FOUR IN ONE INDIVIDUAL PERSONAL PROTECTION POLICY

Between BEE INSURANCE CORP, hereinafter called the Insurer, with location of its main headquarters located at 1110 Brikell Avenue, Suite 406, Miami, USA, ZIP CODE 33131, whose Tax Address is the same as identified above, and the Policyholder, identified in the Policy Receipt Table, have agreed to sign this Insurance Contract, which is formed and will be governed in accordance with the provisions of the General Conditions and the Particular Conditions of the Policy, in the Insurance Application, the Annexes, if any, and other documents that form an integral part thereof.

GENERAL CONDITIONS FOUR IN ONE

CLAUSE 1. PURPOSE OF THE INSURANCE

Through this insurance, the Insurer undertakes to cover the risks mentioned in the Particular Conditions and Annexes, if any, and to compensate the Insured Holder or the Beneficiary, as the case may be, the sums that may correspond to him as a result of an incident covered by this contract, up to the Insured Sum indicated in the Policy Receipt Table.

CLAUSE 2. DEFINITIONS

For the purposes of this contract, it is expressly agreed between the parties that the following terms will have the meanings indicated, and that the masculine gender will also include the feminine, when applicable, unless a different interpretation appears from the text of this Policy:

INSURER: BEE INSURANCE CORP, who assumes the risks covered in this Policy.

TAKER: Natural or legal person who, acting on his or her own account or on behalf of another, contracts insurance with the Insurer, transferring the risks to it and being obligated to pay the premium.

INSURED: Natural person who is himself exposed to the covered risks indicated in the Particular Conditions and annexes of the policy, if any, for the purposes of this policy will be the Insured Holder and.

TITLE INSURED: Person indicated with this character in the Policy Receipt Table, who exercises the rights of the Insurer.

BENEFICIARY: Natural or legal person designated by the Principal Insured in whose favor the compensation to be paid by the Insurer has been established

PARTICULAR CONDITIONS: Those that contemplate aspects specifically related to the risk that is insured.

POLICY RECEIPT BOX: Document that indicates the particular data of the policy, such as: policy number, complete identification of the Policyholder, Insured and Beneficiary, identification of the Insurer, address of the Policyholder, collection address, name of the insurance producer, risks covered, Insured Sum, premium amount, deductible, form and place of payment, validity period and signatures of the Insurer and the Policyholder.

DOCUMENTS THAT ARE PART OF THE INSURANCE CONTRACT: The Insurance Application; the Provisional Coverage document, if any; the General Conditions; the Particular Conditions; the Policy Receipt Box; the annexes that are issued to complement or modify the Policy and other documents that by their nature form part of the contract.

AGE REACHED: Age that corresponds to the birthday closest to the start date of this Policy, which will be established based on the identity card, birth certificate or other legal verification to the satisfaction of the Insurer.

INSURANCE APPLICATION: Questionnaire provided by the Insurer, which contains a set of questions related to the identification of the Policyholder, the Proposed Insured and the Beneficiary and other data that may influence the risk estimate, which must be answered in full and accurately by the Insurer. Policyholder or the Proposed Insured, said declaration constituting the legal basis for the issuance of the insurance contract.

PREMIUM: Consider that, depending on the risk, the Policyholder must pay to the Insurer by virtue of the conclusion of the contract. The premiums for this insurance will correspond to annual, semi-annual, quarterly, monthly and any other periods agreed between the parties, and will be determined based on the rates that the Insurer applies for each modality.

RISK: Possible chance occurrence of an event that does not depend exclusively on the will of the Policyholder, the Insured or the Beneficiary, that causes an economic need, and whose actual appearance or existence is foreseen and guaranteed in this contract.

SINISTER: Materialization of the risk that gives rise to the obligation to indemnify on the part of the Insurer, which corresponds in accordance with this contract.

ASSURED AMOUNT: Maximum limit of liability of the Insurer, indicated in the Policy Receipt Table.

CLAUSE 3. EXEMPTIONS OF LIABILITY.

The Insurer will not be obliged to pay compensation in the following cases:

1. If the Policyholder, the Insured, the Beneficiary or any person acting on their behalf presents a fraudulent or misleading claim, or if at any time they use deceptive or fraudulent means or documents to support a claim or to derive other benefits related to this contract.

2. If the incident has been caused by fraud on the part of the Policyholder, the Insured or the Beneficiary.

3. If the incident has been caused by serious fault of the Policyholder, the Insured or the Beneficiary. However, the Insurer will be obliged to pay compensation if the incident has been caused in compliance with legal duties of relief or in protection of common interests with the Insurer with regard to this contract.

4. If the incident begins before the validity of the contract and continues after the risks have begun to be borne by the Insurer.

5. If the Policyholder, the Insured or the Beneficiary does not use the means at their disposal to reduce the consequences of the incident, provided that this failure occurred with the clear intention of harming or deceiving the Insurer.

6. If the Policyholder or the Insured acts with intent or serious negligence, as indicated in Clause 9 (Declarations in the Insurance Application), of these General Conditions.

7. If the Policyholder, the Insured or the Beneficiary intentionally omits to notify the Insurer about the contracting of policies that cover the same risk covered by this contract or if they have entered into the second or subsequent insurance contracts, on the same risks, with the purpose of obtaining an illicit benefit.

8. If the Policyholder, the Insured, the Beneficiary or any person acting on their behalf, acting with intent or gross negligence, hinders the rights of the Insurer stipulated in this Policy.

9. If the insured fails to comply with any of the obligations established in this contract.

10. Other exemptions from liability established in the Particular Conditions of the Policy.

CLAUSE 4. VALIDITY OF THE CONTRACT

The effectiveness of the contract will be annual, semiannual, quarterly, and monthly or any other duration that has been agreed between the parties, and in any case, it will be recorded in the Policy Receipt Table, indicating the date of issue, the time and day of initiation and expiration. In the absence of express indication, the risks covered begin to be borne by the Belayer at 12 am. on the day of the beginning of the validity of the contract and will end at the same time on the day of its expiration.

CLAUSE 5. PREMIUM PAYMENT

The Policyholder must pay the premium within a period of ten (10) continuous days from the start date of the contract. If the premium is not paid or its collection becomes impossible for reasons attributable to the Policyholder within the established period, the Insurer will have the right to demand the corresponding payment or terminate the contract.

In the event of termination, this will take effect from the beginning of the term of the contract, without the need for prior notice to the Policyholder.

If an incident occurs within the agreed period for payment of the premium, the Insurer will pay the compensation, provided that the Policyholder pays the corresponding premium before its due date.

The payment of the premium only keeps the contract in force for the time to which said payment corresponds, as stated in the Policy Receipt Table.

If the payment of the premium is in installments, it is understood that such installment is an ease of payment and does not imply modification of the period of validity of the contract. In this case, if the Policyholder does not pay any fraction of the premium within five (5) business days following the date of completion of the last fraction paid, the Insurer has the right to demand the premium

due or to terminate the contract, of these General Conditions and if a covered incident occurs during that period, the Insurer will proceed in accordance with the following rules:

1. Deduct the fraction of premium due from the compensable amount. However, if the amount to be paid is for the entire Insured Sum, the Insurer may deduct the fractions of outstanding premiums to complete the entire premium for the period of validity of the contract.

2. If the compensable amount is less than the fraction of premium due, the Insurer will pay the compensation, provided that the Policyholder pays the aforementioned fraction of premium due, before the period provided for in this Clause.

In the event of termination due to non-payment of a fraction of the overdue premium, this will take effect from the end date of the period covered by the last fraction of the premium paid, provided that the Insurer has previously notified the Policyholder or the Insured.

Against payment of the premium or any of its fractions, the Insurer will deliver to the Policyholder the Policy Table Receipt or corresponding premium receipt, signed and sealed. The delivery of this document may be made in printed form or through the electronic mechanisms provided for this purpose and agreed upon by the parties included in the insurance application.

Premiums paid in excess will not give rise to any liability on the part of the Insurer for the excess, but only and exclusively to the reimbursement without interest of the surplus, even if they have been formally accepted by it.

CLAUSE 6. PLACE AND METHOD OF PAYMENT OF PREMIUMS

The premiums corresponding to this contract will be paid directly at the Insurer's offices. However, the latter may collect the premiums at home and give notice of their due dates and, if he does so, he will not set a precedent of obligation and may suspend this management at any time, with prior notice. Premiums may be paid under any mechanism or means agreed upon by the parties.

CLAUSE 7. RENEWAL

After updating the health declaration and/or compliance with medical protocol required by BEE INSURANCE CORP sixty (60) days before the expiration of the current term and the conditions for renewal have been approved, the term of the Contract will be deemed renewed at the end of the last day of the previous term and for an equal period, provided that the INSURED promptly pays the Premium corresponding to the new validity period at the corresponding opportunity.

The costs of examinations or medical protocol are the responsibility of the insured. In either case, BEE INSURANCE CORP is not required to automatically renew the policy; and must notify non-renewal thirty (30) days before the expiration of the current term.

CLAUSE 8. GRACE PERIOD

Thirty (30) continuous days of grace are granted for the payment of the renewal premium, counted from the date of termination of the validity of the previous contract. If the contract is valid monthly, the grace period will be fifteen (15) continuous days.

If an accident occurs within this period, the Insurer will pay the compensation, after deduction of the corresponding premium. If the amount of the claim is less than the renewal premium, the Insurer will pay the compensation, provided that the Policyholder pays the premium within the grace period granted. If the premium is not paid within the aforementioned period, the contract will be without validity and effect from the date of termination of the validity of the previous contract.

CLAUSE 9. DECLARATIONS IN THE INSURANCE APPLICATION

When filling out the application, the Policyholder or the Proposed Insured must accurately declare to the Insurer, in accordance with the questionnaire and other requirements indicated, all the circumstances known to him or her that may influence the risk assessment. The Insurer must inform the Policyholder or the Insured, within a period of five (5) business days following knowledge of a fact not declared in the application that may influence the assessment of the risk, and may adjust or terminate the contract, by communication addressed to the Policyholder or the Insured, as appropriate, within a period of one (1) month, counted from knowledge of the facts.

In the event of termination, this will occur from the sixteenth (16th) continuous day following its notification, provided that the proportional part of the premium, deducting the commission paid to the intermediary of the insurance activity, corresponding to the period remaining for elapse, is available to the Policyholder in the Insurer's box. The premiums relating to the insurance period elapsed will correspond to the Insurer at the time this notification is made. The Insurer may not terminate the contract when the fact that has been subject to reservation or inaccuracy has disappeared before the incident.

If the incident occurs before the Insurer makes the participation referred to in this Clause, the compensation will be reduced proportionally to the difference between the agreed premium and the one that would have been established if the true nature of the risk had been known. If the Policyholder or the Insured acts with intent or gross negligence, the Insurer will be released from paying the compensation and returning the premium.

When the contract refers to several people, goods or interests and the reservation or inaccuracy is contracted only to one or more of them, the contract will subsist with all its effects with respect to the rest, if this is technically possible.

CLAUSE 10. OMISSIONS, FALSEHOODS AND RETICCENCES

Omissions, falsehoods and reluctance on the part of the Policyholder or the Insured made in the Insurance Application, duly proven, will be cause for absolute nullity of the contract, if they are of such a nature that the Insurer, if known about them, would not have contracted or would have made under other conditions.

In the event of falsehoods and reluctance on the part of the Policyholder, the Insured or the Beneficiary in the claim for the loss, duly proven, they will be cause for absolute nullity of the contract and will exonerate the Insurer from payment to the Beneficiary of the monetary benefit for the sum indicated in the Policy Receipt Box.

There is no place for the return of premium to the Insured Policyholder in the cases of nullity of the contract contemplated in this Clause.

CLAUSE 11. PAYMENT OF COMPENSATION

The Insurer must pay the corresponding compensation within a period not exceeding thirty (30) consecutive days, counted from the date on which it received the last payment requested, except for strange causes not attributable to the Insurer.

CLAUSE 12. REJECTION OF THE CLAIM

The Insurer must notify in writing to the Policyholder, the Insured or the Beneficiary, within the period indicated in the previous Clause, the factual and legal causes that in its opinion justify the rejection, total or partial, of the compensation required.

CLAUSE 13. ARBITRATION

The parties may submit to an arbitration procedure any differences that arise in the interpretation, application and execution of the contract. The arbitration processing will comply with the provisions of the law that regulates the matter.

CLAUSE 14. EXPIRATION OF SHARES

The Policyholder, the Insured or the Beneficiary will lose all right to take legal action against the Insurer or agree with it to submit to the Arbitration provided for in the previous Clause, if they have not done so before the expiration of the period of one (3) months counted from from the date of notification, in writing:

1. Of the total or partial rejection of the claim.

2. The decision of the Insurer regarding the disagreement of the Policyholder, the Insured or the Beneficiary regarding the amount of compensation or compliance with the obligation through suppliers of inputs or services. For the purposes of this provision, the judicial action will be deemed to have been initiated once the libel of claim is filed with the jurisdictional bodies.

CLAUSE 15. OBLIGATIONS OF THE POLICYHOLDER, INSURED OR BENEFICIARY

1. The Policyholder and the Insured must complete the Insurance Application and declare, with absolute sincerity, all the circumstances necessary to be able to appreciate the extent of the risks, in the terms indicated in this contract.

2. The Policyholder must pay the premium in the manner, frequency and time agreed in this contract.

3. The Insured must use the care of a diligent parent to prevent the accident.

4. The Insured or the Beneficiary will inform the Insurer, within five (5) business days of becoming aware of it, of the occurrence of an incident, clearly expressing the causes and circumstances of what occurred.

5. The Insured or the Beneficiary must declare, at the time of demanding payment of the claim, the insurance contracts that exist and that cover the same risk.

6. The Insured or the Beneficiary must prove the occurrence of the accident by submitting all the information necessary for compensation for the accident, which is requested by the Insurer.

7. The Insured, in the event of a change of collection address, domicile, room or office, as the case may be, must notify the Insurer in writing within fifteen (15) business days following the date of making the change unless this obligation is considered an aggravation of the risk, in which case the period provided for this will apply.

8. The Insured must comply with each and every one of the obligations, responsibilities and conditions established in the different documents that make up this contract.

9. Accurately declare everything that represents a significant or permanent change in your state of health or an aggravation of risk.

CLAUSE 16. OBLIGATIONS OF THE INSURER

1. Inform the Policyholder or the Insured, by delivering the Policy and other documents, the extent of the risks assumed and clarify, at any time, all doubts and queries that the latter may ask.

2. Deliver the Policy Receipt Table to the Policyholder along with a copy of the Insurance Application, the General Conditions, the Particular Conditions, the annexes, if any, and the other documents that form an integral part of the insurance contract. Upon renewal, the obligation will apply to new documents or to those that have been modified. The delivery of the indicated documents must be carried out in the terms agreed between the parties.

3. Proceed to evaluate the damage, after receiving the notification and the necessary precautions for the processing of the incident, in accordance with the provisions of the Specific Conditions of this contract.

4. Pay the Insured Sum or the corresponding compensation in the event of an accident, within the deadlines established in this contract or reject coverage of the accident, by means of written and duly motivated notice.

5. Deliver to the Insured or its insurance activity intermediary a copy of the loss adjustment report containing the calculations used to determine compensation.

6. Comply with each and every one of the obligations, responsibilities and conditions established in the different documents that make up the insurance contract.

CLAUSE 17. MODIFICATIONS

The modification of the Insured Sum or the deductible will always require express acceptance from the other party; In the event that there is no express acceptance, it will be presumed accepted: by the Insurer, with the issuance of the Policy Receipt Table, in which the Insured Sum or the deductible is modified and, by the Policyholder or the Insured, with the payment of the difference corresponding premium, if any.

If the modification is effective from the extension of the contract, it must be communicated to the Policyholder by means of notification made in printed form or through the electronic mechanisms

agreed for this, with a period of one (1) month in advance of the conclusion of the period insurance in progress.

In the event of disagreement by the Policyholder, the Insurer will maintain or renew the contract under the same conditions of Sum Insured and deductible in force at the time of the modification proposal.

The modifications will be recorded through Annexes, duly signed by a representative of the Insurer and the Policyholder, which will prevail over the Particular Conditions and these over the General Conditions of the Policy.

If the modification requires payment of additional premium, the provisions of Clause 4. Term of the Contract, Clause 5. Payment of Premium and Clause 6. Place and Method of Payment of Premiums, of these General Conditions, will apply.

CLAUSE 18. NOTICES

Any notice or communication that one party must give to the other regarding this contract will be made by acknowledgment of receipt, by written communication or email addressed to the address of the Policyholder and the Insured that appears in the contract or to the main address or branch of the Insurer, or through electronic means agreed upon by the parties.

The intermediary of the insurance activity will be civilly liable in the event that it has not delivered the correspondence to its recipient, within a period of five (5) business days, counted from its receipt.

CLAUSE 19. SPECIAL ADDRESS

For all effects and consequences derived or that may arise from this Policy, the parties choose a special domicile, unique and exclusive of any other, the place where the insurance contract was concluded, to whose Jurisdiction the parties declare to submit.

FOUR IN ONE PARTICULAR CONDITIONS

CLAUSE 1. PARTICULAR DEFINITIONS

For all purposes related to this Policy, it is expressly agreed that the following terms will have the meaning assigned to them below:

ACCIDENT: Fortuitous event in which the Insured suffers a bodily injury derived from a violent, sudden, external cause and beyond the intention of the Policyholder or the Insured.

REASONABLE COST: Average cost, calculated by the Insurer, of the surgical and hospital medical expenses of medical care centers located in the same geographical area, which are of the same category or equivalent to that where the Insured was treated, which correspond to the same intervention or treatment or similar, free of complications, and that are covered in accordance with the conditions of this Policy. Said average will be calculated based on the statistics that the Insurer has of the expenses billed in the calendar month immediately preceding the date on which the Insured incurred said expenses, increased according to the Consumer Price Index (CPI)

established by the government institution that corresponds, registered in the same month, or the scales of the medical care centers that are in force for the aforementioned date. When this average cannot be obtained, the reasonable cost will be the amount invoiced.

STATE OF DRUNKENNESS: Presence in the blood of more than 0.80 grams per thousand of alcohol, as long as the sample has been taken a maximum of two (2) hours after the Accident occurred.

HOSPITAL INSTITUTION: Permanent establishment with a valid health permit to provide medical care authorized by the competent public body. Hospital institutions will not be considered for the purposes of this Policy, places of rest, nursing homes, spas, hydro clinics and any institution that provides similar treatments, exclusive centers for the treatment of drug addicts, dipsomaniacs (alcoholics), mentally ill or behavioral disorders, nor places where naturopathic treatments, alternative therapies and acupuncture are provided.

TOTAL AND PERMANENT INVALIDITY: Anatomical loss or functional impotence of limbs or organs of the Insured's anatomy in an irreversible manner that, according to medical criteria, totally disables the Insured from carrying out any lucrative activity or remunerative employment.

INJURY: Any physical damage suffered by the Insured, provided that it has as a real, immediate, necessary, direct and exclusive cause, wounds or blows caused by the sudden, violent and fortuitous action of an external force or agent, independent of the will of the Insured. , objectively verifiable, and that is the basis for a claim in accordance with the terms of this policy. 10

DOCTOR: A physician is understood to be a medical professional, legally authorized to practice medicine under the laws of the jurisdiction where the service has been provided and who is practicing within the limits of any relevant legal authorization. The doctor must have the specialty directly linked to the diagnosis, treatment or care of the health disorders covered under this Policy.

MEDICALLY NECESSARY: Treatment, service, medications or stay in a Hospital Institution, which:

- It is appropriate and essential for the diagnosis and treatment of the Insured's illness or injury.

- Does not exceed in scope, duration or intensity the level of care necessary to provide a safe, adequate and appropriate diagnosis or treatment.

- Has been prescribed by a doctor.

- It is consistent with professional standards widely accepted by the medical community of the Country where the medical service or treatment is provided.

- In the case of a patient admitted to a Hospital Transplant Institution, it cannot be administered outside said Center due to risk to the patient. Medical necessity is determined by the Insurer based on the previous definition, the fact that a treatment, service or supply that is not related to the incident, even if it has been prescribed, recommended, approved or provided by a doctor is not necessarily sufficient for the Insurer to consider it as medically necessary.

ACCIDENTAL DEATH: The loss of the life of the Insured as a result of an accident covered by this policy.

DEATH FROM ANY CAUSE: The loss of the life of the Insured due to any natural or accidental cause.

PASSENGER: Person who uses a transportation vehicle (air, land or sea) operated by a scheduled commercial transportation company on an established passenger service route. The person who is driving, providing service or receiving learning or instruction in the means of transport or users of non-commercial means of transport (air, land or sea) is not considered a passenger.

FUNERAL SERVICE: These are the services provided by legally established funeral homes, such as: religious services, chapel and cafeteria services (inside the funeral home), hearse vehicles for transporting the deceased, vehicles accompanying family members, preparation and arrangement of the deceased, coffin, press notice, transfer of the deceased by land within the National territory, carrying out legal procedures, cremation or plots in the cemetery and cross of flowers.

FUNERAL HOMES: Companies legally authorized to provide funeral services. The Funeral Homes provide their services independently and the consequences of the provision of their services will not generate liability on the part of the Insurer.

PASSENGER: Person who uses a transportation vehicle (air, land or sea) operated by a scheduled commercial transportation company on an established passenger service route. The person who is driving, providing service or receiving learning or instruction in the means of transport or users of non-commercial means of transport (air, land or sea) is not considered a passenger. WAITING

PERIOD: Period within the validity of the coverage of this insurance contract, during which the Insurer does not cover certain risks.

CLAUSE 2. BASIC COVERAGE

2.1 ACCIDENTAL DEATH

If, as a result of an Accident suffered by the Insured and covered by this Policy, death occurs within one (1) year from the date of occurrence of the Accident, the Insurer will compensate the designated Beneficiaries, or in the absence of these, to the legal heirs of the Insured, the amount of the Insured Sum indicated in the Policy Receipt Table for this coverage, in force at the time of the Accident.

2.2 TOTAL INVALIDITY AND PARTIAL INVALIDITY

If, as a consequence of an Accident suffered by the Insured and covered by this Policy, any of the disabilities listed in the Compensation Scale occur within one (1) year from the date of occurrence thereof, the Insurer will pay to the Insured, the amount resulting from applying the percentage stipulated in said scale, to the amount of Sum Insured indicated in the Policy Receipt Table for this coverage, in force at the time of the Accident.

SCALE OF COMPENSATION

Total and Permanent Disability: % Compensation
Total and permanent paralysis 100%
Absolute and incurable mental insanity or loss of consciousness 100%
Bilateral absolute blindness 100%
Total loss of hearing and speech 100%
Incurable spinal cord injuries that completely prevent movement 100%
Complete loss or absolute and permanent functional impotence of 100%
two upper or lower limbs, or one upper and one lower, including the hands and feet

Permanent Partial Disability due to amputation or disablement due to absolute functional impotence of:

One eye with a decrease in the visual acuity of the other by more than
50%, as long as this is uncorrectable 75%
An eye with enucleation 55%
without enucleation 40%
Reduction of vision in both eyes by more than 50% Four. Five%
Bilateral total deafness 65%
Unilateral total deafness 35%
Total loss of one ear 25%
Total loss of both ears Four. Five%
Total loss of nose 40%
loss of speech 60%
Total loss of the lower jaw or total ablation of the mandible Four. Five%
Serious disorders in the joints of both jaws 25%
Complete loss of smell or taste 10%

Complete loss of movement of the cervical spine with or without
neurological manifestations Four. Five%
Complete loss of movement of the dorsal column with or without
neurological manifestations Four. Five%
Complete loss of movement of the lumbar spine with or without
neurological manifestations Four. Five%
Complete loss of hip movement 70%

Of the Upper Extremities:

Total loss due to amputation or mutilation of: RIGHT LEFT
An arm 75% 55%
A hand 75% 55%
Thumb 35% 30%
Index finger 30% 25%
middle finger twenty% fifteen%
Ring finger twenty% fifteen%
Pinkie fifteen% 10%
Index finger and thumb 55% Four. Five%
A phalanx of the thumb twenty% fifteen%
A phalanx of the index finger fifteen% 10%
A phalanx of any other finger 10% 7%
Two phalanges of the index finger twenty% fifteen%
Two phalanges of any finger other than the thumb fifteen% 10%
Complete loss of wrist movement 30% 25%
Complete loss of shoulder movement 35% 30%
Complete loss of elbow movement 35% 30%
Poorly consolidated fracture of an arm 30% 25%

orly consolidated forearm fracture: RIGHT LEFT
Of the two bones 30% 25%
of a single bone 25% twenty%

Of the lower extremities:

Loss due to amputation or mutilation of:
One leg above the knee 75
One leg below the knee 65%
A foot 65%
Big toe 25%
Any other toe fifteen%
Complete loss of knee movement 55%
Complete loss of throat movements in one foot 35%
Complete loss of motion of the subtalar joint 25%
Poorly consolidated fracture of the femur or leg bones 55%
Poorly consolidated fracture of a foot 35%

Shortening of a lower limb:

More than 8cm 35%
Between 4 and 8 cm 25%
less than 4cm fifteen%

If the Insured is left-handed, the percentages indicated in the Compensation Table will be reversed for loss or disablement of the upper extremities.

For the above purposes, Loss is understood to mean the amputation or total and irreparable disablement of the use of the affected member or part of the body.

In the case of injuries not mentioned above, but that are considered permanent, they will be evaluated by the doctor designated by the Insurer, comparing them if possible with this Compensation Scale, for the purposes of determining the percentage to be compensated.

In cases of mental derangement, paralysis, loss of speech and deafness, in addition to their condition being irreparable, in the opinion of the doctor designated by the Insurer, it is required

that they have had an uninterrupted duration of not less than one hundred and eighty 14 (180) days from the date of the Accident.

In the event of several losses or disablements caused by the same Accident covered by this benefit, the amounts corresponding to each of them will be added, without the total being able to ever exceed the Insured Sum indicated in the Policy Receipt Table for this coverage.

In the event that several losses or disablements affect the same member, the total compensation may not exceed the value established for the total loss of said member.

The loss of members or organs already disabled before the Accident will not give rise to compensation, but rather for the difference between the degree of disability presented before and after the Insured's Accident.

Any payment made for the loss of limbs, hearing or sight will be deducted from the amount compensable for Total and Permanent Disability.

If the Insured suffers a disability covered by this Policy and before the Insurer has made the corresponding payment, the Insured dies as a result of the same Accident that caused such disability, compensation will only apply for the Accidental Death coverage.

If the Insured Holder is declared Totally and Permanently Disabled, he or she will serve as the Policyholder in the renewal, being registered in the same, but the coverages that were affected at the time of the Accident or that could give rise to future compensation for this concept will be excluded of the declared disability.

2.4 TELEMEDICINE SERVICE.

We guarantee telemedicine services to the insured through our Medical Call Center 24 hours a day, seven days a week, 365 days a year.

The coverage included and its scope are included in a special annex, which is an integral part of this contract.

2.5 FUNERAL SERVICE The Insurer undertakes to provide a funeral service or pay the expenses incurred for the provision of the Funeral Service to anyone who reliably demonstrates having paid the expenses up to the Insured Sum indicated in the Policy Receipt Table; all this as a consequence of the death of the Insured that occurred during the term of the Policy, always fifteen and when said death has occurred due to the causes established by this Policy. This coverage has a waiting period of three (3) months.

The coverage or services included and their scope appear in a special annex, which is an integral part of this contract.

2.6 DEATH FROM ANY CAUSE.

If the Insured dies by accident or in the event of natural death, the Insurer will compensate the designated Beneficiaries, or in their absence, the legal heirs of the Insured, the amount of the Sum Insured indicated in the Policy Receipt Table for this coverage, in force. for the time of death.

CLAUSE 3. INCLUSION OF INSURED PARTIES (APPLIES ONLY FOR GROUPS)

Insurable people who have not been included in the Insurance Contract at the time of the conclusion of the Contract may register at any later date, the effectiveness of the insurance beginning from the moment when the insurance application is received or at a later date and their inclusion is accepted by the Insurer.

The inclusion of a new Insured causes an additional premium to be paid by the Policyholder, the non-payment of which will cause the same effects as the non-payment of the premium established in the general conditions of the Insurance Contract, with respect to the Insured to be included.

CLAUSE 4. EXCLUSIONS FOR COVERAGE

The Insurer will not compensate the Insured or its Beneficiaries, if the claims are due to:

1. Injuries as a result of: war, invasion, act of a foreign enemy, hostilities or war operations (whether there has been a declaration of war or not), military insubordination, military uprising, insurrection, rebellion, revolution, internal war, civil war, military power or usurpation of power, proclamation of a state of emergency, act of terrorism or any act of any person acting on behalf of or in relation to any organization that carries out activities aimed at the forcible removal of the government or influencing it through terrorism or violence.

2. Injuries caused by: seismic movements, floods, storms, hurricanes, volcanic eruptions, as well as any other phenomenon of a catastrophic or extraordinary nature, or events that, due to their magnitude and severity, are classified by the competent authorities as "catastrophe or national calamity."

3. Epidemic diseases or endemic diseases declared as such by the competent authorities, from the moment the declaration is made.

4. Radioactive contamination.

5. Accidents and their consequences, suffered prior to the validity of the policy.

6. Intoxications, health disorders due to the action of light, temperature and atmospheric pressures, health disorders due to the use or exposure of radioactive materials.

7. Criminal act of the Insured or when the Insured is in a state of drunkenness, mental insanity, under the influence of drugs not prescribed medically or in a state of sleepwalking.

8. Injuries inflicted on himself by the Insured, as well as those caused by his suicide or attempt.

9. Homicide or attempted homicide caused intentionally by any Beneficiary, of this or any other insurance that the deceased Insured has contracted with this or another company, leaving aside the rights that may correspond to the other designated Beneficiaries, who have not been participants or causes of the event.

10. Pilot or be a member of the crew of an aircraft of any class, unless the Insurer has accepted the risk, by issuing the respective annex and the Policyholder has paid the corresponding premium.

11. Injuries due to accidents suffered by the Insured when not traveling as a passenger in any means of transport (air or sea).

12. Carrying out activities, practices, training or competitions of the following high-risk sports: contact sports at a professional level, big game hunting or horseback riding, deep sea fishing, any underwater or nautical sport, coleus and rodeo, mountaineering, boats by rowing or sailing; hang gliding, ultralights, icaros, paragliding, balloons and aerostats, Benji launches or skydiving, karting, motor racing, motorcycling, mountain biking, scooters, water or snow skiing or any other winter sport, use of motor vehicles or animals in any type of competition, unless the Insurer has accepted the risk by issuing the respective annex and the Policyholder has paid the corresponding premium.

13. Injuries when the Insured is serving as a member of any police, fire brigade, or military unit, unless the Insurer has accepted the risk by issuing the respective annex and the Policyholder has paid the corresponding premium.

14. The voluntary ingestion of any poison or medications not prescribed by a doctor.

15. Suicide of the Insured occurring within the first year of validity of the insurance contract. The period of one (1) year will be counted from the date of the start of the contract or its registration in the Policy. If an increase in the Insured Sum has been made, the period of one (1) year will begin to be counted from the date of said increase and the provisions of this section will apply only to the amount of the increase.

16. Active participation of the Insured in fights, provided that it is not in self-defense, disturbances of public order, criminal acts, riots, civil commotion, strike, riots, sabotage, civil war, military, naval or civil uprising, insurrection, rebellion, terrorism, events that occur during the performance of military service, looting, coups d'état, revolution, conspiracy or usurpation of power, martial law or state of siege, or any of the events or causes that determine the proclamation of martial law or state of site.

17. Disappearance of the insured.

18. If you do not comply with any of the obligations established in the general or particular conditions.

19. If not, I will notify the insurer of the known aggravation of risk.

CLAUSE 5. PROCEDURE IN THE EVENT OF AN ACCIDENT

When an incident covered by this policy occurs, the Policyholder, the Insured Party or the Beneficiary will be obliged to:

1. Give written notice to the Insurer within fifteen (15) continuous days following the date of becoming aware of the occurrence of the incident, indicating the existence of any other insurance contract on the same risks covered by this policy.

2. Provide the Insurer within thirty (30) continuous days from the date of notification, the following documents:

In case of Accidental Death and Non-Accidental Death:

a) Claim declaration and report form, which the Insurer has in its offices for this purpose, with all the data specified therein.

b) Original and photocopy of the Insured's identity card.

c) Original and photocopy of the death certificate of the Insured.

d) original and photocopy of the forensic medical certificate (if applicable): “death certificate” stating the cause of death and the ID number with which the body was identified.

e) Original and photocopy of authorization from the judge of the child and adolescent court, naming the person who must withdraw the corresponding benefit, when the Beneficiaries are children or adolescents.

f) Original and photocopy of declaration of sole and universal heirs, if there are no designated Beneficiaries.

g) Original and photocopy of the birth record or identity documents of the Beneficiaries or legal heir(s).

h) Narrative letter of the circumstances of how the accident occurred, indicating place and time, if possible.

i) Original and photocopy of the report from the competent authority that intervened in the accident (if applicable).

j) in cases of disappearance of the Insured, the provisions of the first book “of the people, title XII of those not present and those absent, of the civil code of the Bolivarian Republic of Venezuela.

in case of Disability:

a) Claim declaration and report form, which the Insurer has in its offices for this purpose, with all the data specified therein.

b) Original and photocopy of the treating doctor's report, which states the degree of disability, or type of disability and duration of disability, of the Insured.

in case of Funeral Service:

Claims under this Policy will be processed on the basis of submission of original documents. To process a claim before the Insurer, the Policyholder, the Principal Insured, or the Beneficiary must:

1. Notify the occurrence of the incident through the forms established by the Insurer for this purpose, immediately or at the latest within thirty (30) continuous days following the date on which you become aware of it.

2. Deliver to the Insurer within ten (10) business days following the date of notification and duly completed, the forms available to the Insurer to make the claim or request for service, along with the following documents:

a) Identity card of the Insured.

b) Death certificate of the Insured.

c) Forensic medical certificate (if applicable): "Death certificate" stating the cause of death and the identification number with which the body was identified.

d) Invoice of Expenses for Funeral Service.

If there is a remaining payment for the Beneficiaries:

e) Authorization of the Judge of the Court of the child and adolescent, naming the person who must withdraw the corresponding benefit, when the Beneficiaries are children or adolescents.

f) Declaration of legal heirs, if there are no other designated Beneficiaries.

g) Birth registration or identity documents of the Beneficiaries or legal heir(s).

h) Report from the competent authority that intervened in the Accident (if applicable).

In case of Telemedicine Service:

a) Call the contact center

b) Download the APP, log in and video call.

CLAUSE 6. OTHER DISCLAIMERS OF LIABILITY

The Insurer will not be obliged to pay the benefit in the following cases:

1. When the Policyholder, the Insured or the Beneficiary fails to comply with any of the obligations established in clause 5 (Procedure in the event of a Loss) of these Specific Conditions, to unless the non-compliance is due to an extraneous cause not attributable to the Policyholder, the Insured or the Beneficiary or another that exonerates it from liability.

2. Duels, quarrels or criminal acts committed by the Insured, or the consequences thereof, of which he is the author or participant.

3. Activities carried out in compliance with mandatory military service.

4. Infringement of the current Laws of the Bolivarian Republic of Venezuela or in any other country where they occur, by the Insured, as long as such infringement in itself constitutes a crime or misdemeanor at the time it occurs and is the determining cause of the incident.

5. Injuries as a result of the Insured actively participating in riots, civil commotion, popular unrest, labor unrest and malicious damage.

6. For expenses whose invoices presented do not comply with the requirements of the legislation of each country.

CLAUSE 7. COMPLICITY IN THE ACCIDENT

If a Beneficiary or third parties acting on his behalf intentionally cause the death of the Insured, any designation made in his favor will be null and void. In this case, the compensation that may apply will be payable to the other Beneficiaries who have not participated in the fraudulent act, or to the sole and universal heirs of the Insured.

CLAUSE 8. GEOGRAPHICAL EXTENSION OF THE INSURANCE

The Accidental Death, Total and partial Disability, and Funeral Service benefits granted by this policy are valid anywhere in the world, where the Insured is located, and will proceed under the reimbursement modality when a network of service partners does not operate. The telemedicine service will establish in a special annex the territorial limitations that apply.

CLAUSE 9. PAYMENT OF COMPENSATION

The Insurer will pay the compensation, once all the documentation required by the Insurer for the analysis and settlement of the incident has been received, as follows:

a) In the event of the death of the Primary Insured, the Beneficiary designated by the Primary Insured will be paid; if there are several Beneficiaries, the payment will be made in accordance with the distribution indicated by the latter in the insurance application; If the distribution percentages have not been indicated, it will be understood that it will be equitable. If the designated Beneficiaries die before or simultaneously with the Insured Principal, the part corresponding to them will be distributed, in equal parts, among the remainder and if all have died, it will be paid to the sole and universal heirs of the Insured Principal. If there are no designated Beneficiaries, to the sole and universal heirs of the Insured Holder. The Insurer will pay the Insured Sum, in equal parts, among those who have proven such character, leaving the Insurer exempt from all liability towards the people who present themselves as sole and universal heirs after the payment of the compensation provided for in this policy.

b) In the event of the death of the named beneficiary(s), it will be paid to the sole and universal heirs of the Deceased Insured.

c) In case of disability, the Insured or his/her representative will be paid.

CLAUSE 10. EXPERTISE

If a disagreement arises between the Insured and the Insurer regarding the determination of the amount of compensation that may correspond, in accordance with the contracted coverage, the Insured may undergo the following procedure:

1. Appoint in writing a single expert by mutual agreement between the parties.

2. In case of disagreement regarding the appointment of the sole expert, two (2) experts will be appointed in writing, one for each party, within a period of one (1) calendar month from the day on which one of the two parties has required of the other such designation.

3. In the event that one of the two parties refuses to appoint or fails to appoint the expert within the aforementioned period, the other party will understand that it is withdrawing from the procedure.

4. If the two (2) experts thus appointed do not reach an agreement, the point(s) in disagreement will be submitted to the ruling of a third expert appointed by them, in writing, and his/her assessment will exhaust this procedure.

5. The sole expert, the two (2) experts or the third expert, as the case may be, will decide in what proportion the parties must bear the expenses related to the expert opinion.

The death of any of the two (2) experts, which occurs in the course of the expert opinion operations, will not nullify or diminish the powers, rights or attributions of the surviving expert, likewise, if the sole expert or the third expert dies before the final opinion, the parties or the experts who have appointed him according to the case are empowered to replace him with another.

The sole expert, the two (2) experts or the third expert, as the case may be, must know the matter related to the expert opinion.

The experts must give their ruling in writing within a period of thirty (30) continuous days after accepting the appointment.

For the purposes of this clause, an expert is understood to be a doctor legally authorized to practice the medical profession who must have a specialty recognized by a university legally authorized to grant the title.

The expert opinion procedure provided for in this clause will be mandatory if disagreement arises between the Policyholder, the Insured and the Insurer for setting the amount of the disability percentage.

CLAUSE 12. MEDICAL EXAMINATIONS AND AUTOPSY

The Insurer has the right to subject the Insured to the necessary and reasonable medical examinations and examinations, at the time of evaluation of any claim presented by the Insured, with the expenses arising from such concept being the responsibility of the Insurer.

In the event of the death of the Insured, the Insurer reserves the right to demand an autopsy or exhumation of the body to establish the causes of death, and the Beneficiaries or successors must give their consent and assistance if essential to obtain the corresponding official authorizations. The autopsy or exhumation must be carried out with a summons from the Beneficiaries or successors, who may designate a doctor to represent them. All expenses incurred will be borne by the Insurer, except those derived from the doctor representing the Beneficiaries or successors.

CLAUSE 13. RESPONSIBILITY OF THE COMPANY

The responsibility of the companies limited solely to the payment of medical expenses covered by this contract. In no case will you be liable for the consequences of the acts of the medical or

paramedical personnel involved in the care. The contractor or the Beneficiary or for the services provided by any Hospital, diagnostic or pharmaceutical Institution.

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THE TAKER BY THE INSURER