Individuals

Income protection plan agreement

For members with an income protection plan whose period of cover starts on or after 01 January 2023.

William Russell

2018-2021 Trusted Service Award feefo

Welcome to William Russell	3
General conditions	4
Your obligations	6
Administration of your plan	7
Your income protection plan	9
What you're not covered for	11
How to make a complaint	12
How we process your information	13
Definitions	14

Welcome to William Russell

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

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

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

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

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

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

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

William Russell

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

Allianz

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

Your right to cancel within 30 days

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

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

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

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

Contact details

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

General conditions

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

Eligibility for cover

To be eligible for cover under the income protection plan:

- **you** must not be living in any of the following countries: Iran, North Korea, Libya, South Sudan, Syria, Yemen or Switzerland.
- **you** must be at least 18 years of age, on the date that **your** plan commences
- **you** must not be more than 60 years of age if **you** are applying for the plan
- **your** occupation must be 100% office-based (if **your** occupation is not 100% office-based, **you** must provide **us** with a full job description)

Maximum income benefit

The highest benefit **we** can offer on **your** plan is US$144,000 or £108,000 or €144,000. Please see pages 8 & 9 for full details of the maximum income benefit **you** are entitled to.

When your plan ceases

Your plan will automatically cease:

- on the date **you** reach **your** 65th birthday
- if **you** take up residence in any of the following countries: Iran, North Korea, Libya, South Sudan, Syria, Yemen.
- at the **renewal date** immediately following the date of **your** return to live in the USA, if **your country of nationality** is the USA.
- at the **renewal date** immediately following the date of **your** becoming a resident of Switzerland, regardless of whether Switzerland is **your country of nationality**.

When we have the right to cancel your plan

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

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

If **we** cancel **your** plan for any of the above reasons, **we** may also report the matter to the relevant authorities (if appropriate). If **your disablement** commences after **your** cover has ceased, no benefit will be payable, even if the **disablement** arises from an injury or illness that existed whilst **your** plan was in force.

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

Limitations on actions

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

Article L. 114-1 of the French Insurance Code

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

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

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

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

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

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

Article L. 114-2 of the French Insurance Code

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

Article L. 114-3 of the French Insurance Code

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

Additional information

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

Your obligations

Full disclosure about your medical history

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

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

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

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

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

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

A change in your occupation

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

If you become unemployed

You must inform **us** immediately, in writing, by email to contact@william-russell.com if **you** become unemployed.

This **agreement** allows for temporary periods of unemployment of up to 4 consecutive months. If **you** remain unemployed for longer than 4 months, **your** plan will automatically cease, even if **your premiums** have been paid. **Premiums** paid in respect of the period commencing 4 months after the date on which **you** became unemployed will be reimbursed.

If **you** should find new employment after **your** plan has ceased **you** can re-apply for the plan by completing a new **application form**. **We** reserve the right to request further medical evidence at **our** sole discretion and impose **special terms** in respect of **your** new application, or to decline to accept **your** new application.

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

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

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

If you participate in hazardous activities

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

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

If you return home

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

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

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

Administration of your plan

Claiming your reimbursement of medical fees

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

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

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

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

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

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

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

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

Payment of premiums

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

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

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

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

Unpaid or late premiums

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

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

Waiver of premiums

Whilst **you** are receiving benefit under **your** plan, **we** will waive the cost of **your premiums** from the **renewal date** which follows the end of **your deferment period**, until such time as **your** claim ends.

Insurance premium tax

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

Renewing your plan

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

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

Maximum ages for renewing your plan

You cannot renew **your** plan once **you** have reached the age of 65 years.

Your plan will be cancelled on **your** 65th birthday.

Age-related premiums

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

Applying for an increase in benefit

You may apply for an increase in benefit at any time up to the age of 60 by completing a new **application form**. Upon receipt of **your** application for an increase in benefit **we** will advise **you** of **our** medical requirements to underwrite the increase in benefit **you** require. Any increase in benefit must be within the maximum benefit limits stated in this **agreement**.

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

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

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

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

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

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

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

Applying for a reduction in benefit

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

Cancelling your plan

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

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

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

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

Your income protection plan

When we pay your income benefit

Your annual income benefit becomes payable if **you** suffer an illness or injury during **your period of cover** as stated on **your Certificate of Insurance** which results in **you** becoming totally **disabled** from carrying out **your own occupation** for a period longer than **your deferment period**, provided **you** are not following any other occupation, except as provided under the **reduced income benefit**.

Cover during periods of unemployment

The plan only provides cover whilst **you** are in employment and have a salary to insure, or if **you** are temporarily unemployed up to a maximum period of four consecutive months. If **you** remain unemployed for longer than 4 months, **your** plan will automatically cease, even if **your premiums** have been paid, and no benefit will be payable for **disablement**.

Your deferment period

The **deferment period** is stated on **your Certificate of Insurance**. No benefit is paid in respect of **your deferment period**.

If, within a period equal to twice **your deferment period you** suffer successive periods of absence from work as a direct cause of the same illness or injury, **you** can apply for **your** income benefit to start once the total amount of time **you** have been unable to work due to that illness or injury equals **your deferment period**.

The benefit you are entitled to receive from your plan during your first 24 months of claiming

Once **we** have accepted **your** claim, **we** will pay **your** benefit monthly in arrears from the end of **your deferment period** at a rate of 1/12 (one twelfth) of the annual benefit.

The **annual income benefit** will be the lower amount of:

- the benefit amount stated on **your Certificate of Insurance**
- 80% of the **gross annual earnings** being paid to **you** at the time **you** became totally **disabled** from following **your own occupation**, less the sum of any **other income** being paid to **you** whilst **you** are **disabled**
- US$144,000 or £108,000 or €144,000.

During **your** period of **disablement** from work **you** must continue to provide **us** with updated medical records from **your** attending physician as often as **we** may reasonably require. **We** reserve the right to appoint an independent medical examiner to examine **you** if **we** deem this necessary.

Once **we** have accepted **your** claim, **we** will continue to pay **your** benefit for a period of up to 24 months whilst **you** remain totally unable to perform the duties of **your own occupation**.

Linked claims

If, following a period of **disablement** from work during which **we** have paid **your** benefit, **you** return to work and within 26 weeks of **your** return, **you** suffer a relapse due to the same cause, **we** will re-start **your** benefit from the date on which **you** are unable to return to work following the relapse.

If **you** suffer a relapse more than 26 weeks after **your** return to work, **your deferment period** will be applied again.

The benefit you are entitled to receive if you return to restricted duties at a reduced income

If during the first 24 months of receiving **your** benefit **you** resume **your own occupation** but **your disablement** restricts the scope of the duties **you** are able to perform, and, as a result there is a reduction in **your gross annual earnings**, **you** may be eligible to claim a **reduced income benefit**.

In calculating **your reduced income benefit we** will reduce the **annual income benefit we** have been paying **you** by the amount of the payment **you** receive for **your** reduced work. **We** will not take account of any reduction in **your gross annual earnings** unless it is directly due to **your disablement**.

When your entitlement to your reduced income benefit ceases

Your entitlement to **your reduced income benefit** will automatically cease upon the first of the following events:

- after **we** have paid **your reduced income benefit** for a period of 6 months
- when the remuneration **you** receive from reduced work and any **other income you** are entitled to receive exceeds 80% of **your** pre-**disablement gross annual earnings**
- when **you** are medically certified as being fit enough to return to **your own occupation** on a full-time basis
- when **we** have paid **you** annual income benefit and **reduced income benefit** for a period of 24 months in total
- **your** death
- **your** 65th birthday

The benefit you are entitled to receive from your plan after 24 months of claiming

We will only continue to pay benefit after 24 months if **you** are medically certified as being totally **disabled** from following **any suitable occupation**.

When **we** have paid **your** benefit (including any period of **reduced income benefit**) for a total period of 24 months **we** will require that **you** have a medical examination to assess **your** capability to return to **any suitable occupation**. If the medical examiner considers that **you** are medically fit enough to return to **any suitable occupation**, even if it is a less well paid occupation, **your** benefit will cease.

When your entitlement to your benefit ceases

Your entitlement to receive **your** benefit will automatically cease upon the first of the following events:

- when a doctor certifies that **you** are fit enough to return to **your own occupation** (during the first 24 months of receiving benefit)
- when a doctor certifies that **you** are fit enough to return to **any suitable occupation** (after **we** have paid **your** benefit for a period equal to 24 months)
- after 24 months if **your disablement** is as a result of mental, nervous or psychological disorders of any type
- **your** death
- **your** 65th birthday

2% annual increase in your benefit

Once **we** start paying **your** benefit, **we** will increase the benefit **we** pay **you** by 2% compound after 12 months and on each anniversary date thereafter.

Making a claim on your plan

You must advise **us** about **your disablement** as soon as possible and in any event no later than 30 days prior to the expiry of **your deferment period**. In order for **us** to consider **your** claim for benefit **we** will require the following:

- a fully completed claim form including a full declaration of any **other income you** are entitled to receive from the state, another insurance company, a pension fund or **your** employer or business
- a detailed medical report from **your** treating physician with a diagnosis and full information about the onset, cause and prognosis of **your** illness or injury with the degree of **your disablement** and its probable duration
- an official document proving **your** date of birth
- proof of **your gross annual earnings**
  - If **you** are employed, **we** require a letter from **your** employer confirming **your gross annual earnings** at the time **you** become totally **disabled** from carrying out **your own occupation**. This must be an original letter on **your** employer's headed paper, and signed by an official of the company - **we** cannot accept faxes or photocopies. **We** also reserve the right to request **your** recent pay slips.
  - If **you** are self-employed, **we** require proof from **your** accountant of **your gross annual earnings** in respect of the three-year period leading up to the date on which **you** became totally **disabled** from carrying out **your own occupation**. **Your** accountant must provide **us** with proof of **your gross annual earnings** in each 12 month period leading up to the date on which **you** became totally **disabled** from carrying out **your own occupation**, and **we** will take **your** average earnings over this period when assessing **your gross annual earnings**. Proof of **your gross annual earnings** must be on **your** accountant's headed paper, and must be signed by the accountant - **we** cannot accept faxes or photocopies.

We reserve the right to request as much medical and financial information as **we** may reasonably require to enable **us** to make a decision about **your** claim.

All documentation submitted in support of **your** claim must be the original. **We** cannot accept faxes or photocopies.

All documentation, including medical reports, proof of earnings and other financial information **we** reasonably request in connection with a claim, must be provided at **your** own expense.

The deadline for claiming

You must advise **us** of **your** absence from work no later than 30 days prior to the end of **your deferment period**.

The deadline for claiming for **your annual income benefit** is one year after **you** become totally **disabled** from working. No benefit will be paid at all in respect of any claim that has not been notified to **us** within one year after **you** first became totally unable to follow **your own occupation**.

What you're not covered for

What your plan does not cover

No benefit will be paid if **your disablement,** illness or injury, relates to or arises directly or indirectly from any of the following:

- any items specifically excluded on **your Certificate of Insurance**
- a **pre-existing medical condition** or **related condition**, unless **you** have told **us** about it and **we** have agreed to accept cover for it
- **your** active participation in war, warlike activities or terrorist activities
- **your** gross negligence and deliberate exposure to exceptional danger (except in the attempt to save a human life)
- **your** participation in any kind of **professional sport** or **professional racing** (including training or practicing for any kind of **professional sport** or **professional racing**)
- **your** participation in an activity that is illegal in the country in which it is performed
- the consequences of attempted suicide or intentionally self-inflicted injuries, whether sane or insane
- abuse of drugs, alcohol and medication
- normal pregnancy
- loss of **your** licence to carry on **your own occupation**
- war, terrorism, kidnap, murder, assault of any kind, or any other act of violence, sustained whilst **you** are in a country or region that the British Foreign, Commonwealth & Development Office ("FCDO") has advised its citizens to leave, or has advised against all travel to, or has advised against all but essential travel to, due to security reasons (whether **your** presence in that country or region is permanent or temporary).
- any cause whatsoever, if sustained whilst **you** are in Iran, Libya, North Korea, South Sudan, Syria, or Yemen (whether **your** presence in the country is permanent or temporary).

No benefit will be paid for **disablement** that has not been reported to **us** within 12 months of **you** becoming totally **disabled** from working.

Benefit in respect of any **disablement** that results from mental, nervous or psychological disorders of any type will be restricted to one claim per lifetime and to a maximum of 24 months.

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

How to make a complaint

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

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

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

Phone +44 1276 486 455
Email contact@william-russell.com

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

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

Email client.care@allianzworldwidecare.com

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

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

Web mediation-assurance.org

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

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

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

Arbitration and applicable law

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

How we process your information

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

The information we collect

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

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

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

How we use your personal information

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

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

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

Who we may share information with

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

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

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

Processing claims

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

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

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

Where we store your personal information

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

Marketing

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

Obtaining a copy of the information we hold about you

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

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

Phone +44 1276 486 455
Email contact@william-russell.com

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

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

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

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

Definitions

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

Acceptance terms

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

Agreement

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

Annual income benefit

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

Any suitable occupation

Your own occupation or any other occupation for which **you** are reasonably suited by training, education or experience.

Application form

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

Certificate of Insurance

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

Contractual bonuses

Bonuses that are paid to **you** as part of **your** employment contract.

Country of nationality

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

Country of residence

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

Date of entry

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

Deferment period

The period of continuous total **disablement** from following **your own occupation** which must pass before **you** can become entitled to receive benefit under **your** plan.

Disabled/Disablement

The inability to work at **your** normal occupation because of physical or mental impairment that precludes **your** performing expected roles or tasks.

Gross annual earnings (if you are an employee)

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

If **you** are an employee, but **your** earnings are based directly on **your** sales performance, **we** will take into account 50% of **your** commission earnings over the 12 month period leading up to the date upon which **you** became totally **disabled** from following **your own occupation** when **we** assess **your gross annual earnings** for a claim under **your** plan.

If **your** commission earnings fluctuate, **we** will take an average of **your** commission earnings during the period of 36 months immediately preceding the date upon which **you** became totally **disabled** from following **your own occupation**.

Gross annual earnings (if you are self-employed)

Your gross personal income from **your** business during the 12 months immediately preceding the date upon which **you** became totally **disabled** from following **your own occupation**, and before the deduction of income tax, excluding income **you** receive from dividends, savings, investments or gifts.

If **your** earnings fluctuate, **we** will take an average of **your gross annual earnings** during the period of 36 months immediately preceding the date upon which **you** became totally **disabled** from following **your own occupation**, when assessing a claim under **your** plan.

Hazardous activities

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

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

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

Insurance premium tax

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

Insurer

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

Other income

Other income includes any disability benefit **you** are entitled to receive from the state or another insurance company, any salary or other payments from **your** employer or business, or any pension **you** receive.

Period of cover

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

Pre-existing medical condition

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

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

Premium

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

Premium due date

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

Pro rata refund

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

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

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

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

Professional racing

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

Professional sport

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

Reduced income benefit

A reduced benefit that may be paid if **you** are able to return to **your own occupation**, during the first 24 months of claiming, on a part-time or reduced basis.

Related condition

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

Renewal date

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

Special terms

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

Us, we, our

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

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

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

You, your, yourself

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

Your own occupation

Your occupation as declared to **us** on **your application form** or subsequently.

William Russell

We're here to help

Call us on
+44 1276 486 455

Visit
william-russell.com

2018-2021 ★★★★★ feefo
Trusted Service Award

bsi ISO/IEC 27001 Information Security Management CERTIFIED

17 November 2022 | v1