SEPS
SFPE
Seniors of the European Public Service
Seniors de la Fonction Publique Européenne

VADE – MECUM

Part 1
Explanatory notes

January 2013

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- *This document is designed to inform third parties of your wishes should you be unable to do so in person*
- *It provides useful information, procedures and rules (in the event of illness, accident or death) for yourself or for those who may have to take care of you*
- *Annexes (parts 2, 3, and 4)*

This document is intended for retired officials of the European Institutions who do not have access to My IntraComm

Most of these texts are available on My IntraComm : www.myintracomm-ext.ec.europa.eu

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Table of contents

Page

Introduction 3

I. Illness / Accident

1. Sickness: Community JSIS 3
2. Optional supplementary health insurance 4
3. Optional accident insurance 5
4. General procedures for reimbursement claims 5
    - 4.1. Illness: JSIS 5
    - 4.3. Specific accident insurance 6
    - 4.2. Supplementary health insurance 6
5. Important rules for pensioners
    - 5.1. Receipt / bill / description of treatment received. 6
    - 5.2. Reimbursement claim 6
    - 5.3. Prior authorization 7
    - 5.4. Reimbursement of dental treatment 7
    - 5.5. Direct billing to the Commission 7
    - 5.6. Non-medical expenses 8
    - 5.7. Request for an advance and for priority treatment 8
    - 5.8. Serious illness 9
    - 5.9. Health screening examinations for pensioners 11
    - 5.10. Cenvalescent and post-operative cures 12
    - 5.11. Thermal cures 13
    - 5.12. Nursing and convalescent homes (for long-term residence) 15
    - 5.13. Miscellaneous medical treatment 18
    - 5.14. Spectacles (frames & lenses) and contact lenses 19
    - 5.15. Special reimbursement : Article 72(3) of the Staff Regulations 20
    - 5.16. Family members 21
6. My wishes in respect of my surroundings 21
7. My wishes in respect of my illness 21

II. Death

1. Prior actions 22
2. Measures to be taken by heirs/ family / persons concerned 22
3. Financial aspects for the heirs 22
4. Making your last will and testament 23
5. My final wishes 24

III. Organization of the PMO 25

IV. Social services of HR DG C1 26

V. Complaints and appeals

1. Requests for assistance 27
2. Requests under article 90(1) 29
3. Complaints under article 90(2) 31
4. Appeals to the European Union Civil Service Tribunal 34
5. The Commission's mediation department 34

VI. Lawyers service/advice 35

VII. List of annexes 36

Introduction

Several years ago the SEPS administrative board produced a relatively comprehensive Vade-mecum for members of the association.

- This document is designed to inform third parties of your will or wishes should you be unable to express them in person.

- It contains much useful, indeed essential, information for yourself and, especially, for your family or relations in the event of illness, accident or death.

Everyone can be victim of an accident, incapacitating illness or sudden death. Those called upon to help you or deal with your personal business in such unfortunate situations are very often at a loss. They wish to act in your interests (or those of your children, spouse or dependents) but have no knowledge of your will or wishes since - owing to mental illness, coma, or death - you are no longer able to express them.

Therefore, it is in your own interests to put your main wishes down on paper, together with all administrative indications, in order to help those suddenly landed with the task of helping you or your family by dealing with the necessary administrative formalities.

This year, our organization has produced a new version for you to fill out as comprehensively as possible, depending on what you consider is useful and acceptable to put in writing.

Once completed, this document should be kept where your family can find it or a copy be given to one or more members of your family. It should be updated as and when your situation or the Commission's administrative rules change. It is not intended to replace your last will and testament.

I. Illness / Accident

Useful information and formalities in the event of illness or accident

1. JSIS : Health and hospitalization cover

Pensioners are still covered by the JSIS[1] : reimbursement at 85 % (80 % for dental treatment) for sickness, hospitalization, accident, etc., as during active employment. Reimbursement is at 100 % in case of recognized serious illness.
Article 72(3) still applies. Supplementary reimbursement may be requested if, over a 12-month period, the expenditure incurred that has not been reimbursed, taking account of ceilings and exclusions (and expenses considered excessive) exceeds half the average basic monthly pension.
Hence, the risk is small but there are still ceilings, which can increase the non-reimbursable portion. A pensioner may wish to reduce the risk[2] and take out supplementary insurance[3].

2. Supplementary sickness insurance policies

A serious operation with subsequent long-term rehabilitation (in hospital) and care can prove expensive: some tens of thousands of euros. It can be necessary, in these circumstances, to have some back-up cover, especially if it enables you to go over the JSIS ceilings.

Two group insurance policies are available to retired Commission staff affiliated to the JSIS (both are private but linked to JSIS rules), limited to hospital treatment:

- the " **AFILIATYS option HR"** group supplementary health insurance policy (BCVR 86**72**), negotiated by AFILIATYS with Vanbreda Int. and Allianz BE;

- the "**AIACE option High Risk and Accident**" group supplementary health insurance policy (BCVR 86**73**), negotiated by the AIACE with Vanbreda Int. and Allianz BE.

There is one group insurance policy and one individual policy available to retired Commission staff affiliated to the JSIS (all three private but linked to JSIS rules) which cover more than just hospital treatment:

- the "**AFILIATYS option Hospi safe Plus"** group supplementary health insurance policy (BCVR 86**72**), negotiated by AFILIATYS with Vanbreda Int. and Allianz BE;

- The "**DKV EU Plus**" individual supplementary health insurance policy, negotiated by the FFPE with DKV Luxemburg and WYRSCRL, Brussels.

These policies cover treatment (for pensioners) following an accident, to top up the JSIS reimbursement, if the medical acts are specifically covered.

Information can be found at the following addresses:

www.eurprivileges.com/EUR/PUBLIC/FR/
Vanbreda International, Plantin en Moretuslei 299, 2140 Antwerpen Belgium
Tel. + 32 3 217 57 56 Fax + 32 3 271 02 47 E-mail: eurprivileges@vanbreda.com

www.dkv.lu/fr -
Courtier WYRSCRL, 1, Bt 2, av des Eoliennes 1200 - Bruxelles wyrscrl@telenet.be
Tel; +32 478950834

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[1] References: General Implementing Provisions (GIPs): C(2007)3195 / 01.07.2007.
PMO practical guide to reimbursement of medical expenses, March 2008.
SEPS, Vade-mecum edition 2010 EN.

[2] E.g. a retired Director-General who is divorced and obliged to pay high alimony to an ex-spouse.

[3] Where there is top-up insurance, article 72(3) is "taken over" by that insurance.

3. Specific accident insurance policies

Pensioners no longer benefit from any specific JSIS cover for accidents. Hospital and/or medical care following an accident is reimbursed by the JSIS at 85% (80% for dental fees). There are also ceilings and limits on various types of treatment (physiothec.py, etc. - cf annex M23).

The **Vanbreda–AXA accident insurance negotiated by the AIACE** accident insurance provides for 100% top-up of the JSIS reimbursement (provided the expenses are ”reasonable”) for treatment required after an accident (hospitalization, consultations, physiotherapy, medicine, etc.). Coverage is worldwide.

This policy also provides for a capital payment upon invalidity or death (three options –with or without a 5% excess):

Other options are available, for example the **EAS accident/savings package** whereby a large proportion of the annual premium is paid into a savings account while keeping enough capital in case of invalidity or death resulting from an accident. The savings can be withdrawn at any time (contract is denounced) with interest.

4. Reimbursement procedures

4.1. Sickness: Community JSIS

a: following payment of costs by the member

Forms in annex M1 and on My Intracomm

The rules are given in the “General implementing provisions (GIPs) for the reimbursement of medical expenses and the codes” (1 July 2007) – available from PMO.3, on Intranet or from the SEPS secretariat.

You will find the reimbursement rates and conditions for each case in these provisions. Many reimbursements are at the rate of 85% (or 80%) and 100% in the event of serious illness or accident.

The JSIS sends a reimbursement statement as shown in annex M2.

b: following request for direct billing to JSIS

Pay all additional costs, such as telephone, mineral water, etc., not included in the bill sent to the JSIS by the hospital.

You will receive a statement of reimbursement from the JSIS (see example in annex M3) showing the sum payable by the member that will be deducted from subsequent reimbursements (or from pension/salary later).

In case of accident

Although retired staff and other family members covered by the sickness insurance scheme do not benefit from accident insurance, in the event of an accident for which an identified third party is responsible, an accident report should be submitted. For retired staff and other family members, medical expenses incurred as the result of an accident are reimbursed as normal medical expenses, and not at a rate of 100%. (Annex M9).

Where a person covered by a member's insurance in accordance with Article 72 of the Staff Regulations, or, of course, a member himself/herself, is the victim of an accident for which a third party is responsible, the official or temporary staff member concerned is required to provide the Accidents & Occupational Diseases Insurance Sector with the following information:

- name and address of the third party, and of his/her insurance company;
- proof available (to enable the Institution to lodge a claim against the third party);
- existence and progress of any amicable arrangements or legal procedures initiated privately vis-à-vis the third party.

Please note that if any amicable arrangement or settlement is reached with the third party, the signature must be accompanied by the words "subject to compliance with Article 8 of the common rules on accidents and occupational disease and Article 85a of the Staff Regulations of officials of the European Communities". A copy of any such document must be sent to the Accident and Occupational Disease Section, which reserves the right to claim back any amounts which the member has been paid twice.

4.2. Optional supplementary health insurance

Procedure:

State « Van Breda » in the relevant column on the request for reimbursement (see annex M1 and paragraph 4.3 below).

Forward the reimbursement statement received from the JSIS (cf annexes M2 or M3) to Van Breda to obtain the supplementary reimbursement, which varies according to the agreements with the Commission (often 80% of the sum not reimbursed by the JSIS).

4.3. Optional accident insurance with Van Breda

Procedure:

Declare the accident to Van Breda within eight days and provide a medical certificate. Do not forget JSIS declaration (cf 2. above).

Costs reimbursed at the rate of 100%, in two instalments.
Possible invalidity payment.

For 1st instalment: send reimbursement request to the JSIS settlements office as for sickness but stating « accident » with the date (see annexes M1 and M9).

For 2nd instalment: send request for supplementary reimbursement to Van Breda (or other supplementary insurance body).

5. General procedure for reimbursement claims and important rules for pensioners

5.1. Receipt / bill / description of treatment received

An official receipt stating the sum paid by the member[1] must be provided for every medical consultation, visit or purchase of medicine. This document must also state the name of the patient, the date of the consultation or visit, the nature or code of the treatment, the name of the medicines and their respective cost, the name and official references of the medical officer and the amount paid.

The JSIS will reimburse if this information is given. Therefore, there is no need to obtain a receipt in accordance with the Member State's system. However, for your own protection, it is preferable to ask for such a receipt.

[1] In the case of direct payment, the receipts, documents from the complementary insurance or invoices are to be stamped and signed by the practitioner (doctor, chemist, etc.).
In the case of payment by credit card, bank transfer or postal order, a copy of the bank statement (or of the home bank's transfer) must be attached to the invoice or bill.

5.2. Claim for reimbursement

All claims for reimbursement must be made on the form provided (see annex M1), which should be photocopied or downloaded from My Intracomm.

Any other reimbursements received must be specified in the relevant column (e.g. supplementary insurance from Van Breda).

If the claim is related to an accident, this must be specified.

Do not forget to state your pension number and sign the claim.

The form must be accompanied by original receipts and proof of payment as stated in 4.1 above.

N.B.

Do not staple the documents and do not fold them! These documents have to be scanned.

The documents must be sent to your *settlements office.* Addresses are given in part 3, annex PMO, and on most of the JSIS forms in part 4.

5.3. Prior authorization

Prior authorization is required for certain medical or paramedical treatment (e.g. treatment at a spa, plastic surgery, artificial limbs and so on). Please fill out the form in annex M4 and send in to the JSIS. Addresses appear on the form.

5.4. Reimbursement of dental treatment

There are special forms for dental treatment:

- prior authorization is needed for anything other than normal treatment (e.g. fillings) – please use the forms in annexes M5 and M7.

- statement of fees (form in annex M6)

Send to your settlements office (address: part 3, annex PMO)

5.5. Direct billing by the Commission

The total cost of hospital stays (including one-day stays) and treatment may be paid direct by the Commission to the hospital.

The JSIS sends a letter (by fax) confirming direct billing to the hospital on the basis of a request for advance sent by the member (see form M11).

Addresses are given in part 3: annex PMO.

The portion of fees payable by the member (20%, 15% or whatever appropriate) will be deducted:

- either from subsequent reimbursements requested by the member for other medical expenses (most frequent solution),
- or from the member's salary/pension.

Exclusions

Members who are eligible only for JSIS top-up cover will not be granted direct billing unless it can be established, by means of the necessary documentation, that the JSIS is to take the place of the primary scheme in accordance with the provisions on top-up cover.

Rules
Members must apply for direct billing in advance, except in an emergency or a case of force majeure.

Direct billing is granted in the following instances:

- In the event of hospitalization, direct billing covers the main invoices and the surgeon's fees.
  - If they are invoiced separately, invoices from the anesthetist and the assistant may also be covered by direct billing.
  - The duration of direct billing of this type is 60 days. If the stay in hospital exceeds 60 days, an application for an extension should be submitted to the Medical Officer, together with a medical report explaining the need for the extension.
- Intensive out-patient care as part of a serious illness, (e.g. radiotherapy, chemotherapy or dialysis).
- Expensive medicines that must be bought repeatedly, such as growth hormones, repeated use of a standard or light ambulance, or expensive tests, if the monthly cost exceeds 20% of the member's pension or basic salary.

In the event of direct billing, after the reimbursement rates have been calculated the costs to be met by the member are, as a rule, deducted from later reimbursements, or from the salary, pension or other sums owing from the institution. At the request of the settlements office, the balance may be reimbursed by a transfer to the JSIS bank account.

How to apply for direct billing:

1 Fill in the form "request for direct billing" (annex M11)
2 Send it by fax or by mail to your settlements office (addresses appear on the form too)

5.6. Non-medical expenses

Partial reimbursement may be made for care services, or transport by ambulance or taxi on the basis of a prior authorization (annex M4), following the opinion of the Medical Adviser to the settlements office or, in an emergency, subsequently.

Addresses and telephone numbers appear on the form M4.

5.7. Request for an advance and for priority treatment

In well justified cases it is possible to obtain advances on reimbursements of medical expenses (see annex M13)

Priority treatment can be accepted for those members who are covered on a primary basis, provided their pension or basic salary is equal to or less than an AST2/1 official and if the medical cost incurred by the member, in a month, totals more than 20% of their basic pension or salary.

For an advance:

1 Fill in the form "request for an advance" (Annex M13)
2 Send it to your settlements office (addresses appear on the form)

It is also possible to receive priority treatment of a request for reimbursement of medical expenses (see annex M12)

An advance on reimbursement may be granted, for members who are covered on a primary basis, provided the costs incurred during the last 15 days represent an amount of 600€ or more.

For the priority treatment of a reimbursement request:

1 Fill in the form "request for reimbursement" (Annex M1)
2 As cover page, fill in and attach the sheet called "request for a priority treatment" (Annex M12) send all back to the address stated on that sheet.

5.8. Serious illness

Certain illnesses are considered serious, in which case the reimbursement rate is 100 %.

Definition

According to the Staff Regulations, a serious illness is one recognized as such by decision of the appointing authority after consulting the Medical Officer and on the basis of following criteria:

Serious illnesses include

- Tuberculosis
- Poliomyelitis
- Cancer
- Mental illness
- and other illnesses recognized by the appointing authority as of comparable seriousness. Such illnesses typically involve, to varying degrees, the following four elements:
    - a shortened life expectancy (an illness which is likely to be drawn-out)
    - an illness which is likely to be drawn-out
    - the need for aggressive diagnostic and/or therapeutic procedures
    - the presence or risk of a serious handicap.

Rate of reimbursement

The 100% reimbursement rate applies to:

- medical costs which appear, in the light of current scientific knowledge, to be directly linked to the diagnosis, treatment or monitoring of the development of the serious illness, or any complications or consequences it causes
- costs eligible for reimbursement associated with dependence caused by the serious illness.

Ceilings of reimbursement

Expenses incurred in connection with a serious illness are reimbursed at the rate of 100% without a ceiling, except for:

- home nursing care
- dental expenses
- miscellaneous medical treatment
- accommodation costs during a convalescent/post operative cure
- cost of treatment and medical supervision during a thermal cure.

How do I apply for recognition of a serious illness?

1 Fill in the form. (Annex M18)
Attach a detailed medical report.
For an initial application, the report must include:

- the date of the diagnosis
- the exact diagnosis
- what stage the illness is at, and any complications
- the treatment required.

2 Send all in a sealed envelope stating "confidential" to the Medical Officer of your settlements office. (Address on the form M18)

3 You will receive a decision by the Appointing authority (AIPN)

In the case of a favourable opinion, the 100% cover for expenditure related to serious illness is granted from a start date (the date of the medical certificate) to a date in the future, which cannot be more than 5 years.

4 The settlements office will warn the member in due course when the cover is about to expire, in order to give him or her time to submit an application for the cover to be extended, accompanied by a medical report that explains:

- how the illness has developed
- the treatment and/or care still required.

The decision granting 100% cover is reviewed regularly on the basis of up-to-date information on the person's state of health and scientific advances, to reassess, if necessary, the extent of the cover.

N.B.: for any new serious illness, a new request for recognition will have to be made.

How do I apply for the reimbursement of expenses arising from a serious illness?

1 FILL IN A "REQUEST FOR REIMBURSEMENT" FORM (Annex M1)
Tick reimbursement for "serious illness" (giving the corresponding references)

2 ATTACH ORIGINAL SUPPORTING DOCUMENTS (except in the case of complementary reimbursements):

- Receipts and invoices must conform to local legislation in the country of issue, **or** must include the following information:
  - the patient's full name
  - the nature of the treatment
  - the dates and fees paid for each medical treatment
  - the name and official references of the healthcare provider.
- If there has been partial reimbursement by the primary scheme, a copy of the invoices and the original statement of account from the primary scheme detailing the treatment that has been reimbursed must be included with the claim for reimbursement.
- Advances and prepayments will not be taken into consideration unless they are included with the final invoice.
- For medicines: receipts or invoices from chemists containing the following information:
  - the name of the prescribing practitioner
  - the patient's full name

- the name of the prescribed medicine or, for generic medicinal products, the product supplied, or the composition of the preparation for magistral preparations (the preparation number will not suffice)
- the price of each product
- the full price and, for persons with top-up insurance, the price actually paid
- the date on which the medicines were supplied
- the chemist's stamp and signature.

These requirements also apply for repeat prescriptions.

3 SIGN THE COMPLETED FORM

4 SEND ALL TO YOUR SETTLEMENTS OFFICE (Addresses: parts 3 and 4)

5 AFTER CALCULATION, your settlements office will send you a statement.

Backdating

As a rule, 100% cover is granted only from the date of the medical certificate supporting the application for recognition of serious illness.

However, on the basis of a reasoned request from the member indicating the treatment in question as entered on his or her account statements, the 100% cover may be backdated, after consulting the Medical Officer.

The backdating may not, however, extend beyond the time limit for reimbursement laid down in Article 32 of the joint rules.

5.9. Health screening examinations for pensioners

Health screening examinations organized by the JSIS are open to

- members of the JSIS: officials, temporary/contract staff, persons in receipt of a retirement pension or termination of service allowance
- those covered through the members: spouses and children.

Under the rules on sickness insurance, expenses for early detection screening tests are reimbursed at the rate of 100%.

NB: Only the examinations set out in the programme sent to the beneficiaries may be reimbursed as preventive medicine. Any supplementary tests or examinations will be at the patient's expense and reimbursement must be claimed following the normal reimbursement procedure.

The frequency of the screening tests is the following (see also details of different programmes):

- **Women from the age of 40 to 59:** every three years (annex M 19)
  Women over the age of 60: every two years

- **Men from the age of 40 to 59**: every three years (annex M 20)
  Men over the age of 60: every two years

- **Gynaecological examination for women**: every year (annex M 21)

- **Children up to the age of 16**: every year (annex M22)

Annex M 23: list of **approved centres**

Persons entitled to primary or top-up cover by the JSIS may apply for direct billing in respect of health screening expenses.

It is possible for pensioners to benefit from health screening examinations even if they don't live within easy reach of one of the centres.

If there is no approved centre in the pensioner's region, the screening may take place at an institution of his/her choice. Direct billing is possible provided that all the tests are carried out at the same institution (with single bill).

Health screening See addresses and tel n°s in PMO annex of part 3.

5.10. Convalescent and post-operative cures

Definition

Convalescent and post-operative cures qualify for reimbursement **subject to prior authorization** on condition that:

1. they are carried out under medical supervision in convalescent centres with an appropriate medical and paramedical infrastructure; all other types of centre are excluded;
2. they commence within three months of the operation or illness in respect of which they have been prescribed, except where there is a medical contra-indication duly justified in the report accompanying the medical prescription and accepted by the Medical Officer. The authorization may be renewed in the event of a relapse or a new illness.

Rates of reimbursement

- **Accommodation costs**: are reimbursed at the rate of 80% for a maximum period of 28 days per annum, with a ceiling of €36 per day.
  In the case of a cure prescribed in connection with a serious illness such costs are reimbursed at the rate of 100%, with a special reimbursement ceiling of €45 per day.
- **Costs of care**: are reimbursed separately according to the type of care – see annex M24 in part 4.
- **Costs of stay for accompanying person** : In exceptional circumstances, the accommodation costs of an accompanying person may be reimbursed at the rate of 85%, with a ceiling of €40 per day, subject to presentation of a medical prescription and with prior authorization, in the following cases:
  - for a family member staying in the same room, or within the establishment offering the cure, if the person following the cure is under the age of 14 or requires special assistance because of the nature of the condition or on other duly substantiated medical grounds
  - for a child who is being breastfed and has to accompany its mother on the cure.

  In all other cases the accommodation costs of an accompanying person are not reimbursed.
- **Travel expenses are not reimbursed**.

How to claim for reimbursement

To qualify for reimbursement, any cure must be subject to a prior authorization (Annex M4) that must be sent to the Settlements office together with a medical prescription drawn up **within the last three months by a medical practitioner who has no links with a cure centre**. The prescription must be accompanied by a detailed medical report explaining why the cure is necessary. A cure cannot be authorized until it has been recognized as necessary by the Medical Officer on the basis of the medical report mentioned above.

Authorization will not be granted retroactively. The scheme will not reimburse any treatment, examinations or consultations carried out in a cure centre if the cure has not been authorized:

At least 3 months before the cure:

- Fill in a request for prior authorization (Annex M4)
- Attach the medical prescription
- Attach the detailed medical report, explaining why the cure is necessary
- Send everything in a sealed envelope stating "confidential", to the Medical Officer of your settlements office (address on form M4)

After the cure:

- Fill in a claim for reimbursement (Annex M1)
- Attach the receipted detailed bill
- Attach, in a sealed envelope stating “confidential”, a medical report, established at the end of the cure by the medical practitioner of the cure centre, stating the detailed treatment received
- Send everything to your settlements office. (Annex PMO of part 3).

5.11. Thermal cures

Definition

A thermal cure is a stay of not less than ten days and not more than 21 days at a specialist establishment providing treatment under medical supervision using water taken from a spring before it has lost its biological and pharmacodynamic properties which derive from its richness in ions and oligoelements. A stay in a paramedical centre approved by the national health authorities and specializing exclusively in the treatment of chronic illnesses can be considered to be equivalent to a thermal cure.

Conditions for reimbursement

To qualify for reimbursement, the cure must

- be authorized in advance by the settlements office after consulting the Medical Officer and take place in a centre approved by the national health authorities
- include at least two appropriate treatments a day and may not be interrupted, except on presentation of a certificate from the establishment’s doctor in support of the interruption on medical grounds or for urgent family reasons (death or serious illness of a family member, etc.).

Authorization for a cure is limited to:

- one cure a year, up to a maximum of eight cures in the lifetime of the beneficiary, for each of the following categories of pathology:
    - rheumatism and sequellae of trauma to bones or joints
    - phlebology and cardio-arterial diseases
    - neurological diseases
    - disorders of the digestive tract and related structures, and metabolic disorders
    - gynecological disorders and disorders of the kidneys and urinary tract
    - dermatology and stomatology
    - diseases of the respiratory tract

- one cure a year provided that it is taken in connection with the treatment of a serious illness or in the case of severe psoriasis which does not respond to conventional treatment.

Non-reimbursable expenses

The following are not reimbursed as part of a cure:

- travel expenses
- board and lodging
- costs ancillary to treatment
- treatment that is not eligible under the joint rules, such as sea, lake and/or sand baths, thalassotherapy, sauna, solarium, non-medical massages, fitness sessions, yoga sessions, reflexology, shiatsu and similar
- tests, examinations and other services not directly related to the disorder concerned
- treatment using thyme or mistletoe extracts, ozonotherapy, oxygenation, own blood treatment, procaine and any other similar treatment or product.

The following do not qualify for reimbursement:

- cures such as thalassotherapy
- fitness cures.

Rates of reimbursement

- **Cost of care**: the cost of treatment and medical supervision as part of a thermal cure will be reimbursed at the rate of 80%, with an overall ceiling of 64 € a day.
  In the case of a cure prescribed in connection with a serious illness, such costs are reimbursed at the rate of 100%, with a special overall ceiling of €80 per day.
- **Cost of stay for an accompanying person**: the cost of accommodation for an accompanying person may be reimbursed subject to a medical prescription and prior authorization, at a rate of 85%, with a ceiling of 40€ per day:
  - for a family member staying in the same room, or within the establishment offering the cure, if the person following the cure is under the age of 14 or requires special family assistance because of the nature of the condition or on duly substantiated medical grounds
  - for a child who is being breastfed and has to accompany its mother on the cure.

  Accommodation costs of an accompanying person cannot be reimbursed in any other circumstances.

How to claim for reimbursement

Before the thermal cure : at least six weeks before the anticipated date of commencement of the cure:

- fill in a request for prior authorization (Annex M4)
- indicate the dates of the cure and the name and address of the establishment
- attach a prescription from a medical practitioner who has no links with a cure centre
- attach a detailed medical report drawn up within the last three months explaining why the cure is necessary, that will include:
  - the patient's medical history and details of treatments undergone during the previous year for the medical condition for which the cure is necessary; it must describe the most recent developments in the patient's condition and explain the medical grounds for prescribing the cure
  - the duration of the cure, the nature of the thermal treatment to be followed and the type of establishment in relation to the disorder in question, bearing in

mind that only a centre approved by the national health authorities may be considered
    - if applicable, attach the medical prescription of the accompanying person
- send everything, in a sealed envelope stating “confidential”, to the Medical Officer of your settlements office (address on the form in annex M4)

Authorization is granted if the thermal cure is recognized as strictly necessary by the Medical Officer on the basis of the medical report mentioned above and on condition that the insured person has followed the treatment prescribed in the course of the year, that this treatment has proved insufficient and that the cure has proven therapeutic value. Authorization will not be granted retroactively and the scheme will not reimburse any treatment, examinations or consultations carried out in a cure centre if the cure has not been authorized.

After the thermal cure, with granted authorization:

- fill in a claim for reimbursement (Annex M1)
- attach the detailed invoice
- send everything – in a sealed envelope stating “confidential” – to your settlements office. (addresses: annex PMO)

After the thermal cure, without authorization:

- if the cure has not been authorized, reimbursement of the cost of treatment is possible provided that the requirements set out in these general implementing provisions are met, namely:
    - an original prescription from a medical practitioner who has no links with a cure centre, dated within the previous six months and mentioning the diagnosis and the number and type of treatments
    - a detailed invoice corresponding to the medical prescription and indicating the dates and number of sessions and the cost of the treatment. Where treatment is given in an approved thermal cure centre, invoices drawn up directly by the establishment are accepted. Where treatment is given in an establishment which has not been approved, physiotherapy is the only type of treatment that qualifies for reimbursement, and only on condition that the treatment is provided by a qualified physiotherapist and that the corresponding invoice clearly indicates the physiotherapist’s qualifications.
- fill in a claim for reimbursement (annex M1)
- attach – in a sealed envelope stating “confidential” - an original prescription from a medical practitioner who has no links with a cure centre, dated within the previous six months and mentioning the diagnosis and the number and type of treatments
- attach a detailed invoice corresponding to the medical prescription and indicating the dates and number of sessions and the cost of the treatment.
- send everything to your settlements office (annex : PMO)

5.12. Nursing and convalescent homes (for long-term residence)

Definition

The following permanent or long-term residence costs are reimbursed:

1. Residence in a convalescent or nursing home approved by the competent authorities and having a medical and/or paramedical infrastructure for the elderly and/or the disabled.

2. Continuous and permanent residence in a psychiatric home approved by the relevant authorities and having a medical and/or paramedical infrastructure.
3. Residence in an establishment for rehabilitation or functional re-education in cases where the request for prior authorization for reimbursement under the heading of hospitalization has been refused.
4. Continuous residence in a psychiatric hospital for more than 12 months where the request for prior authorization for reimbursement as hospitalization has been refused.
5. Stays in a day centre.
6. Stays in a non-hospital drug rehabilitation centre.

Rates of reimbursement

These stays are linked to the services associated with dependence. Their reimbursement is calculated according to the member's degree of dependence, as shown in the table below, on the basis of the lowest score obtained on one of the two questionnaires, to be completed by the patient's doctor (Annex M15):

Score	Degree of dependence
91 - 100	5
75 - 90	4
50 - 74	3
25 - 49	2
0 - 24	1

Values 1 to 4 on the dependence scale are taken into consideration for the purpose of reimbursing expenses, with 1 being the highest level of dependence. Level 5 dependence does not create any entitlement to reimbursement.

Convalescent and nursing homes

All costs of care and accommodation are reimbursable at the rate of 85%, or 100% in the case of serious illness, with a ceiling of €36 per day for accommodation costs. If all items are aggregated on the invoice so that it is not possible to separate the costs of care from the accommodation costs, the costs will be divided according to the degree of dependence in the proportions given in the following table:

Degree of dependence	Costs of care	Accommodation costs
4	30 %	70 %
3	50%	50%
2	60%	40%
1	70%	30%

In such cases the accommodation costs will be subject to the same ceiling of €36 per day.

Residence and care in a psychiatric home

The costs are reimbursable at the rate of 85%, or 100% in the case of serious illness, under the same conditions as those applying to convalescent and nursing homes.

Continuous residence and care in a rehabilitation or functional re-education establishment or psychiatric hospital

The costs are reimbursable at the rate of 85%, or 100% in the case of serious illness, under the same conditions as those applying to convalescent and nursing homes.

If all items are aggregated on the invoice so that it is not possible to separate the costs of care from the accommodation costs, the costs will be divided according to the proportions for level 1 degree of dependence.

Stays and care in a day-care centre

The costs are reimbursable under the following conditions:

- Daytime attendance only at a convalescent or nursing home for the elderly or a neurological or psychiatric day centre: the costs of accommodation and care are reimbursed under the same conditions as permanent residence in a convalescent and nursing home, with a ceiling of €18 per day for accommodation costs.
- Attendance at a child guidance clinic: care only is reimbursable as provided for in the relevant provisions.

Stays and care in a non-hospital drug rehabilitation centre, or equivalent establishment

The costs are reimbursed at the rate of 85% only, with a ceiling of €36 per day for the accommodation costs. If all items are aggregated on the invoice so that it is not possible to separate the costs of care from the accommodation costs, the costs will be divided according to the proportions for level 1 degree of dependence. Reimbursement is limited to a total stay of 6 months in a 12-month period.

How to claim for reimbursement

Before the stay:

- Send in a request for prior authorization:
  - Fill in a request for prior authorization (annex M4)
  - Attach a medical report justifying the need for the stay and giving details of the care needed by the patient
  - Attach the questionnaires on the degree of dependence of the patient, duly completed by the doctor (annex M15)
  - Send everything, in a sealed envelope stating "confidential" to the Medical Officer of the member's settlements office (address on the form M4).
- After the authorization above, ask for a direct billing:
  - Fill in a request for Direct Billing (annex M11)
  - Send it to the officer in charge at your settlements office (annex PMO).

N.B.:

- direct billing is possible for one-night hospitalization and more
- direct billing is not possible for persons with top-up insurance
- if you have been granted direct billing, the hospital may not request from you the payment of a deposit.

After the stay:

- If you have paid the invoice:
  - Fill in a claim for reimbursement (annex M1)

- Attach the detailed invoice (e.g. with the INAMI codes for Belgium)
- Attach a medical report in a sealed envelope stating "confidential"
- Send everything to your settlements office (annex PMO)

- If you were granted a direct billing:
  - once the settlements office has completed its calculations, you will receive a statement.
  - your share of the costs (about 15%) will be deducted from future reimbursements.

5.13. Miscellaneous medical treatment:

Kinesitherapy, physiotherapy, infrared rays, ultrasound, aerosol therapy, acupuncture, psychotherapy, psychomotor therapy, speech therapy, etc.

Definition

The cost of treatment prescribed by a doctor is reimbursed provided it meets the conditions laid down in the **table in annex M24**, as regards:

- medical prescription (MP) required or not
- prior authorization (PA) required or not
- ceilings and
- maximum number of sessions over a calendar year.

Conditions of reimbursement

To be subject to reimbursement, medical treatment must

- have been prescribed by a doctor
- if necessary have been granted prior authorization (PA)
- be carried out by professionally qualified and legally recognized practitioners.

Medical prescriptions must:

- be drawn up before the start of treatment
- be dated less than 6 months before the date of the first treatment
- show the patient's name
- include the reason for the treatment
- include the type of treatment and the number of sessions
- not exceed the maximum number of sessions over a calendar year.

N.B.: the following are not reimbursed:

- treatment for aesthetic purposes
- swimming pool subscriptions
- enrolment fees for sports or fitness centres.

Rates of reimbursement

Medical treatment is reimbursed at the rate of 80%, up to the ceiling for each type of treatment.

In case of serious illness, it is reimbursed at the rate of 100%, up to twice the ceiling normally applied.

How to claim for reimbursement

- **Before starting the treatment**, check in the table in annex 24 whether a request for prior authorization (AP) is required or not.
    - If so:
        - fill in a request for prior authorization (annex M4)
        - attach a medical report stating why the treatment is necessary
        - send everything, in a sealed envelope stating confidential, to the Medical Officer of your settlements office (address on the form in annex M4)
        - wait for the answer before starting the treatment.
- **After the treatment**:
    - fill in a request for reimbursement (annex M1).
    - attach the detailed invoice/bill (e.g., in Belgium, with INAMI codes)
    - send everything to your settlements office. (Addresses: annex PMO)

5.14. Spectacles (frames & lenses) and contact lenses

Definition

Reimbursement of the cost of **spectacles** is limited to two pairs, consisting of a frame and corrective lenses regardless of type:

- either one pair of spectacles with single vision lenses for near vision and one pair of spectacles with single vision lenses for distance vision
- or one pair of spectacles with multifocal or progressive lenses and, if necessary, one pair of spectacles for correcting short or long sight.

Except in the case of a medically attested change in dioptre or axis of 0.50 or more, renewal periods for **spectacles** are:

- 1 year for children under 18
- 2 years for persons over 18.

The cost of purchasing conventional and/or disposable corrective **contact lenses**, prescribed by an ophthalmologist or ophthalmic optician, and of products for use with them.

Not reimbursed by the scheme:

- spectacles with non-corrective lenses
- sun-glasses
- non-corrective coloured contact lenses.

N.B.: spectacles for work on a computer screen for staff in active employment are reimbursed by the Medical Service, under the conditions laid down in the Administrative Notice dated 14/10/1999.

Rates of reimbursement

The cost of **spectacles with corrective lenses prescribed by an ophthalmologist** or an ophthalmic optician is reimbursed at the rate of 85%, subject to the following ceilings:

- frames: €120
- lenses: see table below:

	Ceiling per single lense
	EUR
Conventional lense	
Up to 4 dioptres	110
From 4.25 to 6 dioptres	140
From 6.25 to 8 dioptres	180
From 8.25 dioptres and above	300
Multifocal/progressive lense	350

The cost of purchasing **conventional and/or disposable corrective contact lenses, prescribed by an ophthalmologist or ophthalmic optician**, and of products for use with them, is reimbursed at the rate of 85%, with a ceiling of €500 per period of 24 months.

N.B.:

- Reimbursement of the cost of corrective contact lenses does not rule out reimbursement of a pair of spectacles with single focus corrective lenses for near or distance vision or of a pair of spectacles with multifocal or progressive lenses.
- In the case of loss or tearing of the contact lenses before the end of the minimum period for renewal, the cost of replacement is reimbursed only up to the value of any previously unused portion of the ceiling for that period.

How to claim for reimbursement

- Fill in a claim for reimbursement (annex M1)
- Attach the original receipted invoice (and the prescription by the ophtalmologist of by the ophtalmic optician, for contact lenses) stating:
  - the type of vision to be corrected (distance – near – multifocal)
  - a description of the lenses or contact lenses (strength of each corrective lens/dioptres; type of contact lenses: disposable or conventional)
  - the price of the lenses and/or the price of the frame, indicated separately.
- Send everything to your settlements office (addresses : annex PMO)

N.B.: For the reimbursement of spectacles for work on screen, please refer to the Administrative Notice dated 14.10.1999.

5.15. Special reimbursement pursuant to Article 72 (3) of the Staff Regulations

The conditions and arrangements for calculating the special reimbursement provided for in Article 72(3) of the Staff Regulations are set out in Article 24 of the joint rules. This top-up reimbursement applies when the expenditure incurred by the member which is not excluded by these general implementing provisions from the scope of that article and has not been reimbursed, exceeds, over a 12-month period, half the average basic monthly income received under the Staff Regulations over that same period.

The portion of the expenditure which has not been reimbursed and which exceeds half the average income is reimbursed at the rate of 90% to a member whose insurance covers no other person, and at the rate of 100% in other cases.

Special reimbursements are calculated on the basis of the date of treatment and not the date of the account statements.

How to apply for special reimbursement

Members likely to qualify for special reimbursement will be informed automatically or upon request of non-reimbursed expenditure incurred during the previous 36 months. Such reimbursement takes account of the adjustment of remuneration provided for in Article 65 of the Staff Regulations.

The member must then send back the notification with a form (annex M25), duly signed, indicating the 12-month period he or she wishes to choose. If the member fails to make a choice, the period chosen for calculating the special reimbursement will be the one most advantageous to the member.

Expenditure submitted after the special reimbursement has been made cannot give rise to an additional special reimbursement.

If the 12-month period includes fractions of months, the average basic monthly salary, pension or allowance will be calculated by taking into consideration the basic payments from the first month during which the period in question began, until the month during which the period ended.

If the family situation changed during the period in question, the situation used to determine the percentage to be reimbursed will be the one most advantageous to the member.

5.16. Family members

Family members do not benefit from the accident insurance cover provided under Article 72(3). However, all medical expenses, including those incurred as a result of an accident, are eligible for reimbursement by the Joint Sickness Insurance Scheme.

Medical expenses are eligible for reimbursement up to 80-85% within the limits laid down in the sickness rules.

Spouses / recognized partners, dependent children and persons treated as dependent children may be entitled to sickness cover under the scheme.

Change in family circumstances

Any change in family circumstances (marriage/birth, separation, divorce, dissolution of partnership, death, if children start/stop studying) and in your spouse's/partner's employment status is to be notified **in writing as soon as possible** to your administration and settlements office so that your entitlements can be adjusted accordingly.

NOTE

These pages are given exclusively to JSIS members for information purposes only. All details concerning applicable rules can be found in the general implementing provisions.

6. My wishes in respect of my surroundings

Should I no longer be able to look after myself – for reasons of illness or old age – I should like the person concerned for my welfare to abide by the wishes set out in annex D1 (Vade-mecum part 2)

7. My wishes in respect of my illness

Should I be taken seriously ill I should like the person concerned for my welfare to abide by the wishes expressed in annex D2 (Vade-mecum part 2).

II DEATH

1. Prior action

- Fill out the forms in the DP and D annexes ("personal data" and "wishes and wills"
- Draw up a list of persons to be informed – various bodies, companies, etc... At least fill out annex DP 8 – Vade-mecum part 2).
- Make a will.

2. Measures to be taken by heirs/ family / persons concerned

1.

- Obtain a death certificate from a doctor or hospital

- Request the services of an undertaker to take all necessary measures and obtain the authorizations for transport of the body, burial, cremation, donation, etc...

- Depending on the legislation of the Member State, block bank accounts/open a new account for the heirs/close bank accounts. Bank accounts in the name of Mr OR Mrs make the procedure easier following the death of one of the spouses.

- Contact the Commission, PMO – ADMIN – Pensions (see full address in annex PMO)

P M O CONTACT Tel: +32-2-29 97777 (9h00 to 13h00 – in August: 9h00 to 12h00) Email**:** **PMO-CONTACT@ec.europa.eu**

- Send a death certificate to PMO 4 (Pension Unit);

- Send bank particulars of the spouse or heirs to PMO 4

- Send to PMO 4 the name and address of the solicitor/notary dealing with the inheritance

- Inform the relevant authorities (Town Hall, Registry, "Commune", and Consulate)

- Inform the SEPS

SEPS GSM number +32 (0)475 47 24 70
The secretariat's e-mail address is sfpe.seps@numericable.be or info@sfpe-seps.be

- Contact the life insurance company (see chapter I, annex AMA)

- Inform the accident insurance company if death resulted from an accident (Van Breda or other - see chapters I and III, annexes AMA). Some insurance companies reimburse costs and make a payment to the heirs.

- Abide by the wishes of the deceased as set out in annex D3 (part 2 of the Vade-mecum) and in his/her last will and testament.

3. Financial aspects for the heirs

3.1. Funeral expenses

The JSIS will reimburse a member's funeral expenses up to a maximum of € **2.350,** upon presentation of a receipted invoice. Heirs must forward their bank account number to the JSIS (see address above and in annex PMO).

3.2. Deceased's pension

The deceased person's **pension for the month in which the death occurred is paid** into his or her bank account (even if blocked).

The full pension for the next three months will be paid into the heirs' account. Details of this account must be sent to the Pension Unit (see address above and in chapter II.3. annexes PMO).

3.3. Survivor's pension and allowances

A survivor's pension is granted to the spouse if the legal marriage (or equivalent) lasted

- at least one year prior to the official's retirement, or
- at least five years after the official's retirement.

A survivor's pension is granted to the surviving spouse if the latter maintains or has maintained the deceased official's children from a previous marriage.

A survivor's pension is granted to a divorced spouse who is legally entitled to alimony from the deceased official.

A survivor's pension is granted to children of the deceased official who were dependent at the time of death.

Where several spouses are entitled to the survivor's pension, it is shared out amongst them.

A survivor's pension can be cumulated with other income.

A surviving spouse's pension is no longer payable upon remarriage.

Apply to the Pensions Unit (PMO4 –see address below and in part 3 – PMO annexes) for a provisional calculation of the survivor's pension.

Allowances for dependent children are maintained for the surviving spouse. The allowance is doubled for orphans.

3.4. Survivor's pension and JSIS cover for beneficiaries

As a rule, the JSIS can provide health insurance for beneficiaries to complement that provided by the national system.

Should it not be possible for beneficiaries to be covered by a national social security system, the JSIS will step in.

The contribution to the JSIS is calculated on the basis of the survivor's pension.

3.5. The tax situation

The heirs are liable for inheritance tax on:

- the real estate of the deceased in the country in which it is situated and
- the personal estate of the deceased in his or her domicile for tax purposes.

Community tax will be deducted from the survivor's pension at source. Since the pension is paid by the Commission and is subject to community tax, it is free of taxes in the member states.

4. Making your last will and testament

Drawing up a will enables you to avoid disputes among your heirs by clearly identifying what goods you are bequeathing to whom (in accordance with the law of the member state in question : for example, more or less equal shares), and it enables you to prefer one heir to the others (within the limits laid down by the member state in question. It also enables you to bring in an heir that would not legally inherit if you had not made a will.

You may write your own will provided that you write it by hand. Should you write several copies of this **holographic will**, they must be handwritten as well. You must make provision for the will to be found easily after your death. One way is to lodge it with a lawyer, who will enter it on a central register (this procedure is not very costly in Belgium or France). A handwritten will can always be contested or destroyed by an unsatisfied heir. A wise precaution here is to keep several originals in various places as well as lodging one with a lawyer.

It is possible in Belgium and France to make a will before a lawyer and two witnesses. This is known as an **authentic will**. This is a safer procedure as far as the wording is concerned, especially if your wishes are dependent on external circumstances (such as the death of an heir). However, the will may then be less of a secret! Such a will is entered on a central register.

Several countries have signed a convention accepting the **"international last will and testament",** which should not be handwritten and must be signed in the presence of several witnesses. It has the advantage of being implemented more easily in the countries that have signed the convention (France and Sweden).

A will can be changed at any moment. However, in order to avoid any confusion, it should be stated that any earlier will is null and void and you should reiterate all your wishes.

You should also number and sign every page of a handwritten will.

There is no set text for a will: you should simply ensure that your statements are clear and leave no room for misunderstandings. You must state your name and date and sign the document as well as indicating how many originals exist. All the heirs should be correctly identified, with name, surname and address.

N.B.:

The Commission has proposed a Regulation that should make it easier to settle the estates of residents across the internal borders of the EU.

The proposed Regulation will provide for:

- coordinated settlement of cross-frontier estates throughout the EU;
- clear identification of what law applies and what authorities are responsible;
- elimination of parallel procedures and contradictory legal decisions;
- mutual recognition of decisions and judgments relating to inheritance within the EU;
- establishment of a European inheritance certificate that will provide proof of entitlement to inherit, administer or execute an estate.

This proposal, which does not affect national inheritance law, should be adopted in accordance with the co-decision procedure with the European Parliament.

5. My final wishes

Please fill out the questionnaire in annex D3 (Vade-mecum part 2)**.**

N.B.: In order to remove any uncertainty, it is recommended that you attach a medical certificate stating that you are sound of mind at the time of completing the document in annex D3, part 2 of the Vade-mecum.

III. PMO CONTACT (Paymaster's Office)

Addresses in part 3 of the Vade-mecum.

Who are we?

PMO CONTACT is the paymaster's office's welcome and information service.
A team of counsellors is at your service every working day to reply to your telephone calls and e-mails.
However, the offices of PMO CONTACT **are not open to visitors**.

Who can contact us?

- Commission staff
- Members of the Joint Sickness Insurance Scheme of the European institutions
- Pensioners of the European institutions

For what information?

PMO CONTACT provides general administrative information and practical advice in the areas for which the PMO is responsible, such as:

- Rights relating to salaries
- Social security
- Pensions
- Reimbursement of mission expenses

For more detailed questions or those of a legal nature PMO CONTACT will forward your question to the relevant department, which can reply personally to your specific question.

The service we offer you

PMO CONTACT undertakes:

- to reply to your question at once;
- or, for specific questions concerning the management of a file,
    - to give you the contact details of the relevant person or department;
    - to direct you to another department or person, outside the PMO, who can reply to your question (for example, DG ADMIN).

When and how to contact us?

Our department is open:

- from Monday to Thursday from 09.00 to 13.00 +32 (02)29.97777
  If the line is engaged or if you call outside the opening hours of the service, PMO CONTACT offers you the possibility of leaving your contact details and message by voice mail. The counsellors will call you back as soon as possible.

- **By e-mail:** Please send an e-mail to: pmo-contact@ec.europa.eu

For questions of a legal nature, the counsellors will inform you of a time limit within which you can expect a reply.

PMO offices' addresses, tel., fax, e-mail – see part 3 of the Vade-mecum, annex PMO

IV. The social services of DG HR C1

Social and psychological assistance for pensioners – Brussels and Luxembourg

For questions relating to the Commission, consult its **Social Service**.

Please note that, as a pensioner, you may have certain entitlements in your place of residence and that the Commission's social service has only limited possibilities. Perhaps you do not yet have problems with shopping, housework or other daily chores but, when and if you do require extra help, the local social or pensions department can provide such help.

However should you find yourself in a particularly difficult situation, please do not hesitate to contact us and we shall try to find a solution to the problem.

Who are we?

We are a multilingual team of professional social workers dealing with pensioners and their families.

In Admin C we deal with questions from pensioners as well as help and support in the case of death of an active member of staff.

What do we do?

Our role is to offer social help to pensioners in difficulty – whether personal, administrative or financial and to help them adapt to the changes in their life after retirement.

Pensioners can consult us for a number of different issues – adapting to change after retirement, health issues, illness, financial difficulties, disability, bereavement, or conjugal difficulties.

The Social Policy unit has budget headings to help you deal with one-off financial difficulties. Financial assistance can take the form of home help, social aid or loans to the pensioners and financial aid to dependent handicapped children.

If you would like to discuss your plans after retirement our social workers are here to guide you and help you adapt to this new period of your life and the new challenges that come with it.

In the case of death of a member of staff, a team of multilingual social workers is there to offer psychosocial bereavement help to you and your family at such a difficult time. They will direct you and your family towards the various departments of the Commission which deal with the administrative side of a bereavement.

Finally, we offer useful information as well as support and professional guidance. We will do our utmost to resolve any problems that you may have and we guarantee that all our services are strictly confidential.

Your contacts: annex PMO, part 3 of the Vade-mecum.

V. Complaints and appeals[1]

At certain moments in your professional life, situations may arise in which you feel you are being treated unfairly. The Staff Regulations offer a number of possibilities to deal with such circumstances. As a first step, you should try to resolve the matter by contacting your hierarchy or the relevant department to discuss your problem and explain your point of view. You may also consider the possibility of contacting the Commission's Mediation Service, which is at the disposal of active and retired staff members to help resolve conflicts.

Should you not be able to find a suitable solution, the Appeals Unit (Annex R3) may provide you with the necessary information and guidance. The Unit has ten lawyers specializing in public-service law whose main task is to process requests and complaints under Articles 24 and 90 of the Staff Regulations. However, officials filing such requests and complaints often do so because they are not familiar with the applicable law or because they are not satisfied with the information they have been given by the departments responsible.

In an attempt to give staff a clearer understanding of the provisions of the Staff Regulations and their implications, the Appeals Unit has set up a telephone help desk for all those covered by the Staff Regulations. The number to ring is (+32-2-29) 66662 and the line is open from 09.00 to 12.30 and from 14.30 to 17.00.

Callers will be given information on procedural matters, including how to file requests or complaints or the departments responsible for certain decisions, as well as on legal matters. The Appeals Unit will not, however, as part of the help desk service, compile files or examine any documents which callers might subsequently include in an Article 90 request or complaint.

In this section you will find information on:

- requests Article 90(1)
- complaints Article 90(2)
- requests for assistance (Article 24)
- recourse to the European Union Civil Service Tribunal (Article 91 in Annex R4)

1. Requests for assistance (Article 24)

1.1 Context

Article 24 of the Staff Regulations relates to the Commission's duty to provide assistance to its staff, in particular in proceedings against any person perpetrating attacks on person or property to which an official or other staff member or a member of his family is subjected by reason of his position or duties. In carrying out their duties members of staff also run the risk of being at the receiving end of threats and insulting or defamatory acts or utterances; they may also be subject to harassment.

Article 24 also provides that the institution may compensate the official for reasonable legal costs, insofar as the official did not either intentionally or through grave negligence cause the damage and has been unable to obtain compensation from the person who did cause it.

It should be noted that the duty to provide assistance relates to the defence of officials[1], by the institution, against the actions of third parties and not against the acts of the institution itself, monitoring of which is governed by other provisions of the Staff Regulations.

[1] See www.My Intracomm.ec.europa.eu/pers-admin/appeals/index-en.html

The duty to protect officials, including when they are subject to attacks emanating from other officials, exists only if the facts in question have been clearly established. Hence, while the administration must act, in the face of an incident which is incompatible with the order and security of the service, with due diligence to establish the facts and to draw appropriate conclusions in full knowledge of the facts, it is not obliged to engage in investigative measures solely on the basis of allegations by a member of staff. An official or staff member who requests the protection to which he is entitled must provide, at the very least, **prima facie evidence** of the reality of the attacks to which he asserts he has been subjected. Only if such evidence exists is the institution concerned required to take appropriate steps, by holding an inquiry, to establish the facts at the origin of the request in cooperation with the author of that request.

1.2. Purpose of a request for assistance

If serious accusations are made concerning the professional integrity of an official in carrying out his or her duties, the administration – which has discretionary power in selecting the measures and resources to be deployed – is required to take all the necessary steps to verify whether the accusations are founded. If not, it must refute those accusations and do everything in its power to restore the good name of the official concerned.

Examples:

- In the event of the public and personal **defamation** of an official, the administration must defend its official publicly and by name, and cannot make its action dependent on the official's having first instituted proceedings on his own initiative against the author of the attack on him.
- In the event of a **problem within a department** of the institution (e.g. JSIS, Pensions and transfers, etc.), the administration must, when faced with an incident which is incompatible with the good order and tranquillity of the service, intervene with all the necessary vigour and respond with the rapidity and solicitude required by the circumstances of the case with a view to ascertaining the facts and, consequently, taking the appropriate action in full knowledge of the facts. However, requests addressed to an official by his hierarchical superiors in order to ensure the smooth running of the service cannot contain either serious accusations likely to harm his professional integrity, defamatory comments or attacks on his character.
- In the event of **harassment**, the prima facie evidence must demonstrate sustained abusive behaviour, whether this be repetitive or systematic conduct, words, acts, gestures or writing which undermine the personality, dignity or physical or psychological well-being of a person – so that the institution may, where necessary, take the appropriate steps, by holding an inquiry. However, psychological harassment will only be considered to exist if the behaviour of the alleged harasser is considered to be intentional and repetitive, and to have the aim of discrediting or disparaging the member of staff concerned.

1.3. Steps to submit a request for assistance

Before submitting a request, staff should first approach their hierarchical superiors and/or – in the case of harassment – a member of the network of confidential counsellors (Annex R2). In certain cases, a number of measures may prevent their submitting a request which involves implementing an administrative procedure in which the response may take several months.

[1] Official = active or retired

If the information provided or the measures taken by the Directorate-General or department of employment prove insufficient, the official may contact the Appeals Unit (Annex R3) to obtain further information.

1.4. Procedure

The Appeals Unit is responsible for examining requests for assistance under Article 24 of the Staff Regulations. The rules for making such requests are the same as for requests or complaints under Article 90.

The request should indicate the type of assistance sought. Cover page for request for assistance in Annex R1.

If the addressee of a decision has not received a formal decision on his request for assistance within four months of submitting that request, he may submit a complaint against the implicit rejection of that request. However, **such complaint is unfounded** if the administration has taken the appropriate steps, in particular by **holding an enquiry**, to establish the facts at the origin of the request in cooperation with author of that request (see judgement of the Court mentioned below).

2. Request under Article 90(1)

2.1. Definition

By a request under Article 90(1) of the Staff Regulations, an official (or a person subject to the Staff Regulations) asks the appropriate authority to take a decision concerning him or her.

The purpose is therefore to secure a decision from the appropriate authority, which may either grant the request or, by rejecting it, open the way to a complaint (Article 90(2).

Requests should not seek revision of a decision already taken, unless new evidence comes to light and a request can be submitted to have a decision reviewed.

2.2. Who may submit a request?

Not only the serving staff but also other categories such as probationers awaiting establishment, former staff, those entitled under them in the event of death and candidates in a competition.

2.3. Deadline and method of submission

A request may be made at any time. However, a request concerning the same matter as an earlier request or complaint which has received no reply or a negative reply may not reopen the period for the submission of a complaint allowed by Article 90(2) of the Staff Regulations.

One single copy of the request should be submitted to the Appeals Unit (ADMIN.B.2), by any **one** of the following ways:

- by e-mail, preferably in pdf format, to the operational mailbox ADMIN MAIL B2 (admin-mail-b2@ec.europa.eu) or

- by fax (no. 32-2-295.00.39) or
- by post, to the office address SC11 4/57 or
- handed in at the office address SC11 4/57 (from 09.00 and 12.00 and from 14.00 to 17.00).

To facilitate the procedure, the person concerned should enclose a form (annex R1) with the request.

The registration stamp of the Appeals Unit will be taken as proof of the date the request was submitted. In the case of requests submitted by e-mail, the date of registration will be the date on which it is sent or the first working day following that date if it is a holiday.

In the case of requests which are not sent direct to the Appeals Unit, the date of registration will be the date on which the administration was able to be apprised of the request.

2.4. Form and content

The form, which is not subject to any particular conditions, is not the factor which determines whether a request is to be regarded as such. Only the content does so. Accordingly, the administration may regard a submission inviting it to review an earlier decision as a complaint even if it is entitled 'request'.

A request must normally indicate that it is a request under Article 90(1) of the Staff Regulations and state the identity of the person concerned, its purpose and the reasons why it is being made and include the place, date and signature. Any document providing a better understanding of the problem should be attached.

2.5. Treatment of the request

The Appeals Unit sends the person making the request an acknowledgement of receipt, if possible by e-mail. The acknowledgement of receipt contains information such as the number of the request, the date of registration and the deadline for the reply.

There is no particular procedure for dealing with a request. It includes consideration of the purpose of the request by the department responsible for taking a decision and any checks needed to adopt that decision.

The decision adopted by the appropriate authority must be reasoned and sent to the person concerned, with no particular formality, within four months of the date on which the request is made.

Time periods will be calculated from the date of registration by the Appeals Unit.

If the request is rejected, the person concerned may lodge a complaint within three months from the date of notification of the decision.

Failure to reply to a request within the period of four months given to the appointing authority to adopt its decision means that the request has been implicitly rejected. A complaint against such a decision may also be lodged within three months of the implicit rejection. A late reply by the appointing authority (after the four-month period) does not reopen the three-month period available for lodging a complaint.

Cover page for requests: annex R1.

3. Complaints under Article 90(2)

3.1. Definition

By making a complaint under Article 90(2) of the Staff Regulations, an official contests a decision by the appropriate authority which he or she considers prejudicial; the authority has either taken an explicit or implicit rejection decision or it has failed to take a measure required by the Staff Regulations.

Examples:

- complaint against a refusal to reimburse medical expenses;
- complaint against a decision not to pay certain allowances.

Unlike a request, a complaint presupposes the prior existence of an administrative act taken by the appropriate authority. This act may be challenged if it is final (preparatory acts may not be challenged) and personally and individually prejudicial (the person concerned must have a personal, legitimate, direct, substantive and current interest in having the decision cancelled or amended).

It should be noted that a complaint is the only means provided by the Staff Regulations for a member of staff to contest a decision by the appropriate authority which, in his or her view, affects statutory rights and is prejudicial. Any request for the review or reconsideration of such a decision is therefore to be regarded as a complaint for the purposes of compliance with the deadlines listed below.

3.2. Who may lodge a complaint?

Persons referred to in the Staff Regulations: not only serving staff but also other categories such as probationers awaiting establishment, former staff, those entitled under them in the event of death and candidates in a competition.

3.3. What can a complaint on the part of retired officials or their beneficiaries be about?

- The Joint Sickness Insurance Scheme
- Pension rights : transfer of pension rights acquired under member states' schemes

3.4. Deadline and method of submission

A complaint must be made within three months. This period starts:

- on the date of publication of the act if it is a measure of a general nature;
- on the date of notification of the decision to the person concerned and in any event no later than the day when they become aware of it if it is a measure of an individual nature; however, if an act of an individual nature is such as to be prejudicial to a person other than the person directly concerned, that period shall begin to run with regard to that person from the day when he or she becomes aware of it and in any event no later than the date of publication;
- on the date of expiry of the period prescribed for the reply where the complaint is against an implied decision rejecting a request.

These periods are matters of public policy and may not be negotiated by the parties. The fact that in a reply the appropriate authority deals with the substance of a complaint which is out of time, and so inadmissible, does not derogate from the deadlines and reopen a right of appeal which had otherwise expired.

One single copy of the complaint should be sent to the Appeals Unit (ADMIN.B.2), by any **one** of the following ways:

- by e-mail, preferably in .pdf format, to the operational mailbox ADMIN MAIL B2 (admin-mail-b2@ec.europa.eu) or
- by fax (no. 32-2-295.00.39) or
- by post, to the office address SC11 4/57 or
- handed in at the office address SC11 4/57 (from 09.00 to 12.00 and from 14.00 to 17.00).

To facilitate the procedure, the person concerned should enclose a form (Annex R1) with the complaint.

The date of submission of a complaint for the purposes of deadlines will be taken as that of the registration stamp of the Appeals Unit. No account will be taken of the time taken for transmission by either the public or internal post. In the case of complaints submitted by e-mail, the date of registration will be the date on which it is sent or the first working day following that date if it is a holiday.

In the case of complaints which are not sent directly to the Appeals Unit, the date of registration will be the date on which the administration was able to be apprised of the complaint.

Acts which contain no points not already made in a previous decision are purely confirmatory and do not have the effect of providing the member of staff with further time.

3.5. Form and content

As for a request, a complaint is defined by its nature and content, not by its form.

A complaint should normally state the identity of the complainant, the disputed act and its purpose and the grounds and arguments on which it is based and include the place, date and signature. Documents which assist a correct assessment of the problems raised should be attached.

3.6. Treatment of the complaint

- Opening of the file
- The interdepartmental meeting
- Decision and time

3.7. Opening of the file

Duly registered complaints are the responsibility of the Appeals Unit and processed by it so that the appointing authority may adopt a reply.

The Appeals Unit sends the complainant an acknowledgement of receipt (if possible by e-mail), except in the case of complaints with the same subject submitted by a large number of complainants. These complaints are treated jointly by the Appeals Unit.

The acknowledgement of receipt contains information such as the number of the complaint, the date of registration and the name of the member of the unit responsible for handling the file.

At the same time, the Appeals Unit will collect any information relevant to treating the matter from the departments which took or are affected by the decision being challenged.

Complaints about the Joint Sickness Insurance Scheme are also sent to the Sickness Insurance Management Committee for its opinion.

3.8. The interdepartmental meeting

If it considers it useful, the Appeals Unit may organise an interdepartmental meeting to which the complainant, the departments responsible for the decision being challenged, the Mediation Service and staff representatives appointed by the Central Staff Committee are invited and where the complainant may present his or her version of the facts and the arguments set out in the complaint. The complainant may be accompanied by a person of his

or her choice or an adviser (for example, a member of the SEPS administrative board). The meeting is not an arbitration or decision-making body; it simply enables all the parties concerned to express their views.

After this meeting or when the dossier has been sufficiently considered, a draft reply is prepared. After the Legal Service has given its opinion, the draft is sent to the appropriate authority for a decision. The staff representatives designated to attend interdepartmental meetings will be informed of the action (positive or negative) taken on complaints.

3.9. Decision and deadline

The appointing authority has a period of four months from submission of a complaint to reply to it. After that period, the lack of a reply is an implied decision of rejection. If the complaint is rejected, whether expressly or implicitly, the complainant has three months from the date of notification of the reply to the complaint or the implied rejection to appeal to the European Union Civil Service Tribunal.

When an express decision rejecting a complaint is taken after an implied rejection but within the period of three months allowed for lodging an appeal (but no appeal has been lodged), it reopens the three-month period for making an appeal to the European Union Civil Service Tribunal.

The reply to the complaint is sent either direct to the complainant or to the assistant or Head of the Human Resources Unit of his or her Directorate-General or department or, in the case of staff employed outside the Union, to the Head of Delegation, against signature of an acknowledgement of receipt.

Cover page for complaints: annex R1

4. Appeal to the European Union Civil Service Tribunal

European Civil Servants were defended by the European Court of Justice until this tradition changed in 2007. The Council and the Commission asked the Court to set up a Civil Service Tribunal (CST), attached to the Tribunal of First Instance (TFI), in order to ease the burden on that Tribunal and also to induce officials to think more seriously before deciding to take the institutions – the Commission in particular – to court. The party who loses the case will have to pay lawyers', experts' and court charges, in accordance with the principle "loser pays costs". However, the CST is adopting a flexible approach, taking into consideration the supplicant's situation and the type of complaint: single judge for a speedy procedure, conciliation, etc...

Recourse to the European Court of Justice is governed by Article 91 of the Staff Regulations (Annex R4).

Such recourse is admissible only if a prior complaint was made in due time to the relevant authority under article 90(2) and if the claim is presented within three months from the date of a rejection.

5. The Mediation Service of the Commission

The Mediation Service is open to all staff. The Mediator is Mrs Mercedes de Solá.

Contact:

European Commission
Mediation Service
BERL 06/412
B - 1049 Brussels
Belgium

Tel.: +32 (0) 29 56272

VI. Lawyers service/advice

Legal advice service (Annex R5, part 3)

The Commission makes the services of a legal adviser available to active and retired officials and agents of the Institutions and Community bodies in Brussels and Luxembourg. These consultations are provided by a member of the Brussels / Luxembourg Bar.
The advice covers any legal problem (civil law, tax law, criminal law, commercial law or other areas of law) and/or financial problem facing staff or members of their families.
All issues involving statutory industrial relationships and divorce problems are excluded from these consultations.
It should be noted that the legal adviser cannot act as your legal representative

(Annex R4, 3rd Part).

For Brussels :
To fix an appointment: **(+32) 2 29 66600 or by Email**: hr-b1-conseils-jur@ec.europa.eu .

For Luxemburg :
Consultations are organised on Thursday morning. To fix an appointment: **(+352) 4301-35986**.

VII. Annexes

(Separate parts)

Part 2 (Forms to fill in)

DP Annexes – Personal Data

Annex DP1 Data on retired official
Annex DP2 Data on spouse
Annex DP3 Data on ex-spouse
Annex DP4 Data on children
Annex DP5 Important files and documents
Annex DP6 Keys and codes
Annex DP7 Insurance
Annex DP8 Contacts
Annex DP9 Creditors and debtors

AMA Annexes – Health and accident insurance

Annex AMA1 General JSIS insurance data
Annex AMA2 Supplementary insurance
Annex AMA3 Accident insurance
Annex AMA4 Other health/accident insurance

D Annexes – Relating to special wishes

Annex D1 My wishes in respect of my surroundings
Annex D2 My wishes in respect of my illness
Annex D3 My final wishes
Annex D4. Copy of last will and testament if available
Annex D5. Copy of kind of obituary notice desired, if available
Annex D6. List of persons to be contacted in the event of death

Part 3

PMO Annexes – Useful addresses

Annex P1. Locations of the PMO Services
Annex P2. Settlements offices, medical advisers, request for direct billing …
Annex P 3. In case of accident
Annex P4. Pensions and allowances
Annex P5. Dependence insurance by the Flemish Community
Annex ADMIN HR and Social Services DG

Annexes ACA – Supplementary health insurance policies and accident insurance (addresses)

Annexes R – Relating to complaints and appeals

Annex R1. Cover form for requests and complaints
Annex R2. LIST and addresses of members of the confidential counsellor's network
Annex R3. Articles 24, 90(1), 90(2), 91 of the Staff Regulations
Annex R4. Lawyers' service/advice: conditions and addresses

Part 4

M Annexes – Concerning the JSIS (forms)

Annex M1 Claim for reimbursement
Annex M2 Specimen reimbursement statement from the JSIS (normal case)
Annex M3 Specimen reimbursement statement from the JSIS (Commission direct billing)

Annex M4 Prior authorization
Annex M5 Estimate of proposed dental care treatment
Annex M6 Bill for dental treatment
Annex M7 Estimate for proposed orthodontic treatment – prior authorization
Annex M8 Standard medical certificate
Annex M9 Accident declaration
Annex M10 Medical certificate following accident
Annex M11 Direct billing request
Annex M12 Request for priority treatment of a reimbursement claim
Annex M13 Application for advance on major medical expenses
Annex M14 Application for direct billing for a convalescent or nursing home
Annex M15 Medical questionnaire for the evaluation of the degree of dependence
Annex M16 Application form for recognition of non-marital partnership
Annex M17 Application for family to be covered
Annex M18 Serious illness recognition
Annex M19 Programme for screening test N° 2
Annex M20 Programme for screening test N° 4
Annex M21 Gynaecological programme
Annex M22 Programme for screening test for children
Annex M23 Approved screening centres
Annex M24 Table of medical treatment
Annex M25 New form for applications under Article 72(3)

Notes:

The rules on all typical treatment are available on My Intracomm (under "Reimbursement rules" in several languages) and from the SEPS secretariat upon request. :

accident analyses (medical imaging, laboratory tests and other forms of diagnosis) confinement (and pregnancy) consultations (and visits), contact lenses, cures, thermal cures, dentistry/orthodontic diagnosis (medical imaging, analyses, laboratory tests and other forms of diagnosis), funeral allowance, hearing aids, homes (nursing and convalescent), hospitalization, infertility treatment (and in-vitro fertilization), medical imaging (analyses, laboratory tests and other forms of diagnosis), medicines (pharmaceutical products), miscellaneous treatment (kine, psychotherapy, speech therapy, etc.), negative opinions of the Medical Council, nursing attendance, nursing care (see medical auxiliaries), nursing homes (and convalescent homes), occupational disease, orthodontics / dentistry, orthopaedic appliances (see medical equipment), osteopathy (see miscellaneous treatments), pharmaceutical products (medicines), pregnancy (and confinement), preventive medicine programmes (screening tests), psychotherapy (see miscellaneous treatments), screening tests (preventive medicine programmes), serious illness, spectacles (frames and lenses), speech therapy (see miscellaneous treatments), surgery, transport, visits (and consultations).

Sets of the General Implementing Provisions are also available on My Intracomm and upon request from the SEPS secretariat (DE, EN, FR).

The rules and forms that we have selected for inclusion in our Vade-Mecum are those that are of interest to the majority of pensioners. There are other rules and forms on My Intracomm, often in several languages. These can be obtained via the SEPS secretariat.