General terms and conditions

Dental Insurance with Reimbursement Claims

Index.

Legal information about Insurer -P.3

Definitions -P.3

Article 1. Purpose -P.4

Article 2. Insurance cover -P.4

2.1. Dental services -P.4

2.2. Emergency dental care -P.4

Article 3. Waiting periods and pre-existing conditions -P.4

Article 4. Exclusions -P.4

Article 5. The Insurance Contract -P.5

5.1. Documentation and formalization of the insurance contract and duty to provide information -P.5

5.2. Conditions for inclusion in the insurance -P.5

5.3. Duration of the contract -P.5

5.4. Subrogation -P.6

5.5. Limitation of legal action -P.6

5.6. Communications -P.6

Article 6. Duties and Obligations of the Insured -P.6

6.1. Premiums -P.6

6.2. Payment of benefits -P.7

6.3. Collaboration in processing -P.7

6.4. Taxes and surcharges -P.7

Article 7. Obligations of the Insurer -P.8

7.1. Provision of Cover -P.8

7.2. Information to the Policyholder -P.8

7.3. Personal Data Protection -P.8

Article 8. Complaints -P.9

8.1. Arbitration -P.9

8.2. Competent Jurisdiction -P.9

Article 9. Express Acceptance. Acknowledgement of receipt of information -P.9

General terms and conditions

Dental Insurance with Reimbursement Claims

Legal information about the Insurer

Cigna Life Insurance Company of Europe, SA/NV, Sucursal en España, with its registered office in Pozuelo de Alarcón (28223 Madrid) at Parque Empresarial La Finca, Paseo del Club Deportivo I, Edificio I4, Planta Primera (hereinafter Cigna Healthcare).

Entered on the Madrid Companies Registry in Volume 809, Sheet 205, Section 8, Page M III84; Tax ID No. W-0021205J.

Registered with the Directorate-General for Insurance and Pension Funds under number E0133. Cigna Life Insurance Company of Europe, SA/NV, Sucursal en España is the Spanish branch of Cigna Life Insurance Company of Europe, SA/NV, a privately-held limited liability company incorporated under Belgian law with its registered office in Belgium at Plantin en Moretuslei 309, 2140 Amberes. This entity is subject to the oversight of the National Bank of Belgium and it is also subject to the said regulator, as an insurance entity operating in Spain under the regime for the right to establishment, for matters relating to liquidation.

The oversight authority over the insurance activity in Spain is vested in the Directorate-General for Insurance and Pension Funds pertaining to the Ministry of Economic Affairs and Digital Transformation.

The present General Conditions shall be applicable to all Outpatient Health Insurance contracts, without prejudice to the applicable Particular Conditions and Special Conditions, if any. In the event of any discrepancy between the General, Particular and Special Conditions, the applicable Special Conditions shall prevail over the Particular Conditions, and the latter over the General Conditions.

Definitions

For the purposes of the present Dental Insurance with Reimbursement Claims contract, the following definitions shall apply:

- **Insured.** The natural person resident in Spain to whom the rights deriving out of the contract correspond and who, in the absence of the Policyholder, personally assumes the obligations arising out of the present contract.
- **Dependent Insured.** Spouse or Life Partner of the Main Insured, and/or the children of the Main Insured or of the Spouse or Life Partner.
- **Main Insured.** The Insured party personally assuming the obligations of the policy in the absence of the Policyholder.
- **Waiting Period.** Period of time counted from the date that cover under the Policy begins during which certain items of cover are not effective.
- **Dependent Family Members.** For the purposes ofthe Policy, dependent family members mean:
  a. The Main Member's spouse or life partner with an analogous emotional relationship (not separated de Jacto or legally).
  b. The children of the Main Member or of his or her spouse or life partner with an analogous emotional relationship, regardless of family ties.
- **Physician.** Doctor, graduate or holder of a master's diploma in medicine legally qualified and authorized to treat Illnesses or Lesions medically or surgically in the place where he or she is practising.
- **Stomatologist.** Person who has a PhD, undergraduate degree or master's degree in medicine, who is legally qualified and licensed, and is a Specialist in the study of the mouth and the treatment of its ailments.
- **Odontologist.** Specialist in the study of teeth and the treatment of their ailments, who is legally qualified and licensed.
- **Policy.** This is the insurance contract. It is a document containing the conditions regulating the insurance contract and comprises the General Conditions, the Particular Conditions and the Special Conditions, the insurance application form and the Health Questionnaire, as well as the supplements, appendices or riders issued.

- **Premium.** Price of the insurance. It will include the taxes and surcharges that are legally applicable. The insurance premium is annual, even when their payment is split into instalments.
- **Healthcare professional.** A licensed professional with skills and knowledge specific for the care of people's health, organized by means of official professional associations and holding the corresponding official qualification expressly empowering them to do so.
- **Claim.** Any event that has consequences requiring the provision of medical assistance, which costs are covered, in whole or in part, by the Policy.
- **Sum insured.** The maximum limit of the compensation to be paid by the Insurer in each case. The amount of the Sum Insured for each guarantee contracted will be reflected in the Special Conditions (Plan) of the policy.
- **Policyholder.** The natural or legal person contracting the insurance on their own account or on behalf of others and who is responsible for the obligations and duties arising therefrom, except for those that, by their nature, must be fulfilled by the Insured. If the Policyholder is also the Insured, he or she will be considered to be the Main Insured.
- **Emergency.** Fortuitous appearance (unforeseen or unexpected), in any place or activity, of a health problem of diverse cause and variable severity, which generates the awareness of an imminent need for attention of the Insured who suffers it in such a way that the absence of Health Care Assistance by the Insurer, at that moment, places the life of the Insured or the function of any organ in immediate danger.This assistance may be rendered either at the Insured's home or in a Hospital or Healthcare Centre equipped with an emergency service.

Article 1. Purpose

Within the limits and under the conditions stipulated in these General Conditions, and upon payment of the corresponding premium, the Insurer undertakes to cover the expenses, in the manner indicated in Article 2 of these General Conditions, arising from the dental services required and included in the covers stipulated in Article 2 of these General Conditions.

Article 2. Insurance cover

The coverage referred to in this insurance will be provided while this policy is in force in the manner established in the following subsections:

2.1. Reimbursement claims in Spain

Under the reimbursement option, the Member may seek assistance at any dentist or Dental Clinics in Spain. In such case, the Member will be reimbursed by the Insurer for bills paid by the Member for dental services received, according to the limits established in the Particular Conditions ofthe Policy.

2.2. Coverage outside of Spain

With the conditions and limitations established in this subsection 2.2 and in the rest ofthese general terms and conditions, this insurance covers 50% of expenses for dental care received by the Member outside of Spain [for the] temporary alleviation of acute pain or bleeding or acute infections (without constituting a definitive cure), providing that immediate assistance is necessary and this situation has been certified by a physician. The present coverage has **a limit for reimbursement of thirty euros (€30) per bill, and never more than one case within a period of three consecutive months.**

Once the transitional situation requiring the present coverage has passed, the Member will no longer be [covered] by the same, and curative treatment will be covered under the terms and conditions established in subsection 2.1 of these General Terms and Conditions, provided that care is received in Spain.

Likewise, the present coverage excludes fillings, root canal treatments, and crowns. Any expense accruing due to dental services received by the Member outside of Spain in excess of the economic or frequency limits indicated will not be reimbursed to the Member.

Article 3. Waiting periods and pre-existing conditions

a. No waiting periods are established in this Policy and its coverage will, therefore, take effect as soon as the first Premium has been paid.

b. This Policy guarantees coverage of dental condítions existing pnor to the moment insurance is purchased.

Article 4. Exclusions

The following are excluded from coverage under the insurance:

c) Pharmacological products and products intended for dental prophylaxis, such as toothbrushes, toothpaste, dental floss, and any other items with similar characteristics.

d) Treatments or procedures not expressly contemplated in the Terms and Conditions of the Policy.

e) Illnesses and accidents occurring due to war, whether civil or international, operations of a similar nature, political or social events, acts of terrorism, earthquakes, volcanic eruptions, flooding and other extraordinary seismic or meteorological phenomena.

f) Nuclear risks.

References to the insurance contract act.

Article 5. The Insurance Contract

5.I. Documentation and Formalization of the Insurance Contract and Duty to provide information

Prior to the conclusion of the contract, the Policyholder is under the OBLIGATION to declare to the Insurer, in accordance with the questionnaire submitted by the latter, all of the circumstances known to the Insured that might have an influence on the Insurer's assessment of the risk.

Bearing the foregoing obligation in mind, the present Policy has been arranged on the basis of the declarations made by the Policyholder and/or by the Insured on the Subscription Document or Insurance Application Form, on the Health Questionnaire, and on any other means for the transmission of information admitted by Cigna Healthcare and accepted by the Insured, expressly including electronic and telephonic contracting. The said declarations constitute the fundamental obligation of the Policyholder and/or the Insured regarding the declaration of the risk, especially the Health Questionnaire, and they therefore constitute an essential element of the contract and the basis for its formalization.

The Policyholder has the duty and the obligation to sign each and every one of the documents making up the Policy and to deliver a signed copy thereof to the Insurer.

The insurance shall become effective after the Policy is signed and the corresponding Premium paid.

Should the contents of the Policy differ from the insurance proposal or from the clauses agreed, the Policyholder may require the Insurer to remedy the divergence identified within the term of one month counted from the delivery of the Policy. Once this term has elapsed without any complaint having been made, the parties shall abide by the provisions contained in the Policy.

Once the contract has been formalized and during the course of the same, the Policyholder and/or the Insured must notify the Insurer, as promptly as possible, of any alteration in the factors and circumstances declared at the moment the Policy was contracted that might aggravate the risk and are of such a nature that, had they been known to the latter at the moment the contract was concluded, it would not have entered into it or would have done so on more onerous conditions.

In no case shall any variation in the circumstances regarding the state of the Insured's health be considered an aggravation of the risk and therefore need not be notified to the Insurer.

5.2. Conditions for Inclusion in the insurance

It will not be possible for persons aged 64 or over to enroll, or such other age, if any, specified in the Particular or Special Conditions.

The Insurer and the Policyholder may agree on additional inclusion criteria, which will be reflected in the Particular Conditions.

The Insurer reserves the right to reject inclusion in the insurance or to limit or exclude any of the coverage therein on the basis of disclosures made in any document fumished for that purpose and of the medica! examination, if any.

For the purposes of this contract, any Member who remains in Spanish territory for more than l83 consecutive days is considered to be resident in Spain.

Whenever it is so expressly stated in the Particular Conditions of this contract, coverage will extend to the Member's Dependent Family Members.

The Policyholder represents the Members for all matters arising out of the contents of the Policy. The Policyholder undertakes to provide adequate information about any notices received in connection with this contract to all Members covered under this Policy from time to time.

The Policyholder is responsible for the obligations derived from the contract, except those that, by their nature or through express provisions of this Policy, must be fulfilled by the Members.

When the Insurance is arranged with a contribution by the Members towards the cost, the Policyholder undertakes to provide full payment of the whole amount, without the possibility of alleging to the Insurer any exception whatsoever due to the absence of the aforesaid contribution.

5.3. Duration of the Contract

The insurance cover is stipulated for the period of time foreseen in the Particular Conditions and, on its expiry, it will be deemed to have been automatically extended for the term of one year and so on thereafter on the expiry of the annual period under way.

Both the Policyholder and the Insurer may oppose the extension of the contract by means of written notification sent to the other party at least one month in advance of the conclusion of the cover in the initial period or the annual extension when the party opposing the extension is the Policyholder, and two months when it is the Insurer.

5.4. Subrogation

The Insurer, once the Healthcare Assistance referred to in the present contract has been provided, shall be able to exercise any and all rights and actions that, in connection with the Illness or Accident, might correspond to the Insured against the persons responsible for the same or the public bodies or other entities that may have a legal or regulatory obligation to cover the same pursuant to any compulsory or voluntary insurance up to the limit of the cost for the Healthcare Assistance provided.

This subrogation right shall not be exercised against the spouse of the Insured nor against any other relatives to the third degree of consanguinity, any adoptive parent or adopted child living with the Insured in question. This exception shall have no effect if the liability stems from criminal intent, or if the responsibility is covered under an insurance contract. In this latter case, the subrogation shall be limited in scope in accordance with the terms of the said contract.

In the event where the Insurer and the Insured act jointly against the third party with liability, any collection obtained will be distributed among them in proportion to their respective interest.

5.5. Limitation of legal action

Any lawsuits arising out of this contract shall be time-barred after five years from the moment when they could have been exercised.

5.6. Communications

All communications will be addressed by the Policyholder/ Insured to the Insurer at its registered office, or at any of its offices or another remote electronic address expressly designated by the Insurer for certain communications, provided that this is expressly stated.

Communications of the Insurer to the Policyholder and, if any, to the Insured, shall be made at the address of the latter indicated in the policy and/or email address or other remote electronic means, whenever this is compatible with the content and format of the communication.

Communications effected by an insurance broker or brokerage office to the Insurer on behalf of the Policyholder or the Insured shall have the same effects as if they had been made by the Policyholder in person, except as otherwise indicated by the same. In all cases, the express consent of the Policyholder will be required for the subscription of a new contract or to amend or rescind the insurance contract in force.

Nonetheless, communications made by the Policyholder or the Insured to the insurance broker or brokerage office are not deemed to have been made to the Insurer until they have been received by the latter.

Communications made by the Policyholder or Insured to an insurance agent of the Insurer shall have the same effects as if they had been made directly to the latter.

The Insurer shall obtain the Policyholder's and/or Insured's consent to record the telephone conversations held in connection with the present Policy and to use the same in its quality assurance processes, and, when pertinent, as evidence for any dispute that may arise between the parties, at all events preserving the confidentiality of the conversations.

Those communications made in writing that have been refused, those sent by registered mail and not collected from the Post Office, and those that do not reach their destination because of a change of address that has not been indisputably notified to the Insurer shall have identical effects as those communications received. This also applies in case of change of the place or means of communication established in the Policy that has not been notified to the Insurer.

Article 6. Duties and Obligations of the Insured

6.1. Premiums

The Policyholder shall pay the Insurer the Premium in the manner and on the dates specified in the Particular Conditions to this Policy. If payment by instalments is arranged for the annual Premium, the Policyholder shall be obliged to pay the first instalment at the moment the contract is concluded. Subsequent Premiums must be paid on their corresponding maturities. Payment by instalments of the Premium shall not release the Policyholder from the obligation to pay the full amount of the Premium.

If the first Premium is not paid due to the fault of the Policyholder, or if the Sole Premium is not paid on its maturity, the Insurer is entitled to resolve the contract or to demand payment of the Premium due through forced recovery on the basis of the Policy. If the Premium has not been paid before the Claim arises, the Insurer will be released from its obligation.

In the event of any non-payment of one of the subsequent Premiums, or of any of the instalments if payment of the Premium by instalments has been arranged, then cover by the Insurer shall be suspended one month after the date of maturity. If the Insurer has not claimed payment within the six months following the maturity of the Premium, the contract will be understood to have been extinguished. In any case, when the contract is suspended, the Insurer may only demand payment of the Premium for the ongoing period and it shall be entitled to the fraction of premium for the time during which the cover was suspended.

If the contract has not been resolved or extinguished pursuant to the preceding paragraphs, the cover shall once more be effective from midnight on the date the Policyholder paid the Premium (or the pending instalment(s)).

The Insurer, giving two months' notice to the Policyholder prior to the termination of the ongoing period, may alter the Premiums annually on the basis of the technical and actuarial calculations necessary to determine the impact of the following concepts on the financial and actuarial scheme of the insurance: the increase in the cost of the healthcare services, the increased frequency of the benefits covered by the Policy, the increase in the loss rate, the incorporation into the cover guaranteed of technological innovations emerging or being used after the execution of the contract, or other events with similar consequences.

The Policyholder may opt between the extension of the insurance contract with the new Premiums established by the Insurer for the following annual period, or its extinction on the maturity of the annual period under way. In this case, the Policyholder must notify the Insurer of the decision not to extend the contract giving at least one month's notice prior to the date of the Policy's maturity.

6.2. Payment of benefits.

With regard to the dental procedures referred to in paragraph 2.2 of the General Terms and Conditions, Members shall assume payment of any and all expenses arising out of dental procedures performed on them. Expenses shall be reimbursed by Cigna Healthcare up to the amounts set out in said paragraph 2.2 of the General Terms and Conditions, once eligibility has been verified.

Policyholders/Members must submit their claims to Insurer within seven days of first having a cure performed or receiving care. Any and all supplementary information requested by Insurer shall be submitted by Policyholder/Member within no more than 60 days.

Benefits shall be paid in Spain, in Spanish currency in every case, at the exchange rate that is in force on the date the claim is settled, provided that the benefit concerned is covered as emergency care under the Plan and care has been given outside of Spain.

Claim forms shall be completed and signed by the provider. Failing to meet this obligation shall entitle Insurer to claim any damages caused as a result. This shall not apply if evidence is given that Insurer has been otherwise informed of the claim. Any and all supplementary information requested by Insurer shall be submitted by Policyholder/Member within no more than 60 days.

Policyholder shall return to Insurer all ID cards within no more than 24 hours of the date Member ceases to be covered. If Policyholder fails to fulfill this obligation, Policyholder shall be responsible for any and all expenses incurred by Member for services rendered received within the Cigna Healthcare Dental Network.

6.3. Collaboration in processing

In the event of a Claim covered by this insurance contract, the Policyholder and/or the Insured will be obliged to cooperate with the Insurer to reduce all the consequences of the same, as well as to communicate immediately to the Insurer the occurrence, circumstances and possible consequences of the Claim.

The Insured, any relatives or successors in title musts allow the visit of the Insurer's Physicians, as well as any verification or confirmation that the Insurer may consider necessary for the verification of the Claim, authorizing the delivery to the Insurer of any and all documents related to the cover under the Policy that may be requested.

All complementary information requested by the Insurer to verify the Claim must be sent by the Policyholder or the Insured within the maximum term of sixty (60) days from the occurrence of the Claim.

Together with notification of the Claim, the Policyholder or the Insured must send the Insurer the medical report specifying the diagnosis and nature of the Illness when so required by the Insurer. Documents will be submitted in the manner and with the contents requested by the Insurer.

In addition, the Insured must faithfully observe all the prescriptions of the Physician in charge of curing the condition and must give the Insurer all kinds of information about the circumstances or consequences of the Claim.

Any failure to comply with these obligations will give rise to the possibility for the Insurer to claim back any damages suffered. Should any criminal intent or serious blame attach to the Policyholder and/or Insured, the Insurer shall be released from its obligation to provide compensation.

6.4. Taxes and Surcharges

All taxes and surcharges that may legally be passed on and must be paid in connection with this contract, whether at present or in future, shall be for the account of the Policyholder or the Insured.

Article 7. Obligations of the Insurer

7.1. Provision of Cover

Under this type of cover, the Member may request the dental services covered in their Policy from the Dentists or Dental Clinics of their choice. The Insurer shall reimburse the Member for the bills paid by them, in the percentage and with the limits and conditions established in the General Conditions, in the Specific Conditions and in the Special Conditions, appendices, supplements and annexes of this Policy, where applicable. The Member must necessarily send the Insurer the original invoice for the fees paid in order to determine the amount of the reimbursement, fill in the reimbursement request form prepared by the Insurer for this purpose and, where appropriate, provide any additional information that may be required to verify the Claim and/or the Health Care provided. In this case, the Policyholder or the Member must notify the Insurer of the Loss within a maximum period of seven (7) days from the date of the first Medical Assistance. The notification of the Claim must be completed and signed by the Dentist who attended the Member. In the event of non-compliance with this obligation, the Insurer may claim for damages caused by failure to declare. This effect shall not be produced if it is proven that the Insurer has had knowledge of the event by another means.

7.2. Information to the Policyholder

Pursuant to the provisions contained in the Insurance and Reinsurance Entities (Organization, Oversight and Solvency) Act (Act 20/2015) and the Royal Decree 1060/2015, dated November 20th, 2015, on the Organization, Oversight and Solvency of Insurance and Reinsurance Entities, the Insurer provides the following information, in addition to that already contained in the rest of the Policy:

a) **The law applicable to this insurance contract** is the Insurance Contract Act 50/1980, dated October 8th, 1980, and the Insurance and Reinsurance Entities (Organization, Oversight and Solvency) Act 20/2015, dated July 14th, 2015, as well as the regulations developing the same.

b) **When the contract has been entered into using any remote contracting technique,** and, in accordance with the provisions contained in Act 22/2007, dated July 11th, 2007, on the remote marketing of financial services targeting consumers, the Policyholders shall be able to cancel the present insurance unilaterally, without needing to indicate the reasons and without any penalty whatsoever, within the term of thirty (30) days from the date the insurance was entered into or the receipt by the Policyholder of the contractual terms and conditions and the compulsory prior information foreseen in the aforesaid Act, if this is received after the conclusion of the insurance.

   In order to exercise this right, Policyholders shall send the corresponding notification addressed to the Insurer, using any lasting medium accessible to the Insurer. Policyholders may submit the said notification using electronic means, provided that measures are in place to guarantee the integrity, authenticity and absence of tampering of the notification and enabling the date of the sending and receipt of the same to be confirmed. Coverage of the risk shall cease from the date of issue by the Policyholder of the cancellation notification.

c) **In the event of any complaint or dispute regarding the insurance,** the Policyholder, Beneficiary, Insured or successors in right of any of the same may address the following instances for its resolution:

   i. In writing, to the Incidents Department of Cigna Healthcare Life Insurance Company of Europe, SA-NV Sucursal en España, Parque Empresarial La Finca, Paseo del Club Deportivo 1, Edificio 14, Planta Primera. 28223 Pozuelo de Alarcón - Madrid, or at the following email address: **servicio.incidencias@cigna.com**

   ii. The Cigna Healthcare Client Ombudsman, at C/ Velázquez, 80, 1º Dcha., 28001 Madrid, or at the following email address: **reclamaciones@da-defensor.org**

   The processing of complaints and disputes by the above instances shall never exceed the term legally established and the procedure is regulated in the Regulations for the Defence of Clients at Cigna Life Insurance Company of Europe, available at the Entity's offices.

   iii. Once the internal route of the Insurer referred to in the preceding section has been exhausted, it will be possible to initiate the administrative procedure for complaints before the Complaints Service of the Directorate-General for Insurance and Pension Funds located at Paseo de la Castellana, 44, 28046 Madrid, (www.dgsfp.mineco.es). For this purpose, claimants must demonstrate that the term of one month has elapsed since the date the complaint was submitted to the Insurer's Incident Department, without the same having been resolved or the consideration of the complaint refused or the request denied.

7.3. Personal Data Protection

Cigna Life Insurance Company of Europe, SA/NV, Sucursal en España shall process data related to the applicant/policyholder (in the case of individual insurance policies), insured and beneficiary (jointly, the "Data Subject) as data controller, for the following legitimate purposes and grounds: (a) handle the application and/or insurance contract; (b) comply with all legal obligations; and (c) prevent and investigate fraud, based on legitimate interest. Data Subject's data (including health information) shall be collected directly from the Data Subject or through other sources (insurance broker, employer, in the case of collective insurance policies, or medical professionals, among others). Cigna Healthcare shall share the Data Subject's personal data with third parties, including recipients located in countries that do not ensure an adequate level of protection (United States of America). The Data Subject may exercise, at any time, its rights of access, rectification, objection, erasure, portability and restriction of processing and withdrawal of consent by sending notification via email to **CGHB-EU-Privacy@cigna.com**

For more information on the processing of the Data Subject's personal data, please, refer to the Personal Data Protection Annex of the Policy.

Article 8. Complaints

8.I. Arbitration

If both parties agree, they may submit their differences to the consideration of arbitrators pursuant to current legislation.

8.2. Competent Jurisdiction

If both parties agree, they may submit their differences to the consideration of arbitrators pursuant to current legislation.

Article 9. Express Acceptance Acknowledgement of Receipt of Information

The Policyholder expressly acknowledges the receipt of the General, Special and Particular Conditions making up this Policy and states his or her awareness of and agreement with the same.

Similarly, in accordance with the provisions contained in Section 3 of the Insurance Contract Act, and as an additional agreement over and above the Particular Conditions, the Policyholder states that he or she has read, examined and understood the contents and scope of all the clauses in the present contract and, in particular, those that, duly highlighted in bold print, might limit his or her rights.

Lastly, the Policyholder expressly acknowledges having received from the Insurer, in writing, the corresponding information relating to the legislation applicable to the insurance contract, the various instances for dealing with complaints, the Member State of the Insurer's domicile and its oversight authority, the company name, registered office and legal form of the Insurer, as well as, where appropriate, the minimum information foreseen in Act 22/2007, dated July IIth, 2007, on the remote marketing of financial services targeting consumers.

In the case of collective insurance policies, the Policyholder states that he or she has provided the Insured parties, and will provide any future Insured parties, with the aforesaid information, as well as any other information that may affect the rights and obligations of the Insured parties pursuant to the General, Particular and Special Conditions of this Policy, particularly the information relating to their personal details and the consent to process personal information, prior to their inclusion in the insurance.

Juan José Montes Escribá

Managing Director
Cigna Life Insurance Company of
Europe, SA/NV, Spain's Branch Office.

Parque Empresarial La Finca
Paseo del Club Deportivo, 1, Edificio 14. Planta Primera
28223 Pozuelo de Alarcón (Madrid)

cigna.es

Condiciones_Generales_Asistencia_Dental_Reembolso_2025 CG-SADRE25V1-EN