General Conditions

Generali ON LIFE
Generali ON REPAYMENT

Generali ON **LIFE**
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04/24

Generali Seguros y Reaseguros, S.A.U. Domicilio Social: Paseo de las Doce Estrellas, 4, 28042 Madrid.
Reg. Merc. de Madrid, Tomo 21275, Hoja M-377257, Folio 45, CIF: A-48037642

INFORMATION STATEMENT

The Member State in charge of controlling the company's insurance activities is Spain, and the controlling authority is the Directorate General of Insurance and Pension Funds, which forms part of the Ministry of Economy.

Spanish legislation is applicable to the contract, more specifically, the Spanish Insurance Contracts Act 50/80 of 8 October and Act 20/2015 of 14 July on the Regulation, Supervision and Solvency of Insurance and Reinsurance Companies, and the regulations implemented therein, and the Personal Income Tax Act 35/2006 of 28 November, partially amending the Spanish Corporation Tax, Non-Resident Income Tax and Wealth Tax laws developed therein.

Generali Seguros y Reaseguros, S.A.U. has a **Customer Service Department** and **Customer Ombudsman** for handling and settling any complaints or claims arising from actions taken by the company or its insurance agents or bank insurance brokers, in accordance with the procedure set forth in Order ECO 734/2004 of 11 March.

Policyholders, insured parties, beneficiaries, affected third parties and their entitled dependants may submit their complaints and claims to:

– The Generali **Customer Service Department**, by writing to Paseo de las Doce Estrellas, 4, 28042 Madrid, Spain, or by email: **reclamaciones@generalion.es**

– Or secondly, to the Generali **Customer Ombudsman**, by writing to C/ Velázquez 80, 28001 Madrid, Spain, or by email: **reclamaciones@da-defensor.org**

All complaints and claims submitted by customers shall be handled and resolved within a maximum of one month following their submission.

In the event that the claimant disagrees with the decision handed down by any of the aforementioned bodies, or has not received a response after two months, s/he can submit his/her complaint or claim in writing to the Claims Service of the Directorate General of Insurance and Pension Funds at Paseo de la Castellana, 44, 28046 Madrid.

In addition to the methods for placing claims listed above, disputes may be brought before the relevant judges and courts by legal means.

The **Customer Ombudsman Regulations**, which outline the procedures for handling complaints and claims, are available to customers at all Generali offices. The regulations are also available on the website: **www.generalion.es**, or from your insurance agent.

The registered offices of the insurance company **Generali Seguros y Reaseguros, S.A.U.** are located at **Paseo de las Doce Estrellas, 4, 28042 Madrid, Spain.**

The company has the legal status of a joint stock company.

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PRELIMINARY ARTICLE DEFINITIONS

For the purposes of this contract, the following definitions apply:

- **Insurer:** The insurance company is **Generali Seguros y Reaseguros, S.A.U.,** which underwrites the policy along with the policyholder and undertakes, through collection of the relevant premium, to cover all risks insured hereunder, whether it be survival, death or any other.
- **Insurance policyholder:** The individual or legal entity who signs the policy with the insurer and undertakes to pay the established premiums and fulfil all obligations arising thereunder. The schedule will establish whether s/he acts on his/her own behalf or on behalf of another.
- **Insured:** The person on whose life or physical integrity the policy is issued.
- **Beneficiary:** The individual(s) or legal entity(ies) entitled to the benefits contracted under the policy in the event any of the risks subject to cover occur.
- **Primary beneficiary:** The lending institution designated in the schedule.
- **Additional beneficiary:** In the case of excess insured sum, those individuals or legal entities designated in the schedule.
- **Policy:** The document or set of documents containing the regulatory conditions of the insurance. The general conditions, special conditions, schedule (which individualises the risk) and any endorsements or riders issued to supplement or modify the terms of the policy are an integral part thereof. None of these documents is valid nor has effect without the others.
- **Premium:** The cost of the insurance. The invoice shall also include the legally applicable surcharges and taxes.
- **Insurance age:** The age of the insured on the birthday closest to the day on which the policy takes effect and on each subsequent renewal.

- **Sum insured:** The sum of money that the insurer shall pay the beneficiary in the event any of the risks subject to cover occur.
- **Excess sum insured:** The difference between the sum insured and the sum to be repaid to the lending institution at the time that the risk subject to cover occurs.
- **Claim:** Any occurred event whereby, under the policy, the insurer must pay the sum insured or the benefit provided for in the contract.
- **Suicide:** Death of the insured caused knowingly and intentionally by him or herself.
- **Accident:** An accident is understood as any bodily injury arising from a violent, sudden and external act that was not intended by the Insured.
- **Permanent total disability:** Any medically-proven irreversible physical injury that renders the insured unable to perform any type of remunerated work for at least six consecutive months.

1 OBJECT OF THE INSURANCE

The insurer undertakes to pay the sum insured and/or arrange for the guaranteed benefits in the event the risk or risks subject to cover occur, within the scope and subject to the exceptions and limitations stipulated in the policy, in the schedule and the special conditions.

Unless otherwise expressly indicated in the special conditions or schedule, the policy is first loss insurance. That is, should an event subject to either basic or additional cover occur, the insurer shall assume the consequences provided for in the policy for said risk and **the contract shall thereupon be cancelled,** except for the terms established for cover for serious illnesses.

There are three types of contracts based on how the sum insured will vary:

– Fixed: the sum insured remains constant throughout the validity period of the contract.
– Decreasing: The sum insured adjusts to the pending sum of the loan at the interest rate chosen by the client, as per the French system of repayment.
– Increasing: The sum insured undergoes a yearly geometric growth of 2%.

Under all circumstances, the policyholder may request that the sum insured be adjusted to the sum of the loan pending repayment, **provided that such variations are equal to or greater than 3,000 euros.** This option may be exercised by the policyholder on the date the policy is renewed and shall require the modification of the premium.

The policyholder may request an increase in the sum insured, in which case the insurer must accept the increase and may request a health certificate and medical tests from the insured.

2 POLICY BENEFIT PAYMENTS

1. Obligations in the event of a claim, claim for benefits or expiry of the policy

The policyholder, the insured, or where applicable, the beneficiary, must report the occurrence of a claim to the insurer within a maximum period of seven days from the date on which they become aware of it. The policyholder, the insured or, where applicable, the beneficiary shall provide the insurer with the following original documents or, where applicable, certified photocopies thereof:

Claims for death

– Certified copy of the death certificate.
– Certified copy of the birth certificate (photocopy of the National ID Card of the insured).

– The report from the doctor who attended the insured, describing the cause, progress and nature of the illness that resulted in death, or, where applicable, a complete copy of the court proceedings or documents verifying that death occurred due to an accident, such as the autopsy report.
– Certificate from the General Register of Last Will and Testaments and, where applicable, a copy of the last will and testament of the insured.
– Letter of proof of payment of the relevant taxes, where legally applicable, or proof of exemption, particularly insofar as the Tax on Inheritance and Donations is concerned.

– For the repayment product, a document from the Lending Institution/s indicating the outstanding loan amount or its cancellation by the insured as of the date on which the accident occurs.

Furthermore, in the event both spouses die in the same accident and have underage children, the following must be submitted:

– Certified copy of the death certificates of both spouses.
– Family book.

Exceptionally, in the event the insured dies outside Spain or under any unusual circumstances that make the documents listed above objectively inadequate for accurately verifying the causes and circumstances surrounding the death thereof, the insurer may request any additional documents that are strictly necessary for such purposes.

Claims due to disability

– I.N.S.S. resolution declaring disability, the degree of disability and the effective date.
– Medical reports that describe the cause, progress and current state of the pathologies.
– Photocopy of National ID Card.
– For the repayment product, a document from the Lending Institution/s indicating the outstanding loan amount or its

cancellation by the insured as of the date on which the accident occurs.

Furthermore, in the case of disability due to an accident or road-traffic accident.

– Complete copy of the court proceedings or documents verifying the accident.

Exceptionally, in the event the insured becomes disabled outside Spain or under any unusual circumstances that make the documents listed above objectively inadequate for accurately verifying the causes and circumstances surrounding the disability thereof, the insurer may request any additional documents that are strictly necessary for such purposes.

Claims for serious illnesses

– Medical reports indicating the known medical background and the cause, progress and nature of the serious illness and/or surgery, where applicable.

– Photocopy of the National ID Card of the insured.

The policyholder, insured or, where applicable, beneficiary must also submit any documents or information that the insurer requests with a view to verifying the facts and circumstances surrounding the claim or benefit.

Exceptionally, in the event the serious illness befalls the insured outside Spain or under any unusual circumstances that make the documents listed above objectively inadequate for accurately verifying the causes and circumstances surrounding the serious illness, the insurer may request any additional documents that are strictly necessary for such purposes.

Repatriation Cover

Provision of the services included in the Repatriation Cover must be requested, from the moment the event occurs, by calling the following number: in Spain: 91 000 19 14.

Anywhere else in the world: +34 91 000 19 14.

2. Payment of benefits

In the event the risk provided for under the policy occurs, the insurer will pay the insurance policyholder or designated beneficiary or beneficiaries, as may apply, the contracted benefit at their registered offices once the relevant claim has been processed.

The insurer must pay or allocate the contracted benefit within a maximum period of five days from the date on which the required paperwork is completed.

If the insurer has not paid or allocated the amount without justified cause or for reasons attributable to the insurer within three months from the date of the claim, the insurer shall be in default.

In the event the insured dies, the beneficiaries of the insurance policy may, before the required paperwork has been completed, request an advance on the sum insured subject to the following limits and only under the following circumstances:

- As initial aid for funeral expenses, the insurer may grant **an advance equal to 10% of the sum insured for death, and up to a maximum of 5,000 euros,** upon submittal of a certified copy of the death certificate and the identification documents of the beneficiary or beneficiaries. In the case of a sole beneficiary, s/he will need to present his/her National Identity Document and proof of a bank account in his/her name. In the case of more than one beneficiary, a document in writing signed by all of the beneficiaries will also be required, requesting the aforementioned advance and stipulating which of the beneficiaries should receive it.
- **If the conditions above are not fulfilled, the company will still provide the amount requested as an advance, out of respect for the fact that the family of the insured need the aforementioned**

advance. However, this amount will subsequently be deducted from the total insured amount and the beneficiaries renounce the right to take subsequent action of any type that could arise.

– Once the insurer has authorised the claim payment, the insurer may grant an **advance,** to help with administration costs and tax payments.

3. Loss adjustment proceedings

Should a discrepancy arise with regard to claim classification, its causes, the date of its occurrence or any other relevant circumstance, the insurer and the insured or policyholder may submit the issue to medical experts for decision, of whom each party may appoint one, subject to the written approval of the other party.

Should either of the parties fail to make the appointment, this party shall be bound to do so within eight days from the date on which it is required to do so by the party that has already made its appointment. Should it fail to make an appointment at this time, it shall be understood that it accepts the opinion issued by the other party's loss adjuster and shall be bound by it.

Should the loss adjusters reach an agreement, this will be reflected in a joint document which will record the causes of the claim and all other relevant circumstances. In the absence of such an agreement, both parties shall appoint a third loss adjuster by mutual agreement and if this is not possible, it is possible to make a request in the manner stipulated in the Voluntary Jurisdiction Law or the notarial legislation designated.

In this case, the loss adjuster's report shall be issued within the period indicated by the parties or, in its absence, within thirty days following acceptance of his/her appointment as third loss adjuster.

The parties shall be immediately informed of the opinion of the loss adjusters, albeit unanimous or majority, by a means beyond all doubt, and they will be bound by it, unless either of the parties legally contests it within a period of one month, in the case of the insurer, or

one hundred and eighty days, in the case of the insured, from the date of notification. If no legal action is taken within such periods, the loss adjuster's report shall be unassailable.

In the event the insurer delays payment of an unassailable claim and the insured or beneficiaries are forced to file a legal claim, the benefit shall be increased under the terms of Article 20 of the Spanish Insurance Contracts Act.

Each party shall bear the fees of its own loss adjuster. The fees of the third loss adjuster, where applicable, and any other incurred expenses shall be at the expense and responsibility of the insured and insurer in equal amounts. Nonetheless, if either of the parties have made the loss adjustment report necessary by maintaining a disproportionate assessment of the claim, said party shall be solely liable for these costs.

BASIS OF THE CONTRACT

3 RISK STATEMENT

1. Conditions of the agreement

The statements made by the policyholder and the insured in the application and health and habits questionnaire provided by the insurer, including, where applicable, any statements made to the examining doctor, are essential for assessing risk and form the basis of the policy.

Should the policy's content differ from that of the insurance application or established clauses, the policyholder may, within a period of one month from the date on which the policy is handed over, file a claim with the insurer to rectify the discrepancy. Should this period elapse without such a claim being filed, the terms of the policy shall apply.

2. Statement of circumstances affecting risk

The insurance policyholder and, where applicable, the insured must, prior to the conclusion of the contract and in accordance with the questionnaire that the insurer asks them to complete, declare to the insurer any circumstances to their knowledge that might affect the risk assessment. They shall be released from this obligation if the insurer does not require them to complete the questionnaire or, albeit so required, the pertinent circumstances are not addressed therein.

In the event of withholding or misrepresentation, the insurer may terminate the contract via a statement addressed to the policyholder within a period of one month from the time it learns of said withholding or misrepresentation. The premiums corresponding to the period underway when the declaration is issued will correspond to the insurer, unless due to wilful misconduct or gross negligence by the insurer.

Should the claim occur before the insured issues the statement referred to in the previous paragraph, the benefits provided by the

insured shall be proportionally reduced by the difference between the premium established in the policy and that which would have applied had the true nature of the risk been known. When the withholding or misrepresentation is due to wilful misconduct or gross negligence by the policyholder and/or the insured, the insurer shall be released from its obligation to pay the benefits.

3. Incontestability and misstatement of age

In the event of non-disclosure or misstatement in the statements issued by the policyholder and/or the insured, the insurer may not contest the contract after one year following the conclusion date thereof, unless due to wilful misconduct by the policyholder and/or insured or in the event the age declared by the insured was misstated and the true age of the insured, on the date on which the contract came into force, was higher than the admission limit stipulated therein.

In all other cases, if, as a result of the misstatement of age, the premium paid is less than that which would have been payable, the benefit paid by the insurer will be reduced in proportion to the premium received. If, on the other hand, the premium paid is higher than that which would have been payable, the insurer must reimburse the surplus premium paid interest-free.

4. Nullity

The policy shall be null and void, except for cases stipulated under Law, if at the time of its conclusion, the risk does not exist or the claim has occurred.

Should the policy be null and void, the insurer may claim all expenses incurred in issuing the policy.

4 EFFECTIVE DATE, PERIOD OF COVER AND TERMINATION OF THE POLICY

1. Policy execution and effective date

The contract is executed by consent, as demonstrated by the contracting parties signing the policy. Nonetheless, the contracted cover will not take effect until the first premium has been paid.

Any modifications or additions, where applicable, will take effect pursuant to the terms of the relevant endorsement or rider.

The obligations of the insurer shall begin at midnight on the day both of the previous requirements are met.

If the contract period lasts longer than six months, the insurance policyholder shall be entitled to terminate the contract without giving any reason and without any penalty for a period of 30 days from the date on which the insurer hands the policy or a provisional cover document over to the policyholder.

This unilateral power to terminate the contract must be exercised in writing by the policyholder within the period listed above and shall take effect on the date of its issue.

As of this date, the insurer shall no longer cover the risk, and the insurance policyholder shall be entitled to a refund of whatever premium s/he has paid, minus the portion corresponding to the time for which the contract was in force.

2. Period of cover, extension of cover and generic grounds for cancellation

The policy shall have the period of cover indicated in the schedule.

Either party may oppose the contract's extension through written notice to the other party. The notification period for the policyholder will be at least one month before the end of the period underway and for the insurer it will be at least two months before.

The policy shall be cancelled:

- Upon completion of the period of cover provided for therein.
- When one of the covered risks occurs, as established in the policy, schedule and special conditions.
- Due to the non-payment of due and outstanding premiums, as set forth in article 6.
- **In the case of the main cover, at the end of the insurance year in which the insured turns eighty years old.**
- **Additional cover for repatriation, accidental death, death due to road-traffic accident and death of both spouses shall lapse no later than the end of the insurance year in which the insured turns 80. Additional cover for permanent total disability, accidental permanent total disability and permanent total disability due to road-traffic accident shall lapse no later than the end of the insurance year in which the insured retires, and at a maximum of 70 years of age. Additional cover for serious illness and serious illness affecting women shall lapse no later than the end of the insurance year in which the insured turns 65.**

5 INCREASE AND DECREASE OF RISK

1. Notification in the event of an increase in risk

The insurance policyholder or the insured must inform the insurer, as quickly as possible, of any factors or circumstances included in the questionnaire that increase the risk and are of such a nature that, had they been known to the insurer when the contract was drawn up, it would not have been executed or its conditions would have been more demanding.

The policyholder or the insured do not need to declare any changes in the circumstances relating to the state of health of the insured.

Under no circumstances would this be considered an increase in risk.

The insurer may, within a period of two months from the day on which the increase is declared, propose a modification to the contract. In this case, the policyholder shall have fifteen days from the day on which the proposal was received to accept or reject it.

Should the policyholder reject it or fail to respond within this period, the insurer may terminate the contract after providing the policyholder due notice and affording him/her a new period of fifteen days to respond, after which, and within the next eight days, it shall inform the insurance policyholder of the definitive termination.

The insurer may likewise terminate the policy by sending written notice to the insured within one month from the day on which it was informed of the increase in risk.

Should a claim occur before the increase in risk has been declared, the insurer shall be released from its obligation to provide benefits if the insurance policyholder or the insured have acted in bad faith. Otherwise, the benefits provided by the insurer shall be proportionally reduced by the difference between the established premium and that which would have applied had the true nature of the risk been known.

2. Notification in the event of a decrease in risk

The insurance policyholder or, where applicable, the insured or beneficiary may inform the insurer of any circumstances that decrease risk and are of such a nature that, had they been known by the insurer when the contract was formed, the insurer would have executed said contract under more favourable conditions.

In this case, upon conclusion of the period covered by the current premium, the cost of the future premium shall be reduced by the relevant proportion. Otherwise, the policyholder shall be entitled to terminate the contract and to be reimbursed for the difference between the premium paid and that which s/he would have had to pay from the time the decrease in risk was declared.

6 POLICY PREMIUMS

1. Payment of the premium

The policyholder must pay the premiums established in the schedule.

The first or single premium shall be due upon signing the contract. Any subsequent premiums shall be paid on their corresponding due dates.

The premium due date shall be established in the schedule.

Should no place for payment of the premium be stipulated in the policy schedule, payment is to be made at the residence of the insurance policyholder.

If it has been established that the premiums are to be paid by direct debit, the following rules shall apply:

- The policyholder will provide the insurer a letter addressed to the bank or savings bank, in which s/he provides the necessary instructions.
- The premium shall be considered to have been paid on its due date, unless, due to a lack of funds in the account corresponding to the party under obligation to pay or for any other reason attributable to the policyholder, it could not be collected within a period of one month from said date. In this case, the unpaid premium must be paid at the registered offices of the insurer.

In the event renewal premiums are established, the schedule will indicate whether the policyholder has contracted a premium that will remain constant for the entire period of cover or an index-linked premium. In this second instance, the premium shall be adjusted on each subsequent policy anniversary in accordance with the percentage established in the schedule, and the policyholder may choose between a cumulative or linear adjustment.

In cumulative adjustments, the percentage shall apply to the yearly cost of the current premium immediately preceding the anniversary.

In linear adjustments, the percentage shall apply to the yearly cost of the policy's first premium.

The policy schedule shall indicate the frequency with which the premiums are to be paid and their due dates. The policyholder may subsequently request that the premium payment frequency established in the schedule be changed to any of the payment methods offered by the insurer, in which case the established surcharges, where applicable, shall apply. This change shall take effect on the date established in the relevant endorsement or rider.

2. Non-payment and suspension of cover

If, through fault of the policyholder, the first or single premium is not paid, the insurer shall be entitled to terminate the contract or demand enforced payment based on the policy.

If the premium is not paid before a claim occurs, the insurer shall be released from all obligations.

If one of the subsequent premiums is not paid, the insurer's cover shall be suspended for one month following the premium's due date.

If the insurer does not demand payment for a period of six months from the date on which a premium is due, the contract shall be considered terminated. In any case, while the contract is suspended, the insurer may only demand payment for the current premium.

If in accordance with the previous paragraphs the contract has not been terminated or cancelled, the policy cover shall once again take effect at midnight on the day the insurance policyholder or the insured pays the premium.

3. Taxes and surcharges

All legally applicable taxes and surcharges stemming from this policy, both at present and in the future, shall be paid by the policyholder or beneficiary.

7 POLICY BENEFICIARIES

1. Primary beneficiary. Designation

For the repayment product, which is primarily intended to cover the insured's pending loan, a lending institution must be designated as the primary beneficiary of the policy and the lending institution's name must be indicated in the schedule.

2. Designation and change of beneficiaries. Additional beneficiaries

During the contract period, the policyholder may designate a beneficiary or additional beneficiaries for the excess sum insured corresponding to the repayment product, as well as change the previously indicated designation, without the consent of the insurer, unless the policyholder has expressly waived this power in writing.

The designation or revocation of beneficiaries may be stated in the schedule or in a subsequent written statement to the insurer or in a will. If the beneficiaries are not designated by name but rather generically as spouse, children or heirs, this designation shall be construed as follows:

- **Spouse:** The person that is legally as such at the time the insured dies.
- **Children:** All descendents entitled to an inheritance.
- **Heirs:** Those qualifying as such at the time the insured dies.

In all three cases, it must be specified whether the spouse, children or heirs are as such for the policyholder, the insured or another person. Where unspecified, they shall be considered as such for the policyholder.

Where multiple beneficiaries or multiple additional beneficiaries are designated for the repayment product and no method for benefit distribution is indicated, the established benefit shall be divided equally among them. Where the designated beneficiaries are heirs

and no method for benefit distribution is indicated, the benefit shall be divided in proportion to their share of the inheritance.

Any portion not acquired by any one beneficiary shall be allocated to the others.

If at the time the insured dies no beneficiary or additional beneficiaries have been designated for the excess between the loan sum pending repayment and the sum insured, and no rules for determining the beneficiary have been established, the sum insured shall be included in the policyholder's estate.

In the event of disability or serious illness, the beneficiary of the excess sum insured shall be the policyholder.

3. Policy assignment and pledge

The policyholder may, at any time, assign or pledge the policy, provided that the beneficiary has not been irrevocably designated. The assignment or pledge of the policy involves revoking the beneficiary.

The policyholder must notify the insurer in writing of any assignment or pledge.

8 NOTIFICATIONS AND DUPLICATES OF THE POLICY

1. Notifications between the policyholder and the insurer

Any communication from the policyholder, the insured party, or the beneficiary to the insurer shall be sent to the registered office of the latter, which is stated in the policy, or via email to the email addresses provided by the insurer for such purposes.

Any communication to the policyholder, the insured party, or the beneficiary shall be considered validly executed when it is sent to their address, sent via email, or communicated to the telephone numbers provided by them at the beginning of the contractual relationship or during the same. To this end, it shall be required

that the holders immediately update their postal address, email, and telephone number before the insurer. The insurer shall not be held liable for the consequences derived from the lack of updating of the contact channels above.

The policyholder shall also be required to communicate to the insurer without delay any changes in the bank account where the policy payments are debited.

Notifications sent by an insurance agent to the insurer on behalf of the insurance policyholder shall have the same effect as if sent by the policyholder, unless otherwise indicated.

The insurance policyholder must, at all times, give his/her express approval to enter into a new contract or modify or terminate the insurance contract currently in force.

All changes requested by the policyholder will be reflected in an endorsement provided to him/her as proof of the change.

2. Loss or destruction of the policy

In the event of the loss, theft or destruction of the policy, the policyholder must notify the insurer by registered letter, and the insurer shall issue a copy or duplicate of the policy.

9 LIMITATION PERIOD

The right to take legal action stemming from this contract shall have a limitation period of five years from the date on which it may be exercised.

10 INDEMNITY CLAUSE

INSURANCE COMPENSATION CONSORTIUM INDEMNITY CLAUSE FOR LOSSES ARISING FROM EXTRAORDINARY EVENTS IN PERSONAL INSURANCE POLICIES

Pursuant to the revised text of the Insurance Compensation Consortium Legal Statute, approved by Royal Legislative Decree 7/2004, 29 October, the policyholder of an insurance contract that by law must include a surcharge payable to this public business entity has the power to reach an agreement for the cover of extraordinary risks with any insurance entity that meets the conditions required under current legislation.

The indemnity derived from incidents resulting from extraordinary events that occur in Spain or abroad, when the insured have their primary residence in Spain, will be paid by the Insurance Compensation Consortium when the policyholder has paid the corresponding surcharges in favour thereof and whenever any of the following situations occurs:

a. The extraordinary risk covered by the Insurance Compensation Consortium is not covered by the insurance policy taken out with the insurance company.

b. That, even if it is covered by said insurance policy, the insurance company cannot meet its obligations because it has been judicially declared bankrupt or it is subject to compulsory liquidation proceedings or such liquidation has been undertaken by the Insurance Compensation Consortium.

The Insurance Compensation Consortium shall comply with the provisions set forth in said Legal Statute, in Law 50/1980, 8 October, on Insurance Contracts, in the Regulations on extraordinary risk insurance approved by Royal Decree 300/2004, 20 February, and in all complementary provisions.

Summary of legal regulations

1. Covered extraordinary events

a. The following natural phenomena: earthquakes and tidal waves; extraordinary floods, including those caused by battering of coastal waters; volcanic eruptions; atypical cyclonic storms (including extraordinary winds with gusts of more than 120 km/hr and tornados) and the fall of astral bodies and aerolites.

b. Those caused violently as a result of terrorism, rebellion, insurrection, riots or civil unrest.

c. Acts or actions of the armed forces or of the Security Forces and Services in times of peace.

Atmospheric and seismic phenomena, volcanic eruptions and falling astral bodies shall be certified, at the request of the Insurance Compensation Consortium, through reports issued by the State Meteorology Agency (AEMET), the National Geographic Institute and other relevant public bodies. In the case of political or social events, as well as in the case of damage caused by acts or actions of the armed forces or the security forces in times of peace, the Insurance Compensation Consortium shall be able to collect information about the facts from the competent judicial or administrative bodies.

2. Excluded risks

a. Those that do not give rise to an indemnity according to the Spanish Insurance Contracts Act.

b. Those caused to people or property insured by insurance agreements other than those that include the obligatory surcharge in favour of the Insurance Compensation Consortium.

c. Those caused by armed conflicts, even when not preceded by an official declaration of war.

d. Those derived from nuclear energy, without prejudice to the terms of Act 12/2011, 27 May, on public liability for nuclear damage or damage caused by radioactive materials.

e. Those caused by natural phenomena other than those set forth in section 1.a above of the Regulations on Extraordinary Risk Insurance and, in particular, those caused by a rise in the water table, hillside movements, landslides or soil settlement, falling rocks and other similar phenomena, except where they are obviously caused by the action of rainwater that has, in turn, caused extraordinary flooding in the area and they occur simultaneously with the flooding.

f. Those caused by the actions of people during the course of meetings and demonstrations held in accordance with Organic Law 9/1983, 15 July, regulating the right to assembly, as well as during legal strikes, unless such actions may be considered extraordinary events under the terms of the above section 1.b.

g. Those caused by bad faith on the part of the insured.

h. Those related to claims occurring prior to payment of the first premium or when, under the terms of the Spanish Insurance Contracts Act, the cover provided by the Insurance Compensation Consortium has been suspended or the insurance has been terminated due to premium non-payment.

i. Claims that, due to their magnitude and severity, are classed by the Nation's Government as a national catastrophe or disaster.

3. Scope of the cover

1. The cover of extraordinary risks shall extend to the same persons and the same insured amounts that have been established in the policy for the purposes of cover against ordinary risks.

2. With regard to life insurance policies that, under the terms of the contract and in accordance with the laws regulating private insurance, generate policy reserves, the cover of the Insurance Compensation Consortium shall refer to the sum insured at risk for each insured party; in other words, the difference between the insured sum and the policy reserves that the insurer that issued the policy must have established. The amount corresponding to the policy reserves shall be paid by said insurance company.

Notification of damage to the Insurance Compensation Consortium

1. The indemnity proposal form for damage covered by the Insurance Compensation Consortium shall be lodged with the same by the insurance policyholder, the insured or the beneficiary of the policy, or the person acting on behalf of and in representation of the former, or by the insurance company or insurance agent involved in the placement of the insurance policy.

2. Notification of damage and receipt of information relating to the procedure and the claim status may be made:

- By calling the Insurance Compensation Consortium's Call Centre (**900 222 665** or **952 367 042**).

– Through the Insurance Compensation Consortium website (**www.consorseguros.es**).

3. Valuation of the damage:

The valuation of the damage subject to indemnity, in accordance with insurance legislation and the contents of the insurance policy, shall be carried out by the Insurance Compensation Consortium, without it being bound to any valuations that, if applicable, were carried out by the insurance company covering ordinary risks.

4. Payment of indemnity:

The Insurance Compensation Consortium shall pay the indemnity to the beneficiary of the policy by means of bank transfer.

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