EUROPEAN COMMISSION
DIRECTORATE GENERAL FOR INTERPRETATION

Interpretation Services Management and Professional Support

European Commission

Call for tenders EC-SCIC/2024/OP/0001

Provision of sickness and accident insurance services for Conference Interpreting Agents (ACIs)

Annex Ib

TENDER SPECIFICATIONS

Part 2: Technical specifications

Purpose of the policy

1. This insurance policy is drawn up between the European Commission and the Insurer[1] to provide collective insurance cover for Conference Interpreting Agents (ACIs, the Insured) recruited by the European Institutions.[2] The policy is designed to offer compensation for potential revenue loss resulting from an accident suffered or illness contracted by the Insured in the course or by the fact of an employment contract signed with the European Institutions. The policy also offers a limited reimbursement of medical expenses for recognised insurance claims.

Definitions

2. Subject to provisions defined in the chapter "Exclusions and limitations" of this document, an "**accident**" means a sudden and unexpected event of external factor that causes physical or mental harm to the Insured and occurs in the course or by the fact of the contract of employment.

3. Subject to provisions defined in the chapter "Exclusions and limitations" of this document, an "**illness**" means a sudden and unexpected deterioration of the Insured's health which is not caused by an accident and occurs in the course or by the fact of the contract of employment.

4. **Incapacity** means a medical condition directly related to an accident or illness falling under this policy, certified by a medical practitioner, and temporarily preventing the Insured from working as an interpreter for the European Institutions.

5. **Invalidity** means a medical condition directly related to an accident falling under this policy and certified by a medical practitioner as being beyond hope of improvement. The extent of invalidity is determined as soon as consolidation of the Insured's condition occurs, i.e. the date from which the condition of an Insured who has suffered an accident is deemed to be stabilised from a medical standpoint. No compensation shall be payable in case of permanent total / partial invalidity unless the claim under that item is lodged within three years of the date of the accident. The Insurer may request a medical examination to determine the right to permanent invalidity.

6. **Total** incapacity is a temporary deterioration of physical or mental capacity of the Insured that prevents them entirely from working as interpreters for the European Institutions and results in uninterrupted absence from work.

   Total invalidity is a permanent deterioration of physical or mental capacity of the Insured that prevents them entirely from working as interpreters for the European Institutions and results in uninterrupted absence from work.

7. **Partial** incapacity is a temporary deterioration of physical or mental capacity of the Insured that prevents them from working full-time as interpreters for the European Institutions.

   Partial invalidity is a permanent deterioration of physical or mental capacity of the Insured that prevents them from working full-time as interpreters for the European Institutions.

   The degree of the permanent **partial** invalidity and temporary **partial** incapacity shall be set in accordance with "European physical and mental disability rating scale for medical purposes"

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1 The winner of the call for tenders EC-SCIC/2024/OP/0001 and signatory of the contract resulting from it.

2 This insurance policy is set pursuant to Article 16 of Convention fixant les conditions de travail et le régime pécuniaire des agents interprètes de conférence recrutés par les institutions de l'Union européenne., referred to as the Agreement. French version of this document prevails over English version.

presented in Annex 7 and the assessment by a medical practitioner chosen by the Insured. For cases not listed in the above-mentioned rating scale, the levels are set by comparison of their severity with the cases listed in the rating scale.

Total loss of voice or hearing (and fingers or hand(s) for sign language interpreters only) caused by an accident or illness shall specifically be regarded as total invalidity or total incapacity.

8. By "**relapse**" is meant any new temporary partial / total incapacity which arises within 365 days after the end of an incapacity previously covered, the cause of which can be traced to the same accident or illness.

9. "**Daily remuneration**" means the daily gross remuneration referred to in article 6 of the Agreement, paid to the Insured by the European Commission on its own behalf or on behalf of the other European Institutions for each day contracted as an ACI. As a guide, the daily gross remuneration on 1 July 2023 was €694.63 for experienced ACIs (category 1 ACIs) and €500.14 for beginners (category 2 ACIs).

   The above rates and compensation payments based thereon are subject to retroactive adjustments, in line with the adjustment of the remuneration of officials and other servants of the European Union. In case of negative adjustment of rates, the Insurer has the possibility to regularise the difference in compensation paid directly to the Insured.

   In case of such adjustments, the Insurer will have 60 days from the notification of the new rates by the European Commission to calculate and execute the payment of the retroactive adjustments due for the benefits already paid. Within the same timeframe, the Insurer will adjust the rate of compensation applied to new claims.

10. The number of "**average remunerated days**" is the Insured's weighted yearly average number of remunerated days over the period of the last 3 rolling years preceding the first day of incapacity. The result is rounded up to the nearest integer.

    For the calculation of the "average remunerated days":

    - a paid contract day is equivalent to 1 remunerated day,
    - a paid flat-rate travel allowance or a flat-rate compensatory allowance is equivalent to 0.5 of a remunerated day,
    - a paid remuneration for days not worked (Article 11 of the Agreement) is equivalent to 0.67 of a remunerated day.

    For the calculation purposes, only those rolling years within the above-mentioned period where the Insured had at least one remunerated day are taken into consideration.

    Regardless of their "average remunerated days" each Insured is guaranteed 21 calendar days of compensation in case of incapacity for the same accident or illness. Any claim covering a timespan equal or below this guaranteed duration and duly attested by medical certificate must be honoured in its entirety unless it can be shown that the claim falls under a situation defined in the exclusions and limitations, as enumerated further in this document.

11. The "**annual remuneration**" is used to calculate the compensation due in case of death and permanent total / partial invalidity. It is equal to the Insured's daily remuneration at the time of the compensation payment multiplied by the Insured's "average remunerated days" respecting the 21 days minimum value.

12. For the purpose of this policy, there is no age restriction to be considered.

Schedule of compensation (referred to as "the schedule")

13. The insurance cover shall be not less than the compensation set out in the following schedule of compensation, subject to the remaining provisions of this policy.

Accidents

(a) Death: a lump sum equal to five times the deceased's "annual remuneration".

(b) Permanent total invalidity: a lump sum equal to eight times the Insured's "annual remuneration".

(c) Permanent partial invalidity: a lump sum equal to a percentage of the amount payable in the event of permanent total invalidity proportionate to the degree of invalidity.

In the event of permanent partial invalidity exceeding 66%, a compensation equal to permanent total invalidity is paid.

(d) Temporary total incapacity: a compensation equal to the Insured's daily remuneration covering every calendar day starting from the first day of incapacity not remunerated by the Institutions. The maximum number of incapacity days compensated for the same accident corresponds to the number of the Insured's "average remunerated days" with the first 21 days of compensation guaranteed for each Insured.

After 60 days of compensation, the compensation due for each additional day of total incapacity will be reduced by 50%.

(e) Temporary partial incapacity: a compensation equal to a percentage of the amount payable in the event of temporary total incapacity proportionate to the degree of incapacity, in accordance with the scale in Annex 7. The maximum number of incapacity days compensated for the same accident corresponds to the number of the Insured's "average remunerated days" with the first 21 days of compensation guaranteed for each Insured.

After 60 days of compensation, the compensation due for each additional day of partial incapacity will be reduced by 50%.

(f) Accident related relapse: total / partial incapacity directly related to a prior covered accident: the continuation of the compensation scheme as under (d) or (e) above.

Illness

(g) Death: a lump sum equal to five times the deceased's "annual remuneration".

(h) Temporary total incapacity: a compensation equal to the Insured's daily remuneration covering every calendar day starting from the third day of incapacity not remunerated by the Institutions. The maximum number of incapacity days compensated for the same illness corresponds to the number of the Insured's "average remunerated days" with the first 21 days of compensation guaranteed for each Insured.

After 60 days of compensation, the compensation due for each additional day of total incapacity will be reduced by 50%.

(i) Temporary partial incapacity: a compensation equal to a percentage of the amount payable in the event of temporary total incapacity proportionate to the degree of incapacity, in accordance with the scale in Annex 7. The maximum number of incapacity days compensated for the same illness corresponds to the number of the Insured's "average remunerated days" with the first 21 days of compensation guaranteed for each Insured.

After 60 days of compensation, the compensation due for each additional day of partial incapacity will be reduced by 50%.

(j) Illness related relapse: total / partial incapacity related to a prior covered illness: the continuation of the compensation scheme as under (h) or (i) above.

Reimbursement of medical expenses

(k) Reimbursement of medical expenditure by an Insured up to a maximum of €50,000 in respect of a single accident, illness or relapse.

The Insured can claim reimbursement of medical expenses only if entitled to one of the forms of compensation referred to in (a) to (j) above, including admissible claims for illness lasting less than 2 days waiting period.

Reimbursement of medical expenses can for example also include:

- Hospitalisation, convalescence expenses and home care,
- Travel expenses necessarily incurred in obtaining proper treatment (with exception of repatriation costs for Insured on non-local contracts[3]),
- Orthopaedic and surgical appliances,
- Dental and optical services.

As regards reimbursement of medical expenses, any amount payable to the Insured, in respect of the same occurrence, under a social security scheme or under insurance policies taken out by other organisations or undertakings to which the Insured supplies services shall be deducted from the compensation payable under the policy. The reimbursements obtained under a private supplementary sickness insurance scheme covering that part of the expenditure which is not reimbursable by this insurance scheme should be exempted from the above rule.

If the Insurer considers certain medical expenses to be abnormally high, he may refer to the Medical Committee provided in the Disputes section of this policy. In this case, the expenses incurred in connection with the proceedings of the Medical Committee shall be borne exclusively by the Insurer.

[3] Repatriation costs for ACIs with non-local contract can be claimed under the travel assistance insurance which is separate from this policy.

Period of the insurance cover and its extent

14. ACIs shall be insured from 00:00 hours to 24:00 hours on the days:

    a) they are under contract to supply services to the European Institutions;
    b) for which a flat-rate travel allowance (Article 7 of the Agreement) or a flat-rate compensatory allowance (Article 7bis of the Agreement) is paid or to be paid;
    c) for which a remuneration for days not worked (Article 11 of the Agreement) is paid or to be paid;
    d) for which they can present a proof of (partial) travel to and from the place of assignment in line with the requirements of the service;
    e) on which, for reasons of service, they are obliged, on days other than those referred to under points (a), (b), (c) and (d) above, to remain away from their domicile because of the requirements of their contract.

15. The Insured covered by this policy are free to choose their medical practitioners and hospitals or clinics.

16. The policy shall apply to accidents whether fatal or non-fatal and to illness directly or indirectly caused by natural disasters, strikes, riots, insurrections, revolutions, civil wars, international wars, movements of national or foreign troops or acts of terrorism, unless it be proved that the Insured has voluntarily taken an active part in such events other than by way of legitimate defence.

17. In the event of temporary incapacity the total gross amount paid in compensation plus any other sums which the Insured may receive as daily remuneration, flat rate allowances (Article 7 and 7bis of the Agreement), remuneration for days not worked (Article 11 of the Agreement) or any allowance due to the requirements of the contract from the European Institutions or as payment or benefit under any other social security or insurance schemes, shall not exceed the daily gross remuneration, including all allowances the Insured would be normally entitled to; otherwise the compensation due shall be reduced accordingly.

18. The cumulative amount of compensation paid in respect of the consequences of a single accident or illness under different items of the schedule shall not exceed eight times the Insured's "annual remuneration" or the equivalent of 21 days of the minimum guaranteed compensation, whichever amount is higher, plus the reimbursement of medical expenses (item 13(k) of the schedule).

19. The maximum intervention per event which gives rise to claims by 5 or more Insured is limited to €60,000,000.

Exclusions and limitations

20. The policy does not foresee any other exclusions and limitations than the ones listed below.

21. The policy does not cover any accident or illness directly or indirectly caused by or traceable to:

    - the Insured's risky conduct or an inadequate standard of behaviour. Conduct is tested against what a reasonable person in the position of the Insured would have foreseen and what they could have done to avoid the damaging consequences.
    - inherently dangerous behaviour unrelated and unnecessary to the normal exercise of the contract of employment.

    The following events are nonetheless considered accidents:

    - acoustics shocks and traumas sustained while working for the European Institutions;
    - bodily or mental injuries sustained in an emergency or in self-defence or when saving human life;
    - acute poisoning caused by the sudden and involuntary inhaling of gases, vapours, liquid or solid substances, other than prescribed medicines, or known allergens;
    - the involuntary and sudden intake of substances or objects in the digestive system, respiratory system, the eyes or the ears, causing internal injury;
    - infections, sicknesses and injuries and any other consequences of the bites or stings of animals or insects;
    - sprains, tears, lacerations and ruptures of muscles and tendons caused by normal physical effort.

22. No compensation will be paid under this policy if the incapacity, invalidity or death arises from any of the following:

    - a medical condition that exists prior to the period of the Insured's cover (as defined in article 14 above) and of which the Insured could have been aware, for example because the symptoms of the condition had already manifested themselves or the condition was already diagnosed, tested or treated. For illnesses where a clear start date cannot be determined, a possible start date of the illness should not be determined only by the diagnosis date.
    - a condition that is not medically diagnosable;
    - a complication to the pregnancy, childbirth or abortion procedure other than originating from an accident or an illness covered by the policy;
    - elective procedures deemed not necessary from the medical point of view, such as aesthetic or similar treatments.

23. Injuries to limbs or organs that were already disabled prior to the accident shall be compensated solely as to the difference between the condition prior to and following the accident.

    The assessment of injuries to a limb or organ shall not be influenced by the prior disablement of another limb or organ. If several limbs or organs are affected by the same accident, the level of disability shall be aggregated, without exceeding 100%.

Claim processing and deadlines

24. A claim in respect of temporary incapacity shall be supported by a medical certificate attesting full / partial incapacity to work.

25. The Insured shall send the medical certificate concerning the incapacity to work to the Insurer within 5 calendar days from the day following the occurrence of the accident or manifestation of the illness. The same deadline shall be valid in case of a relapse and extension of the incapacity period. The postmark, e-mail date or the automatic acknowledgement of receipt in case of online upload will act as proof of submission.

26. To assess the admissibility of the claim, apart from the medical certificate, the Insurer may request the Insured to supply any other certificates and proofs which he may reasonably require. This additional medical information should be limited to information provided by the doctor who issued the medical certificate or the Insured's general practitioner.

    The Insurer may, at his own expense, require the Insured to undergo a medical examination or, in the event of death, arrange for a post-mortem examination to be carried out to obtain extra medical information needed for the handling of the claim.

27. The Insurer may reduce the incapacity period indicated on the medical certificate presented by the Insured only for those admissible cases which last longer than the "guaranteed compensation period" and are justified by an external medical examination organised and paid for by the Insurer.

28. Falsified declarations made by the Insured or their beneficiaries regarding the accident / illness or its consequences may result in forfeiture of the claim as a whole, including elements which may have been legitimately due.

29. The time limits for the submission of claims to the Insurer are:

    - Compensation for loss of earnings arising from an accident (article 13(d) to 13(f) of the schedule) or illness (article 13(h) to 13(j) of the schedule): 3 months as from the start of illness / accident.
    - Reimbursement of medical expenses (article 13(k) of the schedule): 18 months as from the last date of treatment but no later than 36 months after the end of the policy.
    - Total/partial invalidity following accident (article 13(b) and 13(c) of the schedule): 3 years after the date of occurrence of the accident.
    - Death following accident (article 13(a) of the schedule) or illness (article 13(g) of the schedule): 3 years after the decease of the Insured.

30. Claims relating to temporary incapacity arising from accidents or illnesses (article 13(d) to 13(f) and 13(h) to 13(j) of the schedule) should be handled by the Insurer and the decision transmitted to the Insured within one month of receipt of the complete claim. A complete claim consists of medical certificate and a claim form.

    The one-month period can be prolonged by another month when an external medical examination is requested by the Insurer.

31. For claims relating to permanent total/partial invalidity arising from accidents (article 13(b) and 13(c) of the schedule) the Insurer should send a settlement proposal to the Insured within one month of receipt of the Insured filling for invalidity compensation. If the Insurer is not able to send the settlement proposal within the time specified above, it will inform the Insured about the precise reasons for the delay and the deadline will be extended by one month.

32. For claims relating to death following accident or illness (article 13(a) and 13(g) of the schedule), the Insurer should send a settlement proposal to the Insured's beneficiaries within one month of receipt of the death certificate. If the Insurer is not able to send the settlement

proposal within the time specified above, it will inform the Insured's beneficiaries about the precise reasons for the delay and the deadline will be extended by one month.

33. Claims relating to reimbursement of medical expenses (article 13(k) of the schedule) should be handled by the Insurer and the decision transmitted to the Insured within one month of receipt of the supporting documents.

34. The Insurer shall not be held liable for delays caused by the Insured / the Insured's beneficiaries to deliver the documents or information required.

35. Payments are to be made within 14 calendar days of the Insurer's decision / the acceptance date of the settlement proposal.

    The Insurer shall pay compensation directly to the Insured or, in the event of death (item 13(a) and 13(g) of the above schedule), shall pay the lump sum in accordance with the law of succession applicable.

    In the event of an uninterrupted period of temporary incapacity, provisional payments to the Insured (compensation and reimbursement of medical expenses) shall be made every four weeks, provided a medical certificate attests that the incapacity will continue beyond the four-week period.

    Any sum overpaid can be recovered. The request for recovery must be made no later than five years from the date on which the sum was paid. Where the Insurer is able to establish that the Insured deliberately misled the Insurer with a view of obtaining the sum concerned, the request for recovery shall not be invalidated even if this period has elapsed.

36. Any tax liability or other consequences resulting from a compensation or reimbursement paid under this policy are the sole responsibility of and are borne entirely by the Insured. Upon request and up to 48 months from the payment date, the Insurer will provide a statement confirming the amounts paid to the Insured for the requested fiscal year.

37. Upon written request and within 30 days from the receipt of the payment, the Insured is entitled to interest on late payment at the rate applied by the European Central Bank for its main refinancing operations in Euros (the reference rate), plus eight points. The reference rate shall be the rate in force on the first day of the month in which the payment period ends, as published in the C series of the Official Journal of the European Union.

    Interest on late payment shall cover the period running from the day following the due date for payment up to and including the date of actual payment.

Optional insurance cover

38. The Insurer will offer the Insured an optional scheme to provide coverage for days where the Insured do not fall under the criteria of article 14.

    The premium occasioned by this optional scheme will be disbursed by the Insured directly to the Insurer. The Insurer must provide for accounting procedures intended to prevent a premium from being paid twice, i.e. both by the European Commission and by the Insured, in respect of days on which an interpreter who has taken out optional insurance is also covered under article 14 above.

    The Insurer will determine the terms and conditions of this complimentary scheme; however, the scheme must be open to all ACIs.

Law applicable

39. The law applicable to the policy shall be that of the Kingdom of Belgium.

40. The Insured's rights of action against third parties liable shall vest in the Insurer up to the amount of payments made to him by the Insurer. The Insurer shall renounce all claims against the European Institutions, its officials and servants and against the members of the Insured's family, household and staff. If the Insured is partially indemnified under the present scheme, they have priority in the recovery against the liable third party.

    The Insured shall provide the Insurer with any information or evidence available to them, to enable the Insurer, where appropriate, to take action against the third party responsible, and give the Insurer all assistance necessary to this end.

Disputes

41. Any Insurer's decision of a medical nature can be referred, within a period of 60 calendar days from the notification of the decision, by the Insured or those entitled under them to a Medical Committee. The request for the matter to be referred to the Medical Committee shall contain the name of the doctor representing the Insured or those entitled under them together with a report from that doctor setting out the medical issues disputed in relation to the Insurer's decision.

42. The Medical Committee shall consist of three doctors:

    - one appointed by the Insured or those entitled under them as indicated in the request;
    - one appointed by the Insurer;
    - one appointed by agreement between the first two doctors.

    The Insurer shall designate its doctor within three weeks of the Insured filing the request for referral to the Medical Committee. The first two doctors shall, within three weeks, designate a third doctor who has no past or present connection with either party.

    Where agreement cannot be reached on the appointment of the third doctor within a period of two months following the appointment of the second doctor, the relevant Belgian Court shall appoint the third doctor at the request of either party. Irrespective of the method of appointment, the third doctor shall have expertise in assessing and treating bodily injury.

43. Once the Medical Committee has been established, it shall have twelve weeks within which to settle the dispute according to the procedures which it considers to be most appropriate. It shall cover medical matters raised by the report from the doctor representing the Insured or those entitled under him and other relevant medical reports.

    The Insurer shall inform the Insured or those entitled under them of the fees and expenses which are liable to be borne by them. The Insured or those entitled under them may not object to the third doctor on account of the amount of the fees and expenses requested. However, the Insured or those entitled under him shall be free at all times to discontinue the procedure for referral to the Medical Committee. In that case, the fees and expenses of the doctor chosen by the Insured or those entitled under them and half of the fee and expenses of the third doctor, shall be borne by the Insured or those entitled under them in respect of the part of the work that has been completed. The Insured or those entitled under them shall remain liable for fees agreed with the doctor appointed by them irrespective of what the Insurer agrees to pay.

44. The Medical Committee shall examine collectively all the available documents liable to be of use to it in its assessment and all decisions shall be taken by majority vote. The Medical Committee shall be responsible for deciding on and adopting its own rules of procedure. The third doctor shall be responsible for providing the secretariat and drafting the report. The Medical Committee may request additional examinations and consult experts in order to

complete its work or obtain opinions which are necessary for carrying out its task. The Medical Committee may deliver medical opinions only on the facts submitted to it for examination.

If the Medical Committee, whose task is limited to the purely medical aspects of the case, considers that the latter may entail a legal dispute, it shall declare that such a dispute is beyond its remit. On completing its proceedings, the Medical Committee shall set out its opinion in a report to the Insurer and the Insured and those entitled under him. On the basis of that report, the Insurer shall notify the Insured or those entitled under them of its decision together with the findings of the Medical Committee.

45. Expenses incurred in connection with the proceedings of the Medical Committee shall be borne equally by both parties with the exception of costs for additional examinations and experts called by the Medical Committee that shall be borne by the Insurer according to the normal reimbursement rules under this policy. The Insured or those entitled under them shall pay the fees and incidental expenses of the doctor chosen by them and half of the fee and incidental expenses of the third doctor.