfurt/Main exchange rate applies as the daily exchange rate, while for non-traded currencies, the rate quoted in the latest issue of "Currencies of the World" published by the German Federal Bank in Frankfurt/Main shall apply, unless that currency which is necessary for the payment of the bills was demonstrably acquired at a less favourable price.
3. HanseMerkur AG is entitled to deduct additional costs that arise if HanseMerkur AG needs to make transfers abroad, or uses particular forms of transfer at the request of the policyholder.
4. Claims to benefits may not be assigned or pledged.
5. Claims under this insurance contract expire in three years. The expiry is measured from the end of the year in which the claim can be made. If the policyholder reports a claim to HanseMerkur AG, the limitation period shall be delayed until receipt of the decision by HanseMerkur AG in writing (e.g. by email, fax or letter etc.).

§ 12 Compensation from other insurance policies and claims against third parties

1. If, in the case of an insured event, compensation can be claimed from another insurance policy, that other policy shall take precedence. This also applies if a secondary liability has also been agreed in one of these insurance policies, regardless of when the other insur-

ance contract was concluded. If the insured event is reported to HanseMerkur AG first, HanseMerkur AG will make an advance payment and will contact the other insurer directly regarding cost sharing. HanseMerkur AG does not require the sharing of costs with a private health insurance if this would disadvantage the insured person, e.g. loss of contribution reimbursement.

2. The claims of the policyholder or, respectively, of the insured person against third parties shall be assigned to HanseMerkur AG to the extent provided for by law, insofar as HanseMerkur AG has reimbursed the claim. The policyholder or, respectively, the insured person is obliged to make a declaration of assignment to HanseMerkur AG, if necessary. The obligation of HanseMerkur AG to pay benefits is suspended until a declaration of assignment is given.
3. The claims of the policyholder or, respectively, of the insured person against caregivers on the basis of excessive fees shall be assigned to HanseMerkur AG to the extent provided for by law, insofar as HanseMerkur AG has reimbursed the corresponding bills. If necessary, the policyholder or, respectively, the insured person is obliged to assist in pursuing the claims. Furthermore, the policyholder or, respectively, the insured person is obliged to make a declaration of assignment to HanseMerkur AG, if necessary.

§ 13 Offsetting

The policyholder may offset against claims of HanseMerkur AG only if the counter-claim is uncontested or legally established.

§ 14 Declarations of intent and notifications

1. Declarations of intent and notifications to HanseMerkur AG must be given in writing (e.g. by sending an email, fax or letters etc.).
2. Should the policyholder fail to notify the insurer of a change in address, a return-to-sender notice from the post office for letters to the last address of the policyholder known to the insurer will suffice as a declaration of intent to be submitted to the policyholder. The statement shall be considered to have been received three days after the letter has been dispatched. Clauses 1 and 2 shall be applied accordingly in the event of a change in the name of the policyholder.

§ 15 Applicable law, contractual language

German law shall apply, to the extent permitted. The language of the contract is German.

§ 16 Profit participation

The insurance policy specified here is not subject to profit participation.

Addresses:

Care Concept AG
Am Herz-Jesu-Kloster 20
53229 Bonn

HanseMerkur Reiseversicherung AG
Siegfried-Wedells-Platz 1
20354 Hamburg

B. Special section: Description of benefits for the respective tariffs of VB-KV 2014/III College (CC14/III)

B I. Care College Basic Tariff

I. Treatment expenses

1. HanseMerkur AG reimburses the cost of medically necessary treatments arising after the waiting period ends, with a deductible of EUR 50 for each insured event. Analogously to § 7 I (2) of the General section A of the insurance terms and conditions, the deductible applies to each medically necessary treatment of illness, each examination and each medically necessary treatment relating to pregnancy. The deductible is EUR 250 EUR for each insured event in the case of childbirths.
2. The reimbursement is made on the basis of the Gebührenordnung für Ärzte (GOÄ) [fee scale for doctors in Germany], up to 1.8 times the GOÄ rate.
3. A medical treatment within the meaning of these conditions is as follows:
   a. treatment by doctors including pregnancy examinations, pregnancy treatment and consequences thereof, if the pregnancy had not yet existed at the start of the insurance contract (technical start) or when an application was made to extend insurance cover (follow-on contract);
   b. medical treatments, including medically necessary treatment during pregnancy made necessary by acute symptoms, medically necessary pregnancy treatments and treatments as a result of miscarriage and medically necessary abortion and childbirth up until the end of the 36th week of pregnancy (premature birth), even if the pregnancy already existed at the start of the insurance contract (technical start) or when an application was made to extend insurance cover (follow-on contract), if the necessity of treatment was not yet established at that point in time;
   c. medically prescribed medicines and dressings;
   d. radiation therapy, light therapy and other physical treatments prescribed by a doctor;
   e. massages, medical dressings and inhalations;
   f. aids prescribed by a doctor that are required for the first time solely as a result of an accident and used to treat the consequences of the accident, up to EUR 250 per insurance year. An insurance year is considered to be a period of 12 months calculated from the start of insurance, including all contractual extensions;
   g. X-ray diagnosis;
   h. in-patient treatment that cannot be delayed in the general care class (shared room) without optional services (private medical treatment);
   i. ambulance services for in-patient treatment in the nearest suitable hospital and to the nearest suitable physician and back in the case of first aid care after an accident;
   j. operations that cannot be delayed;
   k. childbirth after the expiry of the waiting period. The deductible is EUR 250 EUR for each insured event in the case of childbirths;
   l. costs for rehabilitation measures as a medically necessary subsequent treatment.

II. Dental treatment expenses

HanseMerkur reimburses the costs arising during the trip abroad for pain-relieving conservative dental care, including provision of non-dentally adhesive plastic filling (including subfilling) for the affected tooth, up to 1.8 times the amtlichen Gebührenordnung für Zahnärzte (GOZ) [fee scale for dentists in Germany] rate. The insured person is responsible for a deductible of EUR 50 for each insured event. The costs are 100% covered up to a reimbursable bill of EUR 250 for each insured event; above this, the costs are 50% covered. If in order to alleviate pain more than two teeth need to be treated or a gum inflammation needs to be treated, the presentation of a cost estimate (treatment and cost plan) with an explanation from the dentist is necessary before treatment starts. The insurer undertakes to examine the contractual benefits immediately and to notify the policyholder of the contractual entitlement. If this cost estimate is not presented before the treatment, the costs that can be replaced are limited to only EUR 250 for each insured event.

III. Repatriation, repatriation of mortal remains / funeral expenses

With the exception of a stay in the home country, HanseMerkur will pay for the following –

1. the additional costs of a medically appropriate repatriation ordered by a doctor to the home country, up to a maximum of EUR 10,000;
2. funeral costs up to the amount of the expenses that would have arisen as a result of the repatriation of mortal remains, but no more than EUR 10,000;
3. in the event of the death of an insured person, the necessary additional costs for the repatriation of mortal remains to the home country, up to EUR 10,000.

IV. Follow-up liability

If an illness requires further medical treatment which extends beyond the end of the insurance coverage because the insured person is shown to be unable to travel, we are required under these terms and conditions to continue to provide coverage at this respectively agreed rate until the restoration of the ability to travel, though for at most four weeks.

Insurance terms and conditions for travel health insurance for language pupils and students from HanseMerkur Reiseversicherung AG VB-KV 2014/III College (CC14/III)

B II. Care College Comfort Tariff

The Care College Comfort Tariff provides the following addition benefits to the Care College Basic Tariff:

I. Deductible
There is now only a deductible for the insured person of EUR 25 per insured event for gynaecological examinations and treatment, and of EUR 250 for childbirth.

II. Limit based on the fee scale
The reimbursement is made on the basis of the Gebührenordnung für Ärzte (GOÄ) [fee scale for doctors in Germany], up to the 2.3 times the GOÄ rate.

III. Dental treatment expenses
HanseMerkur AG reimburses the costs arising during the trip abroad for pain-relieving conservative dental care, including provision of non-dentally adhesive plastic filling (including subfilling) for the affected tooth, up to 2.3 times the amtlichen Gebührenordnung für Zahnärzte (GOZ) [fee scale for dentists in Germany] rate. The costs are 100% covered up to a reimbursable bill of EUR 500 for each insured event; above this, the costs are 50% covered. If in order to alleviate pain more than two teeth need to be treated or a gum inflammation needs to be treated, the presentation of a cost estimate (treatment and cost plan) with an explanation from the dentist is necessary before treatment starts. The insurer undertakes to examine the contractual benefits immediately and to notify the policyholder of the contractual entitlement. If this cost estimate is not presented before the treatment, the costs that can be replaced are limited to only EUR 500 for each insured event.

IV. Dental prostheses
HanseMerkur AG will reimburse 50% of the costs arising during travel abroad for a medically necessary dental prosthesis and the costs to restore the function of an existing prosthesis (repair) after a waiting time of 8 months in a simple form, up to a maximum of EUR 500 within two insurance years. An insurance year is considered to be a period of 12 months calculated from the start of insurance, including all extensions.

V. Patient repatriation
The additional costs of a medically appropriate repatriation ordered by a doctor to the home country are covered without limit.

VI. Premium refund
The policyholder has the right each insurance year to claim a refund on request of a current monthly premium, if:
- the contract duration was at least 12 months,
- the insurance cover has been maintained without interruption for the last 12 months,
- the insured person has received no benefits during this period and
- the premiums have been paid on time.

VII. Cancellation benefit
The insurer will pay compensation for services in connection with the education programme planned by the insured person that were not used. The compensation will be paid as a flat-rate amount per day of sickness.
The precondition for the benefit is that, due to an insured event, the insured person
- is unable to work following medically necessary in-patient treatment lasting at least 14 calendar days and
- the periods of medically necessary in-patient treatment and the consequent inability to work, confirmed by a doctor, together come to at least 90 calendar days. The admission and discharge days of medically necessary in-patient medical treatment each count as one day. The payment of cancellation benefit is not due until all the above preconditions for the benefit are fulfilled. If the same event (e.g. the same illness or the same accident consequences) triggers a benefit obligation several times, this is also considered to be one event if the preconditions for benefit are fulfilled in different insurance years.

The benefit for all events resulting in a claim is limited to EUR 1,500 for each insurance year started.

B III. Care College Premium Tariff

The Care College Premium Tariff provides the following addition benefits to the Care College Comfort Tariff:

I. Deductible
There is now only a deductible for the insured person of EUR 250 for childbirth. The insured person does not need to apply a deductible for any other insurance case.

II. Medical aids
Medical aids in simple form prescribed by a doctor that are required for the first time solely as a result of an accident and used to treat the consequences of the accident will be reimbursed. Visual aids are eligible for reimbursement up to a bill of EUR 100, after a waiting period of three months. A further entitlement arises only in the event of a change in visual ability of at least 0.5 dioptres.

III. Dental treatment expenses
HanseMerkur AG reimburses 100% the costs arising during the trip abroad for pain-relieving conservative dental care, including provision of non-dentally adhesive plastic filling (including subfilling) for the affected tooth in simple form. If in order to alleviate pain more than two teeth need to be treated or a gum inflammation needs to be treated, the presentation of a cost estimate (treatment and cost plan) with an explanation from the dentist is necessary before treatment starts. HanseMerkur AG undertakes to examine the contractual benefits immediately and to notify the policyholder of the contractual entitlement. If this cost estimate is not presented before the treatment, the costs that can be replaced are limited to EUR 750 for each insured event at 100% and further costs at 50%.

IV. Dental prostheses
HanseMerkur AG will reimburse 70% of the costs arising during travel abroad for a medically necessary dental prosthesis and the costs to restore the function of an existing prosthesis (repair) after a waiting time of 8 months in a simple form, up to a maximum of EUR 1,000 within two insurance years. If the insured event arises as a result of an accident after the start of insurance cover, the costs of a medically necessary dental prosthesis in a simple form are reimbursed at a 100% rate up to a maximum of EUR 2,500 within two insurance years. However, damage to the teeth due to chewing of food and objects and biting is not considered to be an accident. An insurance year is considered to be a period of 12 months calculated from the start of insurance, including all extensions.

V. Repatriation of mortal remains /funeral expenses
With the exception of a stay in the home country, HanseMerkur will pay for the following –
a. in the event of the death of an insured person, the necessary additional costs for the repatriation of mortal remains to the home country, up to EUR 15,000;
b. funeral costs up to the amount of the expenses that would have arisen as a result of the repatriation of mortal remains, but no more than EUR 15,000.

VI. Follow-up liability
If an illness requires further medical treatment which extends beyond the end of the insurance coverage because the insured person is shown to be unable to travel, we are required under these terms and conditions to continue to provide coverage at this respectively agreed rate until the restoration of the ability to travel, though for at most 8 weeks.

VII. Pregnancy and childbirth
Pregnancies already existing when the contract is concluded as well as the subsequent childbirths are included

without a waiting period, with a deductible of EUR 5,000 for pregnancy examinations and care as well as childbirth in hospital or with a midwife, up to a maximum reimbursement of EUR 30,000 within the entire contract period.

VIII. Cancellation benefit

The insurer will pay compensation for services in connection with the education programme planned by the insured person that were not used. The compensation will be paid as a flat-rate amount per day of sickness.

The precondition for the benefit is that, due to an insured event, the insured person

- is unable to work following medically necessary in-patient treatment lasting at least 14 calendar days and
- the periods of medically necessary in-patient treatment and the consequent inability to work, confirmed by a doctor, together come to at least 90 calendar days. The admission and discharge days of medically necessary in-patient medical treatment each count as one day.

The payment of cancellation benefit is not due until all the above preconditions for the benefit are fulfilled.

If the same event (e.g. the same illness or the same accident consequences) triggers a benefit obligation several times, this is also considered to be one event if the preconditions for benefit are fulfilled in different insurance years.

The benefit for all events resulting in a claim is limited to EUR 2,500 for each insurance year started.

B IV. Care College USA Tariff

By derogation to the General Insurance Terms and Conditions and the provisions of the Care College Premium Tariff, the following extensions, restrictions and special contractual obligations apply to the Care College USA Tariff.

I. Scope of cover

By derogation to the provision of § 6 (1b) of the General Insurance Terms and Conditions, the USA, US American territories, Canada and Mexico are also considered to be "abroad" in terms of the insurance contract.

II. Subject matter of the insurance coverage and the extent of the benefits

If participation in further education courses at state or private educational establishments in the USA or the US American Territories (colleges, universities, etc.) is only possible on condition that insurance cover exists for a type of benefit that is explicitly excluded in § 7 or § 8 of the General Insurance Terms and Conditions or in the provisions of section B III or that is not specified (e.g. psychological care), this type of benefit is considered to be covered by insurance as well.

III. Obligations

1. In addition to § 10 of the General Insurance Terms and Conditions, the policyholder or the insured person is obligated after the occurrence of an insured event to provide appropriate proof showing that the form of benefit claimed was a precondition for participation in the further education course.
   Appropriate proof would include an official form or a confirmatory letter from the educational establishment in which the individual forms of benefit are specified which must be insured as a condition for participation in the further education course under the current minimum requirements (waiver, exemption form, etc.)
2. When an insured event occurs, the policyholder or the insured person is obligated before the start of treatment to contact the company MedCare International Inc. to be assigned a contract doctor by the company.
3. The policyholder or the insured person is obligated on request from HanseMerkur AG or Care Concept AG to agree to return to Germany resp. Austria, if such a return journey is medically advisable and feasible. The costs for the medical return journey will then be covered by the insurer.

   If the policyholder or the insured person in need of treatment is for medical reasons not in a position to be able to give consent to return travel on their own behalf, the nearest relative authorised to make decisions under the legal regulations is responsible for this.

IV. Increased deductible

1. If the policyholder or the insured person undergoes medical treatment without prior contact with the company MedCare International Inc. or without accepting the reference to the preferred doctor designated by the company, then the following applies:
   Separately from the consequences of a breach of obligation set out in IV of these provision, a deductible of 20% is created for all costs reimbursable under the tariff, though no more than EUR 25,000. The deductible then applies to each medically necessary treatment of illness, each examination and each medically necessary treatment relating to pregnancy. Exceptions to this are acute illnesses and consequences of accidents which require immediate medical treatment that cannot be delayed.
2. If the policyholder or the insured person refuses to agree to a medically advisable and feasible return journey after an insured event occurs, the following applies:
   Separately from the consequences of a breach of obligation set out in IV of these provision , a deductible of 20% is created for all costs reimbursable under the tariff in the country of destination, though no more than EUR 25,000. The deductible then applies to each medically necessary treatment of illness, each examination and each medically necessary treatment relating to pregnancy.

Insurance terms and conditions for travel health insurance for language pupils and students from HanseMerkur Reiseversicherung AG VB-KV 2014/III College (CC14/III)

Extract from the Insurance Contract Act

§ 8 Right of withdrawal for the policyholder

1. The policyholder may withdraw his contractual agreement within 14 days. The withdrawal must be stated in writing to the insurer and does not need to give a reason; the deadline is met if the statement is sent in good time.
2. The withdrawal deadline starts at the point in time when the following documentation has been provided in writing to the policyholder:
   1. the insurance certificate and the insurance provisions, including the general insurance terms and conditions as well as the additional information pursuant to Article 7 (1 and 2) and
   2. a clearly stated notification of the right to withdrawal and the legal consequences of withdrawal which makes the rights of the policyholder in accordance with the requirements of the communication form used clear and contains the names and complete address of the persons to whom the withdrawal must be addressed, as well as a reference to the start of the period for withdrawal and to the regulations of paragraph 1 (2).
   The proof of the arrival of the documentation under (1) is the responsibility of the insurer.
3. The right to withdrawal does not exist
   1. for insurance contracts with a duration less than one month,
   2. for insurance contracts with provisional cover, unless this is a distance contract in terms of § 312b (1 and 2) of the Civil Code,
   3. for insurance contracts with pension funds based on employment contract regulations, unless this is a distance contract in terms of § 312b (1 and 2) of the Civil Code,
   4. for insurance contracts dealing with a major risk in terms of § 210 (2).
   The right of withdrawal lapses if the contract is considered by both sides at the explicit wish of the policyholder to be fulfilled before the policyholder has exercised his right of withdrawal.
4. In the cases of electronic transactions, the right of withdrawal, contrary to paragraph 2 (1) does not begin before fulfilment of the obligations regulated in § 312 (1) (1) of the Civil Code.
5. The notification to be given under paragraph 2 (1) (2) satisfies the requirements stated there if the sample in the Annex to this Act is used in written form. The insurer may deviate from the sample in format and font size, taking into account paragraph 2 (1) (2), and may insert additions such as the company name or a logo of the insurer.

§ 28 Breach of a contractual obligation

1. In the event of a breach of a contractual obligation to be fulfilled by the policyholder to the insurer before an insured event occurs, the insurer may within one month of learning of the breach may terminate the contract without notice, unless the breach is not due to deliberate intent or gross negligence.
2. If the contract determines that the insurer is not obligated to provide benefits if the policyholder breaches an obligation to be fulfilled under the contract, the insurer is free from liability, if the policyholder has deliberately breached the obligation. In the event of failure to meet obligations as a result of gross negligence, the insurer is entitled to reduce their benefits in proportion to the extent of the policyholder's culpability; the burden of proving that gross negligence did not occur shall be borne by the policyholder.
3. Contrary to (2), the insurer is obliged to provide benefits if the breach of the obligation neither led to the occurrence or establishment of the insured event nor led to the establishment or scope of the benefit that the insurer is obliged to provide. Sentence 1 shall not apply if the obligation has been breached by making fraudulent misrepresentations.
4. The complete or partial freedom from liability of the insurer under (2) presupposes the breach of an obligation to provide information or clarification after the insured event has occurred for which the insurer has drawn the attention of the policyholder to the legal consequences by separate written notification.
5. An agreement under which the insurer is entitled to withdrawal in the event of a breach of a contractual obligation would be invalid.

§ 15 Suspension of limitation on claims

If a claim to the insurer has been made, the limitation period will be suspended until the decision of the insurer is notified to the applicant in writing.

§ 37 Late payment of the first premium

1. If the one-off or first premium is not paid on time, the insurer is entitled to withdraw from the contract as long as payment has not been made, unless the policyholder is not responsible for the non-payment.
2. If the first or one-off premium has not been paid when an insured event occurs, the insurer is not obliged to provide coverage, unless the policyholder is not responsible for the non-payment.
   The insurer is only free of liability if it has informed the policyholder of this legal consequence of non-payment of the premium in a separate written notification or through a prominent notice in the insurance certificate.

§ 38 Late payment of a subsequent premium

1. If a subsequent premium is not paid on time, the insurer can inform the policyholder in writing at the policyholder's expense of a deadline for payment, which must be at least two weeks. The provision only takes effect if the insurer sets out the amounts due, showing the premiums, interest and costs in detail, and states the legal consequences which under paragraphs 2 and 3 are associated with the expiry of the deadline; where contracts have been combined, the amounts must be respectively stated separately.
2. If an insured event occurs after the deadline has expired, and if the policyholder is then in default of the premium, the interest or the costs, the insurer shall not be obliged to provide coverage.
3. After the deadline expires, the insurer can terminate the contract without notice, if the policyholder is in default of payment of the amounts due. The termination can be combined with the determination of the payment deadline in such a way that the termination will take effect upon expiry of the deadline if the policyholder is in default of payment at this time; the policyholder must be explicitly notified of this. The termination shall become ineffective if the policyholder makes the payment within one month after the termination or, if it was combined with the determination of the deadline, within one month after the deadline expires; paragraph 2 is unaffected by this.

§ 39 Early termination of the contract

1. In the event that the insurance relationship ends before the expiry of the insurance period, the insurer is only entitled for this insurance period to that part of the premium which corresponds to the period when insurance cover was provided. If the insurance relationship ends by withdrawal on the basis of § 19 (2) or by a challenge by the insurer due to fraudulent representations, the insurer is entitled to the premium up to the time when the withdrawal or challenge takes effect. If the insurer withdraws on the basis of § 37 (1), a reasonable processing fee can be charged by the insurer.
2. If the insurance relationship ends on the basis of § 16, the policyholder can demand the return of that part of the premium relating to the time after the end of the insurance relationship, after deduction of reasonable costs incurred for this period.

§ 86 Assignment of compensation claims

1. If the policyholder has a basis to claim compensation from a third party, this right shall be assigned to the insurer, provided that this insurer will pay the damages. The assigned claim cannot be used to the disadvantage of the policyholder.
2. The policyholder has to protect his claim for compensation or his right to secure this claim, taking into account the applicable formal requirements and deadlines, and to assist in the pursuit of the claim by the insurer, if necessary. If the policyholder intentionally violates this obligation, the insurer is not obliged to pay benefits, since the insurer will therefore not be able to obtain any compensation from the third party. In the event of failure to meet obligations as a result of gross negligence, the insurer is entitled to reduce their benefits in proportion to the extent of the policyholder's culpability; the burden of proving that gross negligence did not occur shall be borne by the policyholder.
3. If the policyholder's claim for compensation is against a person with whom he was living at the time of the event, the assigned claim cannot be pursued in accordance with paragraph 1 unless this person caused the damage deliberately.

Insurance terms and conditions for travel health insurance for language pupils and students from HanseMerkur Reiseversicherung AG VB-KV 2014/III College (CC14/III)

Care Concept AG
We take care of you!

Extracts from the Social Code I and V

Extract from the Social Code I

§ 21 Benefits from the statutory health insurance

1. Under the statutory health insurance, the following can be claimed:
   1. Benefits to promote health, for prevention and early recognition of illnesses,
   2. treatment in the case of illness, in particular
      a. medical and dental treatment,
      b. provision of medications, dressings, remedies and aids,
      c. domestic health care and home help,
      d. hospital treatment,
      e. medical and additional services to assist rehabilitation,
      f. operational assistance for farmers,
      g. sickness payments,
   3. in the case of pregnancy and maternity, medical care, midwife assistance, in-patient childbirth, domestic care, home help, operational assistance for farmers, maternity payments,
   4. help in family planning and services for sterilisation required due to illness and legal abortion.
2. The responsible bodies are the local, company and guild health insurance funds, the social insurance for agriculture, forestry and horticulture as a farming insurance fund, the German Pension Fund for railway workers and seafarers and the auxiliary funds.

Extract from the Social Code V

§ 5 - Insurance obligation

1. The following must be insured:
   9. Students registered at state or state-recognised institution of higher education, irrespective of whether they have their home or usual place of residence in the country, if they do not have a claim for material services on the basis of international or bilateral state law, until the end of the fourteenth semester of study, though not after age thirty; students after the end of the fourteenth semester of study or after age thirty are only required to be insured if the type of education or family or personal reasons or a longer study period in their faculty justify this, in particular the acquisition of the preconditions for access to Second Opportunity educational establishments.

§ 173 General rights of choice

1. Persons who are required to be insured (§ 5) or entitled to be insured (§ 9) are members of the health insurance fund that they select, unless otherwise specified in the following provision, in the Second Act on Health Insurance of Farmers or in the Artists' Social Insurance Act.
3. Students may also choose the local health insurance fund or any auxiliary fund at the location where their institution of higher education is situated.

§ 175 Exercise of the right of choice

1. The exercise of the right of choice must be notified to the chosen health insurance fund. This is not entitled to reject membership or to obstruct or restrict the statement in paragraph 1 through false or incomplete advice. The right of choice may be exercised after age 15.
2. The selected health insurance fund must issue a membership certificate immediately after the choice has been exercised. If the applicant had been a member of another health insurance fund within the last 18 months before the start of mandatory or optional insurance, the membership certificate can only be issued if the notice of cancellation under paragraph 4 clause 3 is shown. A membership certificate must be issued without delay also when mandatory insurance starts, for the purpose of presentation to the body that is to be notified.

2a. If the supervisory body has reasons to suspect that a health insurance fund contrary to paragraph 1 clause 2 has unlawfully refused membership or has obstructed or restricted the submission of the statement under paragraph 1 clause 1, it must investigate these at once and to require the health insurance fund to cease any breach of law identified and to refrain from future breaches of law. In particular, advice given by the health insurance fund approached is considered unlawful if it leads to the statement under paragraph 1 clause 1 being entirely ignored or to it being only possible to submit under restrictive conditions. The obligation of the health insurance fund under paragraph 1 shall be associated with the warning of a fine of up to EUR 50,000 for each breach. Legal remedies against measures of the supervisory body under clauses 1 and 3 do not have a delaying effect. Members of the management board who deliberately or negligently fail to prevent a health insurance fund contrary to paragraph 1 clause 2 from unlawfully refusing membership or obstructing or restricting the submission of the statement under paragraph 1 clause 1 are liable to reimburse the health insurance fund for the resulting loss as joint debtors. The responsible supervisory body shall after consultation with the member of the management board instruct that the member of the board be so tasked, if the management board has not itself instituted a claim for recourse.

3. Persons required to be insured must promptly present a membership certificate to the body for mandatory notification. If the membership certificate is not presented within at the most two weeks of the start of mandatory insurance, the body for mandatory notification shall register the person liable for insurance from the start of mandatory insurance to the health insurance fund where insurance was last provided; if there was no insurance before mandatory insurance started, the body for mandatory notification shall register the person liable for insurance from the start of mandatory insurance to a health insurance fund that can be chosen under § 173 and to inform the person liable for insurance immediately of the health insurance fund selected. In the cases where a membership certificate under clause 1 has not been presented and no notification is made under clause 2, the Central Federal Association of Health Insurance Funds shall lay down rules as to who is responsible.

3a. If a health insurance fund closes or becomes insolvent, persons liable for insurance must within six weeks of being informed of the closure or the submission of insolvency applications (§ 171b (3) (1)) present a membership certificate to the body for mandatory notification. If the membership certificate is not presented by the deadline, paragraph 3 clause 2 applies accordingly, with the provision that the registration by the body for mandatory notification must be made within two further weeks, with effect from the date when the closure becomes effective. If an insolvency application is submitted, the notification is made on the first day of the current month, at the latest at the point in time when the insolvency proceeding started or the application was rejected due to lack of substance. If the health insurance fund is not closed, membership at this health insurance fund continues. The selected health insurance fund shall send the closed or insolvent insurance fund a membership certificate immediately. Members who do not have a body for mandatory notification must present a membership certificate to the closed insurance fund within three months of the point in time stated in clause 1.

4. Persons for whom insurance is mandatory or optional are bound to the selection of insurance fund for at least 18 months. Notice to terminate membership is possible for the calendar month after next, calculated from the month in which the member gives notice. The health insurance fund must immediately, and at the latest within two weeks of receipt of the notice, issue a confirmation of the notice. The termination takes effect when the member shows before the notice deadline membership of another health insurance fund, by a membership certificate or the existence of another security in the event of illness. If the health insurance fund has for the first time under § 242 (1) claimed an additional contribution or if it increases its additional contribution rate, the termination of membership may, contrary to clause 1, be notified for the end of the month for which the additional contribution was claimed for the first time or for which the additional contribution rate was increased. The health insurance fund must at the latest one month before the date specified in point 5 inform its members in a separate letter of their right to terminate under clause 5, on the extent of the average additional contribution rate under § 242a and to the overview of the Central Federal Association of Health Insurance Funds of additional contribution rates of health insurance funds under § 242 (5)I if the newly claimed additional contribution and the increased additional contribution rate exceeds the average additional contribution rate, the members must be referred to the option to change to a cheaper health insurance fund. If the health insurance fund is late in fulfilling its obligation to a member under clause 6, a notice of termination is considered to be valid for the month in which the additional contribution was claimed for the first time or for which the additional contribution was increased; notices to terminate which were made before the date specified in clause 5 are exempt from this. Clauses 1 and 4 do not apply if the notice to terminate is made by a person liable for insurance because the preconditions of insurance under § 10 are fulfilled; clause 1 does not apply if the notice to terminate is made because membership in a health insurance fund need not be established. The health insurance funds can envisage in their statutes that the deadline under clause 1 does not apply if membership of another health insurance fund of the same fund type needs to be explained.

4a. (deleted)

5. Paragraph 4 does not apply to persons liable for insurance who may become members of a company or guild health insurance fund through the establishment or extension of such a fund or workplace changes, if they make the change within two weeks after the date of establishment, extension or workplace changes.
6. The Central Federal Association of Health Insurance Funds lays down standard procedures and information sheets for the notifications and membership certificates following this regulation.

Insurance terms and conditions for travel health insurance for language pupils and students from HanseMerkur Reiseversicherung AG VB-KV 2014/III College (CC14/III)

§ 186 Start of membership for persons liable for insurance

7. Members of students liable for insurance starts with the semester, at the earliest on the day of registration or re-registration at the institution of higher education.

§190 End of membership for persons liable for insurance

9. The membership of students liable for insurance ends one month after the end of the semester for which they most recently registered or re-registered.

§254 Payment of contributions for students

Students liable for insurance must pay the contributions for the semester in advance to the health insurance fund responsible, before registering or re-registering at the institution of higher education. The Central Federal Association of Health Insurance Funds may envisage other forms of payment. If a person who as a student is liable for insurance fails to fulfil the obligations to the health insurance fund on the basis of this Act, the institution of higher education will refuse the registration or acceptance of re-registration.

Information sheet on data processing

Preliminary comment

It is nowadays only possible for insurance companies to carry out their tasks with the help of electronic data processing (EDP). This is the only way that contractual arrangements can be processed correctly, swiftly and efficiently; EDP also offers better protection of the insurance community against improper use than the previous manual processes.
The processing of the data made known to us about your person is regulated by the Federal Data Protection Act [German abbreviation BDSG]. This only permits data processing and use if the BDSG or another legal regulation permit or if the person involved has consented. The BDSG always allows data processing and use if this is done within the framework of the purpose determined by a contractual relationship or a relationship of trust similar to a contract or if it is required to protect legitimate interests of the body storing the data and there is no reason to assume that the interests of those affected that are worthy of protection take precedence through the exclusion of the processing or use.

Statement of consent

Independently from the balance of interests to be considered in the individual case and with a view to a secure legal basis for data processing, your insurance application includes a statement of consent in accordance with the BDSG. This applies beyond the end of the insurance contract, though ends - except for life and accident insurance - if the application is rejected or after your withdrawal that is possible at any time. If the statement of consent in the application is entirely or partially deleted, the contract may in some circumstances not be concluded. Despite withdrawal or total or partial deletion of the statement of consent, data processing and use may be carried out within the limited framework permitted by law, as described in the preliminary comment.

Statement of release from confidentiality

In addition, the transmission of data which are subject to professional confidentiality - as e.g. with a doctor - requires special permission from the person affected (statement of release from confidentiality). The application for life, health and accident insurance (personal insurance) policies therefore also contains a statement of release from confidentiality. In what follows, we will describe for you a few important examples for data processing and use.

1. Data storage by your insurer
We store data that is required for the insurance contract. This is initially your statements in the application (application data). In addition, technical insurance data for the contract (contract data) are stored, such as customer number (partner number), sums insured, duration of insurance, contribution, banking details and where necessary information on third parties, e.g. a broker, an expert or a doctor. In the case of an insured event, we store your statements on the claim and any information from third parties, such as e.g. the degree of professional incapacity found by the doctor, the findings of your repair workshop regarding a car write-off or the amount to be paid at the end of a life insurance (benefits data).
2. Data transfer to reinsurer
In the interest of policyholders, an insurer will always take care to balance the risks assumed by the insurer. Consequently, in many cases we pass part of the risks to reinsurers in this country and abroad. These reinsurers also need corresponding technical insurance information from us, such as insurance number., contribution, type of insurance cover and the risks and risk premiums as well as in individual cases your personal details. If reinsurers participate in the assessment of risk and claims, they are also provided with the documentation necessary for this purpose.
In a few cases, the reinsurers use further reinsurers, to whom the corresponding data are also passed.

3. Data transfer to other insurers
Under the Insurance Contract Act, the insured person is required to indicate all the important factors for the assessment of risk and the processing of claims when making an application, for any change of contract and when making a claim. These include e.g. earlier illnesses and insured events or information about similar other insurances (applied for, existing, rejected or given notice to terminate). In order to prevent insurance fraud, to clarify any contradictions in the statements of the insured person or to close any gaps in the description of claims arising, it may be necessary to ask other insurers for information or to provide corresponding information on request. In other respects as well, it is necessary in certain cases (duplicate insurance, legal subrogation and sharing agreements) for insurers to exchange personal data. This may involve data of the persons affected being passed on, such as name and address, car registration number, nature of insurance cover and the risk or information on claims, such as the size and date of claims.

4. Central reference systems
In the examination of an application or a claim, it may be necessary for the assessment of risk, further clarification of the facts or prevention of insurance fraud to ask question of the professional association responsible or of other insurers, or conversely to respond to questions by other insurers. For this purpose, the German Insurance Association [Gesamtverband der deutschen Versicherungswirtschaft e.V., GDV] and the Association of Private Health Insurance Funds [Verband der privaten Krankenversicherung (PKV) maintain central reference systems.
The inclusion and use of data in these reference systems is only undertaken for purposes which are allowed to be pursued with the respective system, on condition that specific preconditions are met.

Examples:

Accident insurance
Reports of
- substantial breach of the pre-contract notification obligation,
- Refusal to provide benefits due to deliberate breach of obligations in the case of claims, due to deceptive claims regarding an accident or the consequences of an accident,
- termination for cause by the insurer after provision of benefits or complaints raised about a benefit.

Purpose: Risk assessment and identification of insurance fraud.

General travel liability insurance
Registration of notable claims and of persons for whom there is a suspicion of insurance fraud.
Purpose: Risk assessment, claim investigation and prevention.

Insurance terms and conditions for travel health insurance for language pupils and students from HanseMerkur Reiseversicherung AG VB-KV 2014/III College (CC14/III)

5. Data processing in the enterprise group
A few insurance sectors (e.g. life, health and property insurance) are conducted by legally independent companies. In order to be able to offer the client comprehensive insurance cover, the companies often work together in corporate groups. To save costs, some sectors are stored centrally just once for this purpose, even if you conclude contracts with different companies of the group; your insurance number, the type of contracts, and possibly your birth date, account number and banking details, i.e. your general application, contract and benefit data are maintained in a central data store. The so-called partner data (e.g. name, address, customer number, account number, banking details, existing contracts) are thereby retrievable by all the companies of the group. In this way, incoming post can be correctly assigned and the right partner for telephone enquiries can immediately be identified. Payments can also in case of doubt be correctly assigned in this way without the need for queries. The other general application, contract and benefit data are, however, only retrievable by the insurance companies of the group. Although all these data are only used for advice and support for the respective customers through the individual companies, the law also refers to this as “data transmission”, to which the regulations of the BDSG apply. Access to sector-specific data - such as e.g. health or creditworthiness data - is by contrast limited exclusively to the respective companies.

6. For the case of support by insurance brokers
If you are assisted in your insurance affairs (both as part of the other service offers of our corporate group or our cooperation partners) by an insurance broker, the broker receives from us for these purposes the necessary information for support and advice from your application, contract and benefit data, e.g. insurance number, contributions and extent of insurance benefits, in order to be able properly to carry out his tasks. The responsible broker may also be sent health data, exclusively for the purpose of contractual adjustments in personal insurance. Brokers in this sense are both individuals and brokerage companies. Our brokers themselves process and use these personal data as part of the customer advice and support specified. They are also informed by us of changes in customer-related data. Every broker is legally and contractually required to observe to provisions of the BDSG and its particular confidentiality requirements (e.g. professional confidentiality and data confidentiality). You will be informed which broker is responsible for your support. If his work for our company comes to an end (e.g. through termination of the brokerage agreement or on retirement), the company will regulate your support afresh; you will be informed accordingly.

Information sheet in accordance with § 11 Insurance brokerage arrangement

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Trade register no.:	HRB 8470
VAT ID:	DE813961035
Brokerage register:	Deutscher Industrie- und Handelskammertag (DIHK) e.V. Breite Street 29 10178 Berlin Telephone: 0 180 6005850 (Landline price EUR 0.20/ call; Mobile price EUR 0.60/ call) www.vermittlerregister.info
Chamber of Industry and Commerce register number:	D-KJUH-GSQI4-87
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