Zurich Vida Complet

Terms and Conditions

Zurich Vida Complet

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TERMS AND CONDITIONS

(Model 1/3.04.02.50 November 2019)

This insurance contract is governed by the Insurance Contract Act 50/1980 of 8 October (Official State Gazette of 17 October 1980), the Organisation, Supervision and Solvency of Insurers and Reinsurers Act 20/2015 of 14 July, Royal Decree 1060/2015 of 20 November on the organisation, supervision and solvency of insurers and reinsurers, and by the provisions of the terms and conditions, schedule and special terms and conditions (if any) of this contract, although clauses limiting the rights of the insured which are not specifically accepted by them as a rider to the policy will not be valid. Mere transcriptions of or references to legal provisions will not require such acceptance.

Order ECO 734/2004 of 11 March on customer service departments and the customer ombudsman in financial institutions, and the Distance Marketing of Financial Services for Consumers Act 22/2007 of 11 July may likewise be applicable.

The Private Insurance and Reinsurance Intermediation Act 26/2006 of 17 July will also be applicable.

The State supervising the insurer's operations is Spain and the regulatory authority is the Directorate General of Insurance and Pension Funds.

SOME DEFINITIONS YOU SHOULD KNOW

You. The policyholder, the person or legal entity that has applied for the insurance and taken out the policy with us.

You accept the obligations arising from the contract unless they have to be met by the insured.

Insured. The person whose life is insured by the policy.

This will normally be you, although as the policyholder you may designate another person as the insured when you take out this insurance.

Beneficiary. The person or legal entity entitled to receive the compensation and who is designated by you.

We, us or our. We are Zurich Vida, Compañía de Seguros y Reaseguros S.A. –Sociedad Unipersonal–, Tax ID (NIF) A-08168213, head office at Paseo de la Castellana, 81, planta 22, Madrid, registered in the Madrid Company Register, Volume 16325, Book 0, Folio 189, Section 8, Sheet M-126243, Entry 131, the insurer which covers the contractually agreed risk.

Policy. The policy is the documents containing the information and conditions regulating the insurance. The terms and conditions, the schedule, the special conditions and any endorsements and riders which may be issued as well as the insurance application form, the health declaration and any medical tests taken are an integral part of it.

Premium. The cost of the insurance plus legally applicable taxes.

Issue age. The age used as the basis for calculating your insurance premium. It will be your current age, although if the policy's effect date is more than six months after your last birthday an extra year will be added to your current age.

Product types. At Zurich Vida Complet we have included three product types which are:

- Classic
- Duo
- Disability

Premium options. At Zurich Vida Complet we have included three premium options in this product which we explain below:

a) **Regular premium:** in each policy year you will be charged a premium based on the insured's age and the sum insured taken out.

b) **Flat rate:** in each policy year you will be charged the same premium until a change to the policy leads to a new premium.

c) **Single premium:** at the start of the policy you will be charged a premium which covers the entire lifetime of the policy.

SECTION 1. BASIS FOR YOUR CONTRACT

1.1. THE REPRESENTATIONS

Before concluding the contract, you and the insured (if you are not the same person) will have to tell us all the circumstances known to you which may influence our evaluation of the risk and are in the following documents we give to you:

a) The insurance application form.

b) The insured's health declaration signed by them.

c) Any other written document in which we ask you to expand on information about the state of health, profession or sports activities of the insured.

However, you will not have to do this if we do not give you the above documents or, even though we do, you are not asked about the circumstances which may affect the risk evaluation.

If the content of the policy is different from the insurance application form or the clauses we have agreed, you may ask us to rectify these differences within one month from when the policy is given to you for you to sign it. **If you have not asked us to make any rectifications within this period, the policy's provisions will prevail.**

Once you have received the contract, you may cancel it within the following thirty days. You can do this by writing to us within this period and the notification will take effect from the sending date when our cover of the risk will cease. If you cancel the contract we will reimburse the premium **you have paid as the policyholder minus the part of the risk premium already used.**

If during the term of the contract there are any changes in the factors and circumstances declared in the questionnaire completed by the insured when taking out the insurance which aggravate the risk, you must tell us as soon as possible so we can adjust the policy as needed. However, the insured is not required to report any changes in the circumstances concerning their state of health which will in no case be considered to aggravate the risk.

1.2. CONCLUSION, TAKING EFFECT AND TERM OF THE CONTRACT

You as the policyholder and/or the insured acknowledge that before the conclusion of the contract you have been given full information in writing about the covers, premiums, rights, obligations and the calculation basis used to determine the benefits.

The insurance contract and any subsequent amendments of or additions to it must be made in writing. Every amendment must be signed by both parties.

The covers taken out will come into effect on the date and at the time shown in the schedule as long as you have paid the bill for the premium. Otherwise, our obligations will begin at 24:00 hours on the day when the requirements in the previous paragraphs are met.

The term of the policy will be as shown in the schedule.

You as the policyholder and/or the insured may decide not to renew the contract by writing to us at least one month before the end of the policy period.

1.3. FALSE OR INACCURATE REPRESENTATIONS. INCONTESTABILITY

If there is any falsehood or inaccuracy in the representations you or the insured made and which were the basis on which we accepted the risk, we may cancel the contract by writing to you as the policyholder within one month from when we become aware of the omission or inaccuracy.

You will owe us the premiums for the period current at the time when we give this notification save in the case of wilful misconduct or fault on our part. Finally, if the loss occurs before we send you the termination notification, the beneficiary will receive the covered benefit unless there has been wilful misconduct or gross fault by you as the policyholder, reduced only by the amount of the difference between the premium you paid and the one you would have had to pay had we known the true magnitude of the risk at the time the insurance was taken out. If the insured's age is incorrectly stated, we can only contest the contract if their real age at the time when the contract comes into force is outside the admissible limits we have set.

If their age is not outside our admissible limits but we have charged premiums which are lower than they should have been, when we pay the benefit we will reduce its amount in proportion to the premiums paid. By contrast, if the premiums charged are greater than the ones you should have paid, we will reimburse the part of the premium which has been overcharged without interest.

The policy becomes incontestable one year after its effect date and we cannot challenge what has been agreed in it unless you, the insured or the beneficiaries have acted fraudulently or in bad faith.

Furthermore, we expressly waive the right to cancel the policy unilaterally before its termination date as shown in the schedule unless the premiums are not paid under the terms stipulated in section 5.2.

1.4. TERRITORIAL LIMIT

The coverage in the contract for all the covers taken out is worldwide. However, this is subject to the provisions of section 1.5 of these terms and conditions.

1.5. CHANGE OF RESIDENCE OF THE POLICYHOLDER

This product is designed for customers living in Spain or Andorra in compliance with prevailing legal requirements and tax regulations. If you or the insured are resident in Andorra, the following requirements must also be met in order to take out the product in question: (i) the product must be distributed by an intermediary domiciled in Andorra and authorised to distribute products in Andorra; and (ii) the policy must be concluded through the Zurich Vida representative in Andorra. If you or the insured (if you are not the insured) change your residence to another country during the term of this contract, the legislation of the country to which you or the insured move may affect Zurich Vida's ability to maintain the contract in force under these conditions.

You and the insured must tell Zurich Vida if you intend to move to another country. Zurich Vida is required to tell you about the consequences of your change of residence which, depending on the law applicable as a result of this change, may even lead to the termination of this contract.

If you or the insured do not notify Zurich Vida about a change of residence, Zurich Vida may be legally unable to meet its obligations in this contract either in part or in whole under the terms determined by the jurisdiction which is applicable due to the change of residence.

If you or the insured tell us about a change of residence to another country, with your prior consent Zurich Vida may disclose your personal data to another company in the Zurich Insurance Group to find out whether you can be offered a product suited to your new circumstances and place of residence.

1.6. IMPLEMENTATION OF INTERNATIONAL PUBLIC ORDER

Without prejudice to the conditions of this agreement, the underwriting insurer will not be required to make payments or provide a service or benefit for any insured or third party if such coverage, payment, service or benefit and/or any other business or activity of the insured may be in breach of trade legislation or regulations, trade embargo or economic sanctions affected by an international public order.

Likewise late-payment interest will not accrue if when completing the procedures provided for in such regulations the insurer exceeds the maximum time allowed for compliance with certain obligations.

SECTION 2. SUBJECT-MATTER OF THE INSURANCE

We will cover the risks set out below which you have agreed in the schedule of your policy and subject to the exclusions in section 4 of the terms and conditions.

2.1. MAIN INSURANCE

It covers the insured's death and must be taken out.

2.2. SUPPLEMENTARY INSURANCE

These options supplement the main insurance and may not be taken out separately from it.

a) Absolute and permanent disability.

b) Absolute and permanent disability due to accident.

c) Absolute and permanent disability due to traffic accident.

d) Accidental death.

e) Death due to traffic accident.

f) Serious illness.

g) Total and permanent disability.

Supplementary insurance b) may not be taken out separately from a) or supplementary insurance c) without taking out a) and b).

Supplementary insurance e) may not be taken out separately from d).

SECTION 3. CHANGE IN SUMS INSURED

The initial sum insured is shown in the schedule and you can choose how you want it to change in each insurance year. The choices available for each type of product and depending on the premium option are as follows:

CLASSIC

Regular premium.

a) No increase.

b) Annual cumulative geometric increase by the percentage you choose up to at most 4%.

c) Annual cumulative increase linked to the rise in the Consumer Price Index (CPI). The rise in the year-on-year CPI published by the National Statistics Institute every 1 November will be used for annual renewals during the whole of the following calendar year.

d) Outstanding principal calculated for a front-loaded loan at the start of each insurance year and using as an index the loan interest rate stated by you in the insurance application form, or failing that the market consumer loan or mortgage interest rate, plus a spread we choose to try to make sure the sum insured is greater than the outstanding principal the insurance is linked to. **If the outstanding principal of the loan to which the policy is linked is greater than the sum insured on the date of the insured's death, our payment obligation to the lender which granted the loan will be at most this sum insured.**

Flat rate.

a) No increase.

Single premium.

a) Outstanding principal calculated for a front-loaded loan at the start of each insurance year and using as an index the loan interest rate stated by you in the insurance application form, or failing that the market consumer loan or mortgage interest rate, plus a spread we choose to try to make sure the sum insured is greater than the outstanding principal the insurance is linked to. If the outstanding principal of the loan to which the policy is linked is greater than the sum insured on the date of the insured's death, our payment obligation to the lender which granted the loan will be at most this sum insured.

DISABILITY

Regular premium.

a) No increase.

b) Annual cumulative geometric increase by the percentage you choose up to at most 4%.

DUO

Regular premium.

a) No increase.

b) Annual cumulative geometric increase by the percentage you choose up to at most 4%.

c) Annual cumulative increase linked to the rise in the Consumer Price Index (CPI). The rise in the year-on-year CPI published by the National Statistics Institute every 1 November will be used for annual renewals during the whole of the following calendar year.

SECTION 4. EXCLUSIONS

Under the terms and conditions, the special conditions and the schedule of your policy, we will pay the covered benefits with the following exclusions:

a) **Suicide: the insured's death caused knowingly and voluntarily by themselves is not covered during the first year when the contract is in force. If the contract has been renewed or the sum insured has been increased we will apply the same rule.**

b) **The consequences of illnesses or accidents occurring before the entry into force of this contract and which have not been declared by you or the insured.**

c) **The consequences of an act of recklessness or gross negligence by the insured as determined by a court and also any due to their participation in criminal offences, illegal competitions and/or betting, duels or fights, provided that in the latter case they have not acted in legitimate self-defence or in an attempt to save people or property.**

d) **Losses caused by the insured due to drunkenness or the use of non-prescribed narcotics or drugs. Drunkenness means the presence of alcohol in the blood above 0.60 g/l. Use of non-prescribed drugs or narcotics means the presence in urine or blood of any substance legally classified as a non-prescribed drug or narcotic.**

e) **The consequences of using means of air transport other than as a passenger, and even as a passenger on airlines not duly authorised for the public.**

f) **If the insured's death is voluntarily caused by their sole beneficiary, we will be released from our obligations to this beneficiary and will add the sum insured to your assets. If there are several beneficiaries, those not involved in the death of the insured will retain their rights.**

g) **Losses resulting from doing any professional sport.**

h) **Losses arising from doing extreme sports: motorcycling, motor sports, extreme downhill cycling, any type of sports and/or leisure air activity on non-commercial flights, any type of snow sports in undesignated or off-piste areas, diving, caving, climbing and mountaineering.**

We will have to examine the sports and activities described in paragraphs 4(g) and 4(h) and any others considered to be extreme in order to assess them on an individual basis.

i) **Losses arising from any infectious disease considered to be an epidemic by the official competent authority or, if not, by the World Health Organisation.**

j) **This policy does not cover the risks covered by the Insurance Compensation Consortium or any expressly excluded by it.**

SECTION 5. PAYING THE PREMIUM

5.1. PREMIUM

The premium for this policy together with any legally applicable taxes and surcharges will be charged at intervals which depend on the type of product chosen.

Regular premium.

The premium will be annual and paid in advance.

The first year's premium is the one shown in the schedule. The premium for subsequent years will be determined by the sum insured and the insured's age in each insurance year.

Flat rate.

The premium will be annual and fixed for the entire duration of the policy until a change in the contract results in a new premium.

Single premium.

The premium will be paid once and in advance

In the regular premium and flat rate options you can split the premium into half-yearly, quarterly or monthly payments with a 1%, 2% or 3% surcharge respectively.

In the event of death or disability, we will not charge any outstanding premium or subtract it from the benefit we pay.

In the case of an annual premium, the premiums for successive insurance years shown in the schedule may vary if there are changes in the conditions which have led to a discount on the cost of the premium.

We expressly waive: (i) the unilateral right to refuse premiums payable under the contract; and (ii) the unilateral right to amend the premium rates or benefits agreed in the schedule with the policyholder on an individual basis unless the amendment of these rates is due to the restating of rates for the entire portfolio to which your policy belongs. In all cases the insured retains their unilateral right to decide not to extend the contract.

5.2. METHOD AND TERM FOR PAYING THE PREMIUM

Unless otherwise agreed in the schedule, the premiums are to be paid by direct debit from your current or savings account and you must give your bank a mandate to that effect. The premiums will be considered paid on the agreed dates.

If we do not present the bill for payment within thirty days and when we present it later on you do not have sufficient funds in your account, we will tell you and give you another thirty days from the date on which you receive this notification to pay it.

The first premium is to be paid once the contract is signed. If failure to pay the premium is attributable to you, we may terminate the contract or take legal action to enforce payment. Likewise, if a loss occurs before the premium has been paid, we will not have to pay the benefit unless otherwise agreed

If any of the premiums after the first one is not paid, we will suspend our cover one month after the date on which it fell due.

If we do not ask for payment within the following six months, the contract will be deemed to have been cancelled.

When the contract is suspended, we may only demand payment of the premium for the then current period.

If the contract has not been terminated as specified in the above paragraphs, our cover will come into effect again at 24:00 hours on the day on which the premium is paid.

SECTION 6. GENERAL RULES

6.1. REINSTATEMENT

If the contract has been suspended or terminated, you may reinstate it by moving the effect and expiry dates by the time the premiums were unpaid and passing any medical tests we ask you to take.

6.2. CHANGE OF BENEFICIARY. ASSIGNMENT OR PLEDGING OF THE POLICY

Unless you have irrevocably designated a beneficiary, during the term of the contract you may change this designation without needing to gain our consent.

Any designation of or change in beneficiary may be stated in the schedule or in a subsequent written statement given to us or alternatively in your will.

Likewise, you may assign or pledge the policy provided that you have not made an irrevocable designation of beneficiary.

You must tell us about any assignment or pledging of the policy in writing and this will entail the revocation of the beneficiary.

6.3. MISTAKE IN THE STATED AGE

If the insured's date of birth has been incorrectly stated, we can only contest the contract if their real age at the time when the contract comes into force is outside our admissible limits.

If their age is not outside these limits but we have charged premiums that are lower than they should have been, we will reduce the benefit payment in proportion to the premium charged.

However, if the premiums we charged are higher than you should have paid, we will reimburse the part of the premium which has been overcharged without interest.

6.4. LOSS OR DESTRUCTION OF THE POLICY

If the policy is lost, stolen or destroyed, you must tell us in writing saying what has happened, provide proof of having notified any holders of rights under the contract, promise to return the original contract to us if it appears, and agree to compensate us for any harm caused to us as a result of a third-party claim.

Under the law we have to give you a copy of the policy which will have the same effect as the original which it replaces.

6.5. NOTIFICATIONS BETWEEN YOU AND US

As the policyholder you can ask us at any time for any information you need about your insurance.

Any notifications you send to the insurance agent who is brokering or has brokered the contract will have the same effect as if you had sent them directly to us.

Any notifications sent by an insurance broker to us on your behalf will have the same effect as if you had sent them unless otherwise specified.

We will send our notifications to you at the most recent address shown in the policy. You must tell us about any change in your address.

6.6. PERIOD OF LIMITATION

Actions under this contract become time barred after five years from the date on which they could have been taken.

6.7. JURISDICTION

If either or both of the contracting parties decide to take legal action, they must file their claim with the court for the insured's place of residence provided the insured lives in Spain. This court will be the only one competent to hear the actions derived from this insurance contract.

In all other cases the court for our address will be competent.

6.8. OTHER OBLIGATIONS WE HAVE TO YOU

In addition to paying the benefit when required, we also have to give you the contract or if need be the provisional cover document.

SECTION 7. PAYMENT OF THE COVERED BENEFIT

7.1. REPORTING A CLAIM

When a covered event takes place, you as the policyholder or where applicable the beneficiaries must report it to us within at most seven days from when you become aware of the loss, as specified in section 16 of the Insurance Contract Act, and give us full information about the circumstances in which it took place.

We will pay the benefit to the beneficiaries you have designated.

If you as the policyholder have not designated a beneficiary for the case of death or specified the rules for making this designation, the covered benefit will be paid by exclusionary order of preference to:

1) Your spouse;
2) Failing that, your children;
3) Failing that, your parents;
4) Failing that, your legal heirs.

7.2. DOCUMENTS THAT MUST BE SUBMITTED

The beneficiary will have to give proof of their identity and their right or status of beneficiary.

In addition they will have to give us the following documents.

a) The insured's death certificate.
b) Certificate from the doctor who attended the insured stating the cause, evolution and nature of the illness or accident leading to their death or if applicable statements from court proceedings or documents certifying accidental death.
c) Certificate from the register of wills, a copy of the last will or notarial declaration of heirs certificate or a court record of declaration of heirs as applicable.
d) Complete or partial self-assessment payment of inheritance tax or partial administrative payment.

If need be these documents will have to be authenticated.

7.3. WHAT YOU NEED TO KNOW IF WE ARE LATE IN PAYMENT

If we have not paid the benefit in its entirety within three months of the occurrence of the loss due to an unjustified cause or one entirely attributable to us, we will be in default and will be required to pay for each elapsed day an additional sum equivalent to the statutory rate of interest prevailing at that time increased by 50%.

However, once two years have gone by since the loss occurred the rate of interest may not be less than 20% per year.

7.4. BENEFIT PAYMENT OPTIONS

The benefit covered by your policy may only be paid in a lump sum.

SECTION 8. TAXES AND SURCHARGES

Any legally applicable taxes and surcharges that have to be paid as a result of this insurance will be paid by you as the policyholder, by the insured or by the beneficiary of the policy.

SECTION 9. TAXATION

Any benefits paid under the contract and any withholdings from them will be subject to personal income tax or corporation tax depending on whether the beneficiary is an individual or a legal entity, and as long as they are not subject to inheritance and gift tax, in accordance with legislation for these taxes and supplementary regulations. Specific regional laws may also apply to the payment of the benefits.

SECTION 10. CUSTOMER OMBUDSMAN

If you have a complaint you can contact our Customer Ombudsman under the procedure set out in our Customer Ombudsman Regulations which are available on our website www.zurich.es. These Regulations comply with the requirements of Ministerial Order ECO 734/2004 of 11 March on customer service departments and the customer ombudsman for financial institutions. The Customer Ombudsman will give its decision within at most TWO MONTHS from when it receives your complaint. At the end of this period or if you unhappy with how we've resolved your complaint, you may contact the Complaints Service in the Directorate General of Insurance and Pension Funds (either at Paseo de la Castellana no. 44, 28046 Madrid, or electronically with an electronic signature via the electronic office of the Directorate General of Insurance and Pension Funds: https://www.sededgsfp.gob.es/SedeElectronica/Reclamaciones/Index_Proteccion_Asegurado.asp).

SECTION 11. PROTECTION OF THE INSURED AND OTHER PARTIES TO THE CONTRACT

Without prejudice to the previous article, you as the policyholder, the insured, beneficiaries, injured third parties or the heirs and successors of any of them may lodge a complaint with the Directorate General of Insurance and Pension Funds against insurers which engage in practices that are abusive or injurious to the rights derived from the insurance contract. Complaints should be submitted in writing to the Directorate General of Insurance and Pension Funds.

SECTION 12. PERSONAL DATA PROTECTION

Data controller:

Zurich Vida, Compañía de Seguros y Reaseguros, S.A. –Sociedad Unipersonal–

Purposes of the data processing:

- For the **purpose of managing the contract:** Personal data will be stored in files belonging to Zurich Vida, Compañía de Seguros y Reaseguros, S.A. –Sociedad Unipersonal–, whose purpose is and may be the application for and if applicable the completion, maintenance and monitoring of the insurance contract and conducting statistical studies,

quality studies and technical analysis, managing coinsurance and reinsurance where applicable and also processing by the parent company for the prevention of money laundering and terrorist financing.

Lawful basis: The performance of the contract and insurance regulations, mainly the Insurance Contract Act, the Organisation, Supervision and Solvency of Insurers and Re-insurers Act and prevention of money laundering and terrorist financing regulations. If it is an Assured Pension Plan (PPA) the lawful basis will also be the Personal Income Tax (IRPF) Act.

- For the **purpose of preventing fraud**: These data will also be used to prevent fraud.

  Lawful basis: Legitimate interest.

Likewise, unless you opt out the insurer may process your details:

- For the **purpose of sending you marketing messages by any electronic means** including text, email or an equivalent means of communication in order to offer, promote and purchase the insurer's products and services and additional services included in the insurance taken out (e.g. online will, second medical opinion, etc.).
- For the **purpose of sending you marketing messages on paper and in phone calls** about own products and insurance policies and pension plans from the Zurich Group, i.e. Zurich Insurance plc, Sucursal en España, or other companies legally related to the aforementioned organisations as set out at www.zurich.es/rgpd.
- For the purpose of profiling or segmenting profiles using the data you supply.
- For the **purpose of profiling or segmenting profiles** using data drawn from the information resulting from the use and management of the products purchased.

  Lawful basis: Legitimate interest and the right to object.

You may object to such processing at any time.

Likewise, if you have given your consent the insurer may process your data:

- For the **purpose of sending you marketing messages by any electronic means** including text, email or an equivalent means of communication in order to offer, promote and purchase insurance or pension products and services from other Group organisations, i.e. Zurich Insurance plc, Sucursal en España, or other companies legally related to the aforementioned organisations as set out at www.zurich.es/rgpd.
- For the **purpose of profiling or segmenting for marketing purposes** using own and third-party data (including insurers in the Group).
- For the **purpose of disclosing your data and**, if applicable, **any profiles obtained** to Zurich Group companies in the insurance and pensions industry to send marketing messages by any means (electronic or otherwise) about their products and services.

Lawful basis: Express consent.

Recipients

Your data may be disclosed to any authorities that the insurer is legally obliged to inform, including courts and law enforcement agencies, if required to do so.

Likewise, in the performance of the contract your personal data may be disclosed to reinsurers, coinsurers and other participants in the operation of the contract such as loss adjusters and other service providers.

They may also be disclosed to Zurich Group organisations or third-party organisations if you have expressly consented to such disclosure or when based on a legitimate interest or legal obligations.

Rights

The data subject may exercise their right to request access to and rectification or erasure of personal data and other rights as explained in the additional information.

Additional information

You can view the additional information at www.zurich.es/rgpd

If the policyholder is a legal entity:

- The policyholder's representative (an individual) is notified by this clause that their personal data supplied to perform this insurance contract will be processed by the controller for the purpose of managing the contractual relationship. The legal basis for such processing is the insurance policy.

  The personal data gathered will be retained while such insurance contract remains valid. Once this relationship has ended, they will be retained duly blocked during the periods of limitation set by applicable law.

  The recipients of the personal data will be any organisations in the controller's group which for reasons of internal organisation may require intervention or any suppliers which have been hired.

- If the policyholder provides any other personal data to the insurer in the performance of the contract of insurance, they warrant that prior to such provision they have informed the data subject (whether the insured, beneficiary or any other person) about the processing of their data in the terms set out in this clause and that they have met any other requirements needed to enable the legitimate communication of such personal data to the insurer in accordance with applicable regulations.

  The legal basis for this processing is the performance of this contract or compliance with legal obligations in regulations concerning the organisation, supervision and solvency of insurers and the regulations of the contract of insurance.

  Personal data will not be shared with third parties unless so required in order to comply with obligations contained in applicable regulations.

  Furthermore, where applicable and if the appropriate mechanisms are enabled the insurer may request these other persons involved in insurance in which the policyholder is a legal entity to give their consent or state they do not object in the same cases set out above.

Rights: In both cases the data subject and the representative may exercise their right to request access to and rectification or erasure of personal data and other rights as explained in the **additional information** at www.zurich.es/rgpd.

SECTION 13. INFORMATION

1. The policyholder acknowledges that they have received from the insurer before concluding the contract an information notice written in clear and precise language and containing the following:
   a) The name of the undertaking and its legal form.
   b) The address of the undertaking's head office and the name of the Member State in which the head office is situated.
   c) Law applicable to the contract where the parties do not have a free choice or, where the parties are free to choose the law applicable, the law the insurer proposes to choose.
   d) Internal and external complaints bodies which can be used in case of a dispute as well as the procedure to be followed.
   e) Definition of each benefit and each option.
   f) The term of the contract.
   g) Means of terminating the contract.
   h) Means of payment of premiums and duration of payments.
   i) Indication of any paid-up values.
   j) Information on the premiums for each benefit, both main benefits and supplementary benefits, where appropriate.
   k) Arrangements and time limits for the exercise of the right of termination and, where applicable, the procedure for the exercise of the unilateral right of withdrawal.
   l) General information on the tax arrangements applicable.
2. During the term of the life insurance contract, the insurance undertaking must provide the policyholder, in writing or on a durable electronic medium, with clear and precise information concerning changes in:
   a) The terms and conditions and the schedule.
   b) The name of the undertaking, its legal form or the address of its head office and, where appropriate, of the agency or branch which concluded the contract.
3. In the event of a change in the policy conditions or amendment of the law applicable to the contract, the policyholder must receive all the information listed in paragraphs e) to l) in the previous section.

Evidence that the policyholder and, where applicable, the insured have received all the information required in the preceding paragraphs before the conclusion of the insurance contract or signing of the insurance application form must be given by means of a statement, dated and signed by the policyholder or the insured as applicable, inserted at the foot of the policy or the insurance application form acknowledging receipt of the information beforehand and specifying its nature and the date of receipt.

Likewise, evidence must be given that the policyholder of an individual contract concluded at a distance has received all the information required in this respect in sections 7 and 8 of the Distance Marketing of Financial Services for Consumers Act 22/2007 before the conclusion of the insurance contract or signing of the insurance application form.

SPECIAL CONDITIONS FOR THE MAIN INSURANCE

SECTION 1. INSURED BENEFIT

If the insured dies during the term of the policy, we will pay the benefit shown in the schedule and the contract will be terminated.

1.1. ADVANCE OF THE BENEFIT IN THE EVENT OF TERMINAL ILLNESS

In the regular premium and flat rate options, we will also pay up to €480,000 of this benefit in advance if during the term of the policy and even though the insured has not died, they have been diagnosed via a medical certificate or opinion as having a terminal illness whose cause is other than an accident covered by the policy and have a life expectancy of less than 12 months. We will pay the benefit once these medical reports and any clarifications and additional reports requested by the independent clinic, medical practice or doctor appointed by us have been verified and we have accepted the diagnosis of terminal illness.

This benefit will be paid under the heading of disability. It is incompatible with payment of the benefit in the absolute and permanent disability cover if this has been taken out and will result in the termination of the contract. However, in the case of sums insured greater than €480,000, when this advance benefit is paid the contract will remain in force for the sum insured net of the amount paid in advance until the insured dies.

The beneficiary for this benefit will be the one designated for the absolute and permanent disability cover, and if there isn't one it will be the insured.

1.2. OPINION AND EFFECT OF THE ADVANCE PAYMENT OF DEATH BENEFIT IN THE EVENT OF TERMINAL ILLNESS

In order to request advance payment of the death benefit as compensation for the insured's terminal illness, you must give us a medical certificate or opinion which clearly and unambiguously states the diagnosis of the illness together with its nature and course and expressly mentioning the insured's life expectancy which must be less than twelve months. This certificate must have been issued at most thirty days before you give it to us.

The grounds for the diagnosis must be supported by objective medical tests which substantiate it and the insured will have to submit any clarifications or additional tests requested by the doctors we appoint to accept it. By signing this policy the insured expressly authorises us to request such reports and exempts the insured's doctors from professional confidentiality with respect to us.

We reserve the right to agree to advance payment based on validation of these reports.

In the event of a dispute and if there is no subsequent agreement between the parties, both undertake to refer the case to medical experts following the procedure laid down in section 38 of the Insurance Contract Act.

The effect date of the benefit will be the day on which the last of the reports which are the basis for our acceptance of the diagnosis of terminal illness is submitted.

SPECIAL CONDITIONS FOR THE SUPPLEMENTARY ABSOLUTE AND PERMANENT DISABILITY INSURANCE

SECTION 1. INSURED BENEFIT

If the insured becomes absolutely and permanently disabled during the term of the policy, and once this has been verified and accepted, we will pay the benefit shown in the schedule and the contract will be terminated.

SECTION 2. DEFINITION, OPINION AND EFFECT DATE OF THE DISABILITY

For the purposes of this insurance, absolute and permanent disability is any irreversible physical or psychological condition of the insured as a result of accident or illness which means they are totally and permanently unable to perform any remunerated work as an employee or any self-employed professional activity as specified by Social Security regulations.

In the event of absolute and permanent disability, the insured or you must send us a detailed medical report containing the following information:

a) Certificate issued by the National Social Security Institute stating the insured's absolute and permanent disability.

b) Failing that, a certificate from the doctor who attended the insured stating the origin, course and nature of the illness or accident causing the disability and its degree and prognosis.

The insured may request a report or additional tests if they consider it necessary. We will study the reports and come to our own judgement about whether or not there is absolute and permanent disability.

In the event of a dispute and if there is no subsequent agreement between the parties, both undertake to refer the case to medical experts following the procedure laid down in section 38 of the Insurance Contract Act.

For the purposes of this supplementary insurance, the effect date of the absolute and permanent disability is the date of the decision issued by the National Social Security Institute or, failing that, the date of the decision by our medical services.

We reserve the right to check the insured's condition at any time by means of an examination carried out by a doctor chosen by us.

SECTION 3. EXCLUSIONS

Any disability that occurs after the end of the insurance year in which the insured reaches the age of 70 is excluded from coverage for this risk.

Also excluded from this coverage is any disability incurred as a result of voluntary self-harm. If the contract has been reinstated or there has been an increase in the sum insured, the same rule will apply.

This supplementary insurance ends with the termination of the main insurance.

SPECIAL CONDITIONS FOR THE SUPPLEMENTARY ABSOLUTE AND PERMANENT DISABILITY DUE TO ACCIDENT INSURANCE

SECTION 1. INSURED BENEFIT

If the insured becomes absolutely and permanently disabled as the direct result of an accident, whether immediately or within two years from when the accident took place until the date on which the disability is determined, and once the case has been verified and accepted, we will pay the supplementary benefit shown in the schedule.

The benefit in this coverage may not be greater than the supplementary absolute and permanent disability insurance benefit.

SECTION 2. DEFINITION OF ACCIDENT

Irrespective of how the risk is defined by the parties in the contract, accident means bodily injury resulting from a violent, sudden and external cause that is not intentional on the part of the insured.

The following are also considered accidents provided they occur involuntarily: asphyxiation by immersion; infections when the virus has entered the body through a wound caused by an accident covered by the insurance; inhaling gas or vapours; poisoning or burns caused by toxic or corrosive liquids; frostbite; heatstroke and sunstroke.

The following are not considered accidents: illnesses whatever their nature; bodily injuries due to pathological conditions such as strokes, mental disturbances and dizziness; and injuries due to operations the insured carries out or has carried out on their person unless they are the result of an accident the insured has had.

SECTION 3. EXCLUSIONS

Accidents the insured has after the end of the insurance year in which they reach the age of 70 are not covered by this supplementary insurance.

This supplementary insurance ends with the termination of the main insurance.

SPECIAL CONDITIONS FOR THE SUPPLEMENTARY ABSOLUTE AND PERMANENT DISABILITY DUE TO TRAFFIC ACCIDENT INSURANCE

SECTION 1. INSURED BENEFIT

If the insured becomes absolutely and permanently disabled as the direct result of a traffic accident, whether immediately or within two years from when the traffic accident took place until the date on which the disability is determined, and once the case has been verified and accepted, we will pay the supplementary benefit shown in the schedule.

The benefit in this coverage may not be greater than the supplementary absolute and permanent disability due to accident insurance benefit.

SECTION 2. DEFINITION OF TRAFFIC ACCIDENT

Irrespective of how the risk is defined by the parties in the contract, traffic accident means bodily injury resulting from a violent, sudden and external cause that is not intentional on the part of the insured and which leads to their absolute and permanent disability as a:

a) Pedestrian, as a result of being run over on a public highway.

b) Driver, passenger or occupant in or on a land vehicle with or without an engine.

c) Passenger using sea and air transport.

SECTION 3. EXCLUSIONS

The exclusions for this supplementary insurance are the same as those stipulated in section 3 of the special conditions for the supplementary absolute and permanent disability due to accident insurance.

Accidents the insured has when working as a professional driver or as an employee in the operating staff of land, sea or air means of transport are also excluded from this supplementary insurance coverage.

This supplementary insurance ends with the termination of the main insurance.

SPECIAL CONDITIONS FOR THE SUPPLEMENTARY ACCIDENTAL DEATH INSURANCE

SECTION 1. INSURED BENEFIT

If the insured dies as the result of an accident, whether immediately or within two years from when the accident took place, and once the case has been verified and accepted, we will pay the supplementary benefit shown in the schedule.

The benefit in this coverage may not be greater than the main death insurance benefit.

SECTION 2. DEFINITION OF ACCIDENT

Irrespective of how the risk is defined by the parties in the contract, accident means bodily injury resulting from a violent, sudden and external cause that is not intentional on the part of the insured.

The following are also considered accidents provided they occur involuntarily: asphyxiation by immersion; infections when the virus has entered the body through a wound caused by an accident covered by the insurance; inhaling gas or vapours; poisoning or burns caused by toxic or corrosive liquids; frostbite; heatstroke and sunstroke.

The following are not considered accidents: illnesses whatever their nature; bodily injuries due to pathological conditions such as strokes, mental disturbances and dizziness; and injuries due to operations the insured carries out or has carried out on their person unless they are the result of an accident the insured has had.

SECTION 3. EXCLUSIONS

Accidents the insured has after the end of the insurance year in which they reach the age of 80 are not covered by this supplementary insurance.

This supplementary insurance ends with the termination of the main insurance.

SPECIAL CONDITIONS FOR THE SUPPLEMENTARY DEATH DUE TO TRAFFIC ACCIDENT INSURANCE

SECTION 1. INSURED BENEFIT

If the insured dies as the result of an accident, whether immediately or within two years from when the accident took place, and once the case has been verified and accepted, we will pay the supplementary benefit shown in the schedule.

The benefit in this coverage may not be greater than the supplementary accidental death insurance benefit.

In the regular premium and flat rate options, if the insured and their spouse or common-law partner die as a result of the same traffic accident leaving as beneficiaries their joint children under 18 years of age or legally incapacitated adults, we will pay each of them twice the benefit corresponding to them as beneficiaries of this supplementary cover.

Spouse means the person united to the insured by marriage in accordance with Spanish law. Common-law partner is the person who lives with the insured and is registered with the latter in the common-law couples register of their town or region.

If the sum of the additional benefits to be received by all the eligible beneficiaries is greater than €200,000, we will pay €200,000 in equal shares to each of the beneficiaries.

SECTION 2. DEFINITION OF TRAFFIC ACCIDENT

Irrespective of how the risk is defined by the parties in the contract, traffic accident means bodily injury resulting from a violent, sudden and external cause that is not intentional on the part of the insured as a:

a) Pedestrian, as a result of being run over on a public highway.

b) Driver, passenger or occupant in or on a land vehicle with or without an engine.

c) Passenger using sea and air transport.

SECTION 3. EXCLUSIONS

The exclusions for this supplementary insurance are the same as those stipulated in section 3 of the special conditions for the supplementary accidental death insurance.

Accidents the insured has when working as a professional driver or as an employee in the operating staff of land, sea or air means of transport are also excluded from this supplementary insurance coverage.

This supplementary insurance ends with the termination of the main insurance.

SPECIAL CONDITIONS FOR THE SUPPLEMENTARY SERIOUS ILLNESS INSURANCE

SECTION 1. INSURED BENEFIT

If the insured is diagnosed with any of the illnesses listed in section 2 of these special conditions, and once the case has been verified and accepted, we will pay the amount taken out in this supplementary insurance as an advance on the death benefit covered by the policy up to at most €150,000.

Payment of the benefit terminates this cover while the main insurance and the other supplementary covers will remain in force with a sum insured reduced by the amount paid in advance.

SECTION 2. SERIOUS ILLNESSES. DEFINITION

2.1. HEART ATTACK

This means death or necrosis of part of the heart as a result of insufficient blood supply.

The diagnosis must be based on all the following factors:

- History of typical prolonged chest pains.
- New electrocardiographic changes.
- Increase in cardiac enzymes to levels above those accepted as normal.

The heart attack must have been treated in a hospital.

2.2. CANCER

This means the presence of a malignant tumour with uncontrolled growth and spreading of malignant cells and tissue invasion.

Cancer also includes types of leukaemia other than chronic lymphocytic leukaemia, lymphomas and Hodgkin's disease.

The following are excluded:

- Non-invasive in situ cancer.
- Skin cancer, unless diagnosed as malignant melanoma.

2.3. TRANSPLANTS

Heart, lung, liver, pancreas (except for pancreatic islets transplant), kidney and bone marrow transplants performed as a result of medical diagnosis.

SECTION 3. WAITING PERIOD

We will pay the agreed benefit only when the covered illnesses have been diagnosed at least three months after the contract has been concluded.

SECTION 4. EXCLUSIONS

a) **Illnesses and/or accidents before the contract takes effect.**

b) **Taking non-prescribed drugs and/or narcotics.**

c) **Illnesses and/or accidents caused by excessive drinking of alcohol or excessive smoking.**

d) **Illnesses occurring after the end of the insurance year in which the insured reaches the age of 60.**

e) **Any illnesses and/or surgery not provided for in the policy.**

f) **Cancer due to nuclear hazards.**

g) **Any cancer suffered by the insured when their habitual residence in the three years before the onset of the process has been outside Spain.**

SECTION 5. PAYMENT OF THE BENEFIT

In addition to the requirements stated in section 7 (Payment of the covered benefit) in the terms and conditions, in the event of a diagnosis of serious illness you will have to give us a medical certificate for the illness that has been diagnosed using the form we give to the doctor performing the diagnosis.

We will study the reports and come to our own judgement about whether or not there is serious illness.

In the event of a dispute and if there is no subsequent agreement between the parties, both undertake to refer the case to medical experts following the procedure laid down in section 38 of the Insurance Contract Act.

In the case of a transplant diagnosis, the benefit will be paid at the time of the transplant.

SPECIAL CONDITIONS FOR THE SUPPLEMENTARY TOTAL PERMANENT DISABILITY FOR THE USUAL OCCUPATION INSURANCE

SECTION 1. INSURED BENEFIT

If the insured becomes totally permanently disabled for their usual occupation during the term of the policy, and once the case has been verified and accepted, we will pay the benefit shown in the schedule and the contract will be terminated.

SECTION 2. DEFINITION, OPINION AND EFFECT OF THE DISABILITY

For the purposes of this insurance, total permanent disability for the usual occupation means an irreversible physical and/or psychological condition caused by accident or illness that is beyond the control of the insured and which means they are totally and permanently incapable of performing their usual occupation or job or any other similar activity appropriate for their professional training and skills as stated in the insurance application form or the most recent risk amendment endorsement issued in the policy.

In the event of total permanent disability for the usual occupation, the insured or you as the policyholder must send us a detailed medical report containing at least the following information:

a) Certificate issued by the National Social Security Institute stating the insured's total permanent disability for their usual occupation.

b) Failing that, a certificate from the doctor who attended the insured stating the origin, course and nature of the illness or accident causing the disability and its degree and prognosis.

The insured may request a report or additional tests if they consider it necessary.

We will study the reports and come to our own judgement about whether or not there is total and permanent disability for the usual occupation.

In the event of a dispute and if there is no subsequent agreement between the parties, both undertake to refer the case to medical experts following the procedure laid down in section 38 of the Insurance Contract Act.

For the purposes of this supplementary insurance, the effect date of the total and permanent disability is the date of the decision issued by the National Social Security Institute or, failing that, the date of the decision by our medical services.

We reserve the right to check the insured's condition at any time by means of an examination carried out by a doctor chosen by us.

SECTION 3. EXCLUSIONS

Any disability that occurs after the end of the insurance year in which the insured reaches the age of 70 is excluded from coverage for this risk.

Also excluded from this coverage is any disability incurred as a result of voluntary self-harm. If the contract has been reinstated or there has been an increase in the sum insured, the same rule will apply.

This supplementary insurance ends with the termination of the main insurance.

CLAUSE ON COMPENSATION BY THE INSURANCE COMPENSATION CONSORTIUM FOR LOSSES ARISING FROM EXTRAORDINARY EVENTS IN THE INSURANCE OF INDIVIDUALS

In accordance with the provisions of the recast text of the Legal Statute of the Spanish Insurance Compensation Consortium enacted by Royal Legislative 7/2004 of 29 October, the policyholder of an insurance contract of the type which is required to include a surcharge in favour of the abovementioned public business organisation is entitled to arrange cover of extraordinary risks with any insurer which meets the conditions required by prevailing legislation.

Compensation for losses caused by extraordinary events occurring in Spain or abroad when the insured's usual residence is in Spain will be paid by the Insurance Compensation Consortium when the policyholder has paid the relevant surcharges for it and either of the following situations arises:

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

b) Even though it is covered by the insurance policy, the insurer is unable to meet its obligations because it has been legally declared to be insolvent or subject to a process of compulsory liquidation or has been taken over by the Insurance Compensation Consortium.

The Insurance Compensation Consortium will act in accordance with the abovementioned Legal Statute, the Insurance Contract Act 50/1980 of 8 October, the Extraordinary Risks Insurance Regulations enacted by Royal Decree 300/2004 of 20 February, and supplementary provisions.

SUMMARY OF LEGAL RULES

1. Extraordinary events covered

a) The following acts of nature: earthquakes and seaquakes, extraordinary flooding including when caused by battering by waves, volcanic eruptions, uncharacteristic cyclones (including extraordinary winds with gusts over 120 kph and tornadoes) and falling meteorites.

b) Those caused violently as a result of terrorism, rebellion, insurrection, riots and civil disturbance.

c) Actions by the armed forces and law enforcement agencies in peacetime.

Weather and seismic events, volcanic eruptions and falling meteorites will be demonstrated at the request of the Insurance Compensation Consortium by means of reports issued by the State Meteorological Agency (AEMET), the National Geographic Institute and other relevant public agencies in the field. In cases of political or social events and damage or injury caused by the actions of the armed forces and law enforcement agencies in peacetime, the Insurance Compensation Consortium may gather information about what happened from the courts and administrative bodies.

2. Exclusions

a) **Those which do not qualify for compensation under the Insurance Contract Act.**

b) **Those sustained by people insured by a contract of insurance other than those in which the surcharge for the Insurance Compensation Consortium is compulsory.**

c) **Those produced by armed conflict, even though there has been no prior official declaration of war.**

d) **Those arising from nuclear energy, without prejudice to the provisions of the Liability for Nuclear Damage and Damage Caused by Radioactive Materials Act 12/2011 of 27 May.**

e) **Those caused by acts of nature other than those referred to in paragraph 1.a) above, and in particular those produced by rises in the level of the water table, landslides or land settling, rock falls or similar events, except where these are clearly caused by the action of rainwater which in turn has led to extraordinary flooding in the area and they have occurred at the same time as this flooding.**

f) **Those caused by disturbances occurring during meetings or demonstrations carried out in compliance with the provisions of the Freedom of Assembly Act 9/1983 of 15 July and during the course of legal strikes, except where these disturbances may be classified as extraordinary events pursuant to paragraph 1.b) above.**

g) **Those caused by the bad faith of the insured.**

h) **Those relating to losses that take place prior to the payment of the first premium or when, in accordance with the provisions of the Insurance Contract Act, the Insurance Compensation Consortium's cover is suspended or the insurance is terminated due to non-payment of premiums.**

i) **Incidents which due to their magnitude and gravity are classified by the national government as a "national catastrophe or disaster".**

3. Scope of the cover

a) Cover of extraordinary risks will extend to the same people and sums insured as have been set in insurance policies for the purposes of ordinary risks.

b) In the case of life insurance policies which generate a policy reserve under the provisions of the contract and in compliance with private insurance regulations, the cover of the Consortium will refer to the sum at risk for each insured person, that is to say the difference between the sum insured and the policy reserve which the insurer underwriting the policy must have duly constituted. The amount corresponding to this policy reserve will be paid by the aforementioned insurer.

REPORTING DAMAGE OR INJURY TO THE INSURANCE COMPENSATION CONSORTIUM

a) The policyholder, the insured or the beneficiary of the policy, or anyone acting on their behalf, or the insurer or the insurance intermediary involved in arranging the insurance may report and apply for compensation for damage covered by the Insurance Compensation Consortium.

b) The above people and organisations may report damage and obtain information about the handling and status of claims:

   – By calling the Insurance Compensation Consortium's helpline (902 222 665 or 952 367 042).

   – On the Insurance Compensation Consortium's website (www.consorseguros.es).

c) Damage appraisal: the Insurance Compensation Consortium will appraise damage which is compensable under insurance legislation and the insurance policy and it will not be bound by any appraisals that may have been made by the insurer which covers the ordinary risks.

d) Payment of compensation: the Insurance Compensation Consortium will pay compensation to the insurance beneficiary by bank transfer.

These terms and conditions which along with the schedule are given to the policyholder constitute this contract and have no validity or effect separately.

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