These rules are translated into English from the original version in Lithuanian. In the event of any discrepancy between the rules, the rules in Lithuanian shall prevail.

ERGO Life Insurance SE

ERGO Universal Life Insurance Rules No. 027

Valid from 01-12-2018

I. General part

1. Structure of the Insurance Rules

1.1. ERGO universal life insurance is life insurance linked to investment funds. The ERGO Universal Life Insurance Rules consist of the general part and additional insurance conditions. The additional insurance conditions list insured and non-insured events, and the procedure for determining sums insured and insurance benefits. Provisions of the general part of these Insurance Rules shall apply in cases unprovided for in additional insurance conditions. Insurance agreements shall be subject to conditions of the general part of the Insurance Rules and additional insurance conditions included in the insurance agreement.

2. Key terms used in the Insurance Rules

Insurer – ERGO Life Insurance SE.

Policyholder – adult natural or legal person, who has concluded an insurance agreement with the Insurer in accordance with these Insurance Rules.

Parties to the Insurance Agreement – the Insurer and the Policyholder.

Insured – a person indicated by the Policyholder and named in the insurance agreement, an insured event having happened in the life of whom shall be subject to the Insurer's pay-out of an insurance benefit. There may be several persons insured under one insurance agreement. The term "Insured" used in the Insurance Rules shall apply to any person covered under the insurance agreement.

Principal Insured – a person covered under ERGO universal life insurance on behalf of whom capital is accumulated. The term "Principal Insured" used in the Insurance Rules shall apply to a single person covered under the insurance agreement.

Additional Insured – a person covered under any additional insurance according to additional insurance conditions of these Insurance Rules on behalf of whom the capital is not accumulated.

Beneficiary – a person indicated in the insurance agreement, which acquires the right to an insurance benefit in cases indicated in the insurance agreement.

Insurance Coverage – an Insurer's commitment to pay an insurance benefit in case of an insured event.

Investment Direction – one of directions of investment of the Policyholder's funds offered by the Insurer.

Object of Investment – securities or other investment vehicles where funds of the investment direction are invested to.

Investment Programme – investment directions chosen by the Policyholder and percentage distribution of insurance premiums invested therein.

Investment Unit – a relative unit of capital accounted for in the investment direction.

Accumulated Capital Structure – distribution of the accumulated capital (expressed in investment units) among investment directions.

Accumulated Capital Value – the sum of values of investment units under the insurance agreement calculated as the product of the number of investment units and the price of investment units.

Surrender Value – the sum paid in case of the termination of the insurance agreement. The surrender value shall be calculated having deducted the insurance agreement termination charge set in the insurance policy from the accumulated capital value.

Price of the Calculation Day – the price of the working day before the calculation day published on the Insurer's website. If the price of the day necessary for calculation has not been set, the last known investment unit price shall apply.

Pricelist – deductibles and their terms and conditions set by the Insurer according to these Insurance Rules. The applicable pricelist is published on the Insurer's website and shall form an integral part of the insurance agreement.

One year of insurance – begins on the first day of the insurance cover each year and lasts 12 months, but not longer than until the end of validity of the insurance cover.

Sports activities – means independent exercises of the Insured in sports clubs, amateur regular engagement in the individual or team sports of any type, including participation in training and competitions among amateur teams.

Professional sports – means Insured's exercises and participation in national or international competitions organised by the federation or union of the respective branch of sports, individual or team-based sports activities when for the participation the sportsman receives consideration (on the basis of an employment contract or a civil law agreement), support or scholarship of any type.

Extreme sports/leisure – means activity related with risks higher than in other branches which requires special physical and mental abilities and usually – equipment and clothes suited for such purpose. Extreme types of sports attributed to those listed below or close to them by their nature and used equipment:

a) Car, motorcycle and motor vehicle sports and bicycle sports, riding BMX, HD, FR type and specialised mountain bicycles, skateboarding and roller-skating on ramps, paragliding sports, parachuting (including BASE jumps), bungee jumping, gliding and hang-gliding, flying engineless aviation, spaceships, lightweight and ultra lightweight aircraft, horse riding and equestrian sports, shooting sports. Exclusions – jumps with dome-shaped or wing-shaped parachute-jumps and tandem skydiving with the instructor, licensed hunting, shooting and/or horse riding under supervision of the instructor; highway, cross-country, tract bicycle sports, chartered leisure flights by aircraft when such activities are organised under supervision of entities holding sports licences and are the way of spending free time of the Insured, but are not periodic, aimed at achieving sports results and passing sports rankings;

b) White-water canoeing and kayaking, surfing; swimming long distances in ice-cold water, rafting, riffle and wave rafting, sea yachting, diving in >40 m depth, deep diving without diving equipment, jumping fro rocks to the water, wakeboarding, windsurfing, surfboarding sports, water motorcycles, power kites. Exclusion – leisure-time diving (up to 40 m depth), yachting and mechanical wowing/boating in still water and plain rivers when such activities are the way of spending free time of the Insured, without aiming to achieve sports results and rankings;

c) Skiing with snow power kites, jumping with skis or snowboards, roadless mountain skiing, heli-skiing and paraglider-skiing. Exclusion – leisure-time plain skiing, on routes adapted and intended for and skiing.

d) Alpinism, rock climbing, descent into caves and canyons, climbing frozen waterfalls, rocks, bouldering, running ultra marathons in mountains, parkour, expeditions and trips to areas of extreme climatic conditions (such as polar zone, jungles, desert, offshore, etc.). Exclusion – leisure-time running, except for exercises specially organised under extreme conditions and in extreme areas.

e) Combat sports or contact sports such as boxing, wrestling, karate, fencing, etc. Exclusion – children up to 14 years engaged in such sports.

3. Concluding an insurance agreement

3.1. In order to conclude an insurance agreement, a person shall submit to the Insurer an application of the set form. The submission of the application and the payment of a premium shall not obligate the Insurer to conclude an insurance agreement. The Policyholder and the Insured persons shall complete questionnaires in the form set by the Insurer, if requested by the Insurer. An application for concluding an insurance agreement shall expire, if the Policyholder is not issued an insurance policy within 3 months from the day of signing of this application.

3.2. Having assessed the insurance risk, the Insurer may refuse to conclude an insurance agreement, without indicating any reasons therefor. If an insurance premium was paid according to the submitted insurance application before the assessment of the insurance risk and the refusal of the Insurer to conclude an insurance agreement, such the insurance premium shall be returned to the person having paid it. In case of an insured event provided for in these Insurance Rules having happened during this period of time, the Insurer shall not have to pay an insurance benefit.

3.3. Upon the Insurer's consent to conclude an insurance agreement, the Policyholder shall be issued an insurance policy confirming the conclusion of an insurance agreement. The day of conclusion of an insurance agreement shall be the day of issuance of an insurance policy.

3.4. At the Insurer's consent, insurance risks may be insured according to additional insurance conditions of these Insurance Rules. Insurance risks included in the insurance agreement, terms of validity of their insurance coverage and sums insured shall be indicated in the insurance policy and annexes thereto.

3.5. The insurance agreement shall comprise the following documents:

a) an application for concluding ERGO universal life insurance agreement;

b) questionnaires of the Insured/ insured persons;

c) insurance policy and annexes thereto;

d) ERGO Universal Life Insurance Rules;

e) pricelist and other documents issued by the Insurer;

f) other documents and applications submitted by the Policyholder affecting the conclusion, amendment and performance of the insurance agreement.

4. Insured events

4.1. Insured events shall be:

a) death of the Insured during the validity period of the insurance agreement (except for cases provided for in Item 5);

b) expiry of the insurance agreement, if the Principal Insured lives until then.

4.2. Where a court declares the Insured dead, it shall be considered an insured event if the date of death of the Insured declared by an effective court judgement falls within the insurance coverage validity period.

5. Non-insured events

5.1. Non-insured events, when an insurance benefit shall not be paid, shall include the following:

a) suicide committed by the Insured within the first 3 insurance coverage validity years;

b) death of the Insured related to military actions, introduction of the state of war or emergency, internal unrest and nuclear energy effects;

c) death of the Insured during his engagement in a criminal offense. The existence of a criminal offense shall be proved by investigation material of pre-trial investigation institutions, conclusions, procedural decision or a court judgement;

d) death of the Insured at the time of suspension of insurance coverage;

e) death of the Insured at the intent (acts committed by direct or indirect intent) of the Policyholder, the Insured person or the Beneficiary, except for suicide of the Insured after 3 years of validity of insurance coverage;

f) death of the Principal Insured due to a congenital disorder up to one year of age.

6. Object of insurance

6.1. The object of insurance shall be a property interest related to the life expectancy of the Insured and capital accumulation. Depending on insurance conditions which the insurance agreement is subject to, the object of insurance may also be a property interest related to accidents and/or health of the Insured. Objects of insurance shall be listed in the insurance policy.

7. Sum insured and insurance benefits

7.1. The Principal Insured shall be covered by a life insurance sum insured the amount whereof shall be set in the insurance policy. The Insurer may set the amount of the minimum life insurance sum insured.

7.2. In case of death of the Principal Insured, the insurance benefit amount shall depend on the insurance option (A or B) chosen in the insurance agreement and the sum insured. When the insurance agreement provides for insurance option A, the larger of the two amounts – the life insurance sum insured or the accumulated capital value – shall be paid in case of the death of the Principal Insured. When the insurance agreement provides for insurance option B, the life insurance sum insured and the accumulated capital value shall be paid in case of the death of the Principal Insured.

7.3. At the agreement of the parties to the insurance agreement, additional Insured persons may be covered by life insurance. Sums insured agreed upon for each Insured shall be indicated in the insurance policy. In case of death of an additional Insured person due to an insured event, the life insurance sum insured of this person shall be paid.

7.4. In case of the death of the Principal Insured due to a non-insured event, beneficiaries shall be paid the surrender value. In case of death of an additional Insured person due to a non-insured event, insurance coverage of this person shall terminate, and no insurance benefits shall be paid.

7.5. Where the Insured commits a suicide within the first 3 years from the inclusion of additional life insurance of this person or increase of his sum insured, except for the case provided for in paragraph 5.1 a), an insurance benefit shall be calculated according to paragraphs 7.2-7.3 on the basis of the lowest life insurance sums insured of the Insured valid in the past 3 years.

7.6. If the Principal Insured lives to the expiry of the insurance term, the value of capital accumulated on his behalf indicated in paragraph 15.7 shall be paid out.

7.7. The Policyholder may indicate the desired additional insurance risks and their sums insured in his application. The sums insured separately for each insured insurance risk shall be set by an agreement of the parties to the insurance agreement. The sums insured agreed upon by the parties to the insurance agreement shall be indicated in the insurance policy. The Insurer may set the minimum sums insured.

8. Insurance premiums

8.1. Insurance premium amounts shall be indicated in the insurance policy. The Policyholder shall pay the insurance premium in a lump sum or in periodic instalments. Insurance premiums shall be paid within the terms set in the insurance policy.

8.2. The Policyholder shall have the right to pay additional insurance premiums unprovided for in the insurance policy having submitted to the Insurer an application in the form set. The payment of an additional premium shall not relieve the Policyholder from the duty of payment of periodic insurance premiums provided for in the insurance agreement.

8.3. Separate payments of premiums cannot be lower than the minimum insurance premium amounts. The Insurer shall set the minimum insurance premium amount.

8.4. The share of insurance premiums paid by the Policyholder, which remains having deducted deductibles set by the Insurer applicable to insurance premiums, shall be used proportionately to acquire investment units in investment directions chosen by the Policyholder.

8.5. The share of the paid insurance premium designated for acquiring investment units shall be converted to investment units according to the price of the calculation day and the investment programme selected by the Policyholder. According to the valid insurance agreement, money shall be converted to investment units immediately, but no later than within 5 working days after the day of payment of an insurance premium, unless the insurance agreement indicates otherwise. Insurance premiums paid till the day of issuance of an insurance policy shall be converted to investment units immediately, but no later than within 5 working days from the day of issuance of the insurance policy. If observing these terms is impossible for reasons beyond the Insurer's control, the share of the paid insurance premium shall be converted to investment units later on, but as soon as this becomes possible.

8.6. The date of payment of an insurance premium shall be the day when the payment is credited to the Insurer's bank account. If a payment transfer does not allow determining the insurance agreement under which the insurance premium was paid, the date of payment of the insurance premium shall be considered to be the day of attribution of the premium to the insurance agreement.

8.7. Other persons may also pay an insurance premium on the Policyholder's behalf without acquiring any rights to the insurance agreement and the paid insurance premiums.

9. Insurance deductibles

9.1. A premium deductible shall be deducted from insurance premiums paid in a lump sum and additional insurance premiums.

9.2. The following insurance agreement deductibles set by the Insurer may be deducted from the accumulated capital value on the last day of each month:

a) agreement conclusion deductible for covering costs of conclusion of the insurance agreement. This deductible shall not apply if the insurance agreement was concluded with a lump sum insurance premium only;

b) administration deductible for covering costs of conclusion of the insurance agreement. This deductible may consist of a variable and a fixed component;

c) insurance risk deductibles for covering costs of the selected insurance coverage.

9.3. Deductible amounts applicable to the insurance agreement and their application procedure shall be indicated in the insurance policy and the pricelist. The Insurer shall have the right to change deductible amounts applicable to the insurance agreement having changed the pricelist in the procedure laid down in paragraph 13.16.

9.4. When paying out a part of the accumulated capital to the Policyholder according to paragraph 15.5, a capital withdrawal fee in the amount specified in the Insurer's additional insurance agreement administration service pricelist may be deducted.

9.5. The Insurer shall approve insurance risk deductible tariffs. Amounts of these deductibles shall be calculated according to the applicable Insurer's tariffs and individual data of the Insured persons. Insurance risk deductibles may be increased in light of the degree of the insurance risk of the Insured.

In case of the change of statistical data on insured events and insurance benefits, the Insurer may unilaterally change insurance risk deductible tariffs. The Insurer shall report such changes to the Policyholder 3 months before the effective date of new tariffs. If the Policyholder disagrees with the change of tariffs, he may change insurance agreement conditions that affect the amount of these deductibles free of charge before the effective date of new tariffs, or terminate the insurance agreement according to paragraph 16.5.

9.6. If insurance option A was chosen in the insurance agreement according to paragraph 7.2, the deductible amount of life insurance risk of the Principal Insured shall be calculated according to the difference between the sum insured and the accumulated capital value, and according to the insurance risk deductible tariff set in the insurance policy. If the value of capital accumulated according to such the insurance option is equal to or greater than the sum insured, such an insurance risk deductible shall not be calculated for the Principal Insured.

10. Default on payment of insurance premiums and suspension of insurance coverage

10.1. The Insurer may suspend the validity of the insurance coverage in the following cases:

a) in case of a failure to pay an insurance premium;

b) when the accumulated capital is not enough to cover deductibles.

10.2. If the Policyholder fails to pay a periodic insurance premium or a part thereof within the period of time set in the insurance agreement, the Insurer shall inform the Policyholder thereof in writing. If the Policyholder does not pay an insurance premium within 30 days from the day of sending a notice, the Insurer shall have the right to suspend insurance coverage until the Policyholder pays the insurance premium in arrears.

10.3. If the value of capital accumulated in the course of validity of the insurance agreement becomes lower than the amount of applicable insurance agreement deductibles, insurance coverage shall be suspended. In such a case, the Insurer shall notify the Policyholder in writing about the suspension of insurance coverage, indicating in the notice the amount of the minimum insurance premium necessary to restore the validity of the insurance coverage.

10.4. At the time of suspension of the insurance coverage, deductibles set by the Insurer for the insurance agreement shall be calculated but shall not be deducted from the accumulated capital. Insurance risk deductibles shall not apply for the insurance coverage suspension period. All insurance deductibles that were not paid during the insurance coverage suspension period shall be deducted from the accumulated capital value on the day of restoration of the insurance coverage.

10.5. If the insurance coverage was suspended, its validity shall be restored on the day following the day of payment of the sum indicated in the notice of suspension of insurance coverage. If the Policyholder fails to pay the specified amount within 6 months from the day of suspension of the insurance coverage, insurance coverage may be restored at the Insurer's consent and according to insurance conditions set thereby.

10.6. If the suspension of the insurance coverage lasts more than 6 months, the Insurer shall have the right to unilaterally terminate the insurance agreement.

11. Investment directions and programmes

11.1. The Policyholder shall choose an investment programme at the time of conclusion of the insurance agreement, by indicating in his application the investment programme or the investment directions and the distribution of the paid part of the insurance premium.

11.2. The Policyholder shall have the right to choose investment direction from the list offered by the Insurer. The Insurer shall have the right to change the list of offered investment directions. The Insurer may set the portions that may be invested in certain investment directions, and the number of directions to be selected.

11.3. In cases where at least one of investment directions to be selected under the investment programme is eliminated, the Insurer shall notify the Policyholder thereof at least 30 days in advance. The Policyholder shall present his decision before the day of elimination of the investment direction. If the Policyholder fails to present his decision during this period of time, the Insurer shall change the investment programme and/or distribute the capital accumulated by the Policyholder in the investment direction being eliminated among other investment directions at its own discretion.

11.4. Descriptions of investment directions along with the investment strategy shall be published on the Insurer's website. At the Policyholder's request, the Insurer shall provide the Policyholder with the descriptions of his selected investment directions. The Insurer shall have the right to change those objects of investment of the investment direction, which meet the investment direction strategy.

11.5. In cases where the investment strategy of one of the investment directions changes, the Insurer shall notify the Policyholder thereof at least 30 days in advance. The Policyholder shall present his decision before the date of change of the investment strategy. If the Policyholder fails to present his decision during this period of time, the Insurer shall leave the accumulated capital in that same investment direction or change the investment programme of the Policyholder and/or redistribute the structure of the accumulated capital among other investment directions at its own discretion.

11.6. The Policyholder shall not have the right to file claims with regard to the Insurer's decision on investment directions where the capital accumulated by the Policyholder should be distributed and insurance premiums after the elimination of the investment direction should be directed, or the change of investment strategy of the investment direction, if the Policyholder failed to present such information within the set deadlines and in the specified ways.

11.7. Investment unit prices shall be published on the Insurer's website.

12. Insurance agreement validity terms

12.1. The start of insurance indicated in the Policyholder's application for concluding an insurance agreement shall be preliminary, thus the Insurer may change it considering the receipt of all the data necessary to issue an insurance policy. The validity term of the insurance agreement shall be specified in the insurance policy. The insurance agreement shall take effect in presence of all of these conditions: the Policyholder was issued an insurance policy and the first insurance premium specified therein was paid. The Insurer shall also have the right to declare the insurance agreement effective in the absence of all the listed conditions. In case of a failure to pay the total first insurance premium within 3 months from the day of conclusion of the insurance agreement, the insurance agreement shall terminate, and may be restored only at the Insurer's consent.

12.2. By paying the first periodic insurance premium or paying it in a lump sum, the Policyholder confirms that he agrees with insurance agreement conditions and concludes the insurance agreement.

12.3. The insurance coverage shall take effect on the following day after the day of payment of first periodic insurance premium or paying it in a lump sum, but no earlier than the conclusion of the insurance agreement and no earlier than the start of insurance indicated in the insurance policy. The insurance agreement shall also be valid without the Policyholder's signature on the insurance policy.

12.4. Insurance coverage may be suspended in cases listed in paragraph 10.1 of the Insurance Rules.

12.5. The insurance agreement shall terminate when:

a) the Principal Insured has died. If death of the Principal Insured is not an insured event according to provisions of these Insurance Rules, the insurance agreement may be extended at the Insurer's consent having received the Policyholder's request for the change of the Principal Insured;

b) all insurance benefits have been paid;

c) the Policyholder, who is a natural person, has died, or the Policyholder, who is a legal person, has been liquidated, and there are no successors to his rights and duties. In such a case the Insurer shall pay to the Policyholder's successors or the liquidated legal person the surrender value;

d) the insurance agreement has been terminated;

e) the insurance agreement has expired.

12.6. Additional insurance conditions may provide for other cases of termination of the insurance agreement. Additional insurance coverage shall be valid solely with the main ERGO universal life insurance coverage being valid.

12.7. In case of death of the Insured, insurance coverage which this person is entitled to under the insurance agreement shall expire.

13. Rights and duties of the parties to the insurance agreement

13.1. The Insurer undertakes to familiarize the Policyholder with these Insurance Rules, descriptions of investment directions proposed by the Insurer, insurance premium amounts, and, having concluded an insurance agreement, to issue an insurance policy. The Insurer shall also provide other insurance agreement-related information, which the Insurer is obligated to provide according to laws of the Republic of Lithuania and resolutions of the supervisory authority.

13.2. Both when concluding an insurance agreement and during its validity, the Policyholder shall provide to the Insurer detailed and correct information about the Insured. When completing an application for the conclusion or amendment of the insurance agreement at the time of conclusion of the insurance agreement or in the course of its validity, a report on an insured event or when answering questionnaires or additional questions presented by the Insurer, the Policyholder and the Insured shall present to the Insurer all the information known to them, which is necessary for the Insurer to assess the insurance risk, to determine the circumstances that may have a material impact on the likelihood of happening of an insured event, to investigate the insured event or to determine insurance agreement deductibles, insurance benefit amount or other circumstances important for the insurance agreement. The Policyholder shall inform the Insurer about the increase of an insurance risk in writing, including the insurance risk related to the change of data of the Insured on his work activities. In the performance of the insurance agreement, the Insurer undertakes not to publish the received information about the Policyholder or the Insured, except for cases provided for in the insurance agreement and laws.

13.3. The Insurer shall provide insurance coverage believing that the Policyholder and the Insured have comprehensively and correctly answered all the questions in the Insurer's application for concluding an ERGO universal life insurance agreement and questionnaires, especially those related to the current or previous illnesses, health disorders, ailments, bad habits, hereditary diseases, work activities and hobbies. The Policyholder and the Insured persons shall immediately notify the Insurer in writing about the change of their health condition or other data presented in the application having taken place after the day of completion of the application till the day of issuance of the insurance policy.

13.4. Should it be determined after concluding an insurance agreement that the Policyholder or the Insured defaulted on their obligation to disclose information when concluding an insurance agreement or during its validity, and intentionally or negligently provided the Insurer with incomplete or false information about the Policyholder, the Insured or the circumstances that could have material impact on the assessment of the insurance risk, the likelihood of the happening of an insured event, the determination of insurance agreement deductible amounts or other circumstances significant for the insurance agreement, the Insurer shall have the right to terminate the insurance agreement, to reduce the insurance benefit or to refuse to pay it altogether, except for cases, when circumstances, which the Policyholder and/or the Insured concealed, disappeared before the insured event or had no impact on the insured event.

13.5. If after conclusion of the insurance agreement it is established that the Policyholder or the Insured has insufficiently named the circumstances of the leisure-time and sports, or such circumstances have changed during validity of the agreement and during investigation of insured events by the Insurer it transpired that activities of the Insured should be attributed to the professional or extreme sports/leisure-time, the Insurer shall have the right to propose amendments to the insurance agreement according to the insured person's risk and establish insurance allowances corresponding to the risks for additional insurance covers. If the parties to the insurance agreement fail to agree on the amendment it shall be considered that the insurance agreement does not provide the cover when continuing to engage in professional sports and/or extreme sports/leisure-time.

13.6. The Policyholder shall inform the Insured, its legitimate representative and beneficiary about the concluded insurance agreement and familiarize them with their rights and obligations laid down in the insurance agreement. In case of amending the insurance agreement, the Policyholder shall provide to the persons listed in this paragraph information on amendments to the insurance agreement.

13.7. When concluding and performing the insurance agreement, the Insurer shall have the right to manage personal data of the Insured, the beneficiary and the payer of insurance premiums without their consent, except for special personal data.

13.8. The Policyholder and the Insured persons shall have the right to get familiar with their managed personal data and ways of managing them, to request to correct them, destroy their personal data or to terminate actions of management of their personal data, when data are managed in breach of legal provisions, also to disagree with the management of their personal data. If an insurance agreement participant disagrees with the management of his personal data, the Insurer shall have the right not to conclude and/or to terminate the insurance agreement according to paragraph 16.4.

13.9. The beneficiary shall have the right:

a) to receive information about the course of investigation of the insured event;

b) to request to pay an insurance benefit in the procedure laid down in the insurance agreement.

The beneficiary must provide the Insurer all the available documents and/or information about the circumstances and consequences necessary to determine the insurance benefit amount, which he is entitled to receive in the procedure prescribed by laws.

13.10. Insurance agreement-related notices shall be presented to the Insurer in writing or by other means agreed upon with the Insurer. Such notices shall take effect for the Insurer from the moment of their receipt.

13.11. In cases where laws of the Republic of Lithuania and/or the Insurance Rules provide for a written presentation of information, this requirement shall be considered to have been fulfilled if information to the Policyholder (the Insured) has been presented by mail, e-mail or by other telecommunication terminal equipment allowing to prove the fact of the submission of information, at the agreement of the parties to the insurance agreement.

13.12. The Policyholder shall notify the Insurer about the change of correspondence address, his name, surname or title immediately. If the Policyholder leaves abroad for a period of time longer than 3 months, he shall indicate to the Insurer the person living in Lithuania authorized on behalf of the Policyholder to receive Insurer's notices, or specify his e-mail address for correspondence.

13.13. At the Policyholder's written request and payment according to the Insurer's pricelist for additional insurance agreement administration services, a duplicate insurance policy shall be issued. According to a written application of the Policyholder and his payment of a fee of the set amount according to the Insurer's pricelist for additional insurance agreement administration services, the Insurer may also provide other additional insurance agreement administration services that are not included in the deductible fees.

13.14. The Policyholder shall immediately inform the Insurer in writing about his intention to transfer or to pledge his rights arising out of the insurance agreement.

13.15. Each year, the Insurer shall inform the Policyholder about the value of his accumulated capital, the surrender value amount, and shall provide to the Policyholder other information provided for by laws.

13.16. The Insurer shall present to the Policyholder information about the change of the pricelist no later than 30 days before the effective date of change of the pricelist. If higher deductibles are provided for in the pricelist, except for the mandatory deductible established by laws, the Policyholder shall have the right to terminate the insurance agreement before the effective date of these changes in the procedure laid down in paragraph 16.5 of the Insurance Rules. Having received the Policyholder's application for terminating the insurance agreement, the Insurer shall pay to the Policyholder the amount laid down in paragraph 16.5 within 30 days from the day of receipt of the application.

14. Procedure of determining insurance benefit amounts

14.1. In case of the death of the Insured, the Insurer shall be presented with the following:

a) an official document of the form established by legal acts testifying to the fact of death;

b) a detailed doctor's or health institution's statement on the cause of death, also the beginning and the course of the illness which led to the death of the Insured.

14.2. The Insurer shall be informed about the death of the Insured within 30 days from the death of the Insured or within 30 days from the effective date of the court judgement for declaring the Insured dead.

14.3. The person pretending to receive an insurance benefit shall cover expenses related to the provision of documents necessary for determining and assessing the insured event and the issuance of documents substantiating the insured event.

14.4. In order to determine if insurance benefits must be paid, the Insurer may request for additional documents and/or evidence, or perform the necessary investigation itself at its own expense.

15. Procedure of payment of insurance benefits

15.1. Insurance benefits shall be paid to beneficiaries indicated in the insurance agreement. If the insurance agreement does not indicate any beneficiaries, insurance benefits in case of the death of the Insured shall be paid to successors of the Insured. The Insurer shall pay all other benefits (the surrender value, a part of accumulated capital, etc.) to the Policyholder, persons authorized by him to receive other benefits or his successors according to the insurance agreement, if this is not in conflict with paragraph 15.2 of the Insurance Rules.

15.2. If the Insured is a minor or incapacitated person, benefits shall be paid to the bank account opened on behalf of this person. In case of death of a minor or incapacitated person, the insurance benefit shall be paid to his legitimate successors.

15.3. The Insurer shall pay insurance benefits to the beneficiary at its own expense. Benefits shall be transferred to the account specified by the beneficiary. When transferring benefits abroad, the associated risks shall rest with the beneficiary.

15.4. The Insurer shall pay insurance benefits in euros within 30 days from the day when all information significant in determining the fact of an insured event, the circumstances, consequences and the benefit amount has been received (including additional information from law enforcement authorities, health care institutions, etc.)

In cases where there is an ongoing investigation by law enforcement authorities or an instituted judicial procedure, the Insurer shall have the right to postpone a decision on the insurance benefit till the end of the investigation or the judicial procedure. The Insurer shall make a decision on whether the received information is sufficient to declare an event to be an insured event and to determine the benefit amount.

The Insurer shall determine the scope of the necessary information. When collecting information important in determining the fact of the insured event, the circumstances, consequences and benefit amount, the Insurer shall have the right to request the persons having presented applications for benefits, doctors, hospitals and other treatment, healthcare and nursing or law enforcement institutions of the Republic of Lithuania, also other natural and legal persons documents substantiating the right of succession, identity, affinity, also medical findings, diagnoses, other medical documents, documents confirming the fact of death of the Insured, explanations, conclusions and all other verbal and written information, which, in the Insurer's opinion, is necessary to investigate the event and determine the benefit amount.

15.5. Starting with the second year of insurance, the Policyholder may withdraw a part of the accumulated capital without terminating the insurance agreement, having informed the Insurer thereof 30 days in advance. The balance of the accumulated capital after the pay-out of the accumulated capital part shall be no less than the minimum amount set by the Insurer indicated in the pricelist of additional insurance agreement administration services. A part of the accumulated capital shall be paid upon the Policyholder's payment of the fee of withdrawal of a part of capital in the amount set by the Insurer. This fee may be deducted from the accumulated capital according to paragraph 9.4.

15.6. Upon the expiry of the insurance agreement validity term set therein, the accumulated capital value shall be paid within 7 working days from the expiry of this term, or no later than within 7 working days after the presentation of a written application of the Policyholder or the beneficiary, or other information necessary for the insurance benefit. In cases where an application has been presented before the expiry of the term indicated in the insurance agreement, an insurance benefit shall be paid no later than within 7 working days from the expiry of the term set in the insurance agreement.

15.7. The value of the paid accumulated capital shall be converted to money according to the price of the day of calculation of investment units. The Insurer shall have the right to deduct from the insurance benefit amount insurance deductibles unpaid during the insurance coverage suspension period.

15.8. In case of death of the Principal Insured, the capital accumulated by the Policyholder shall be converted to money no later than within 5 working days from the day of receipt of a notice about the death of the Insured, and shall not be invested. If following these terms is impossible for reasons beyond the Insurer's control, capital accumulated by the Policyholder shall be converted to money later on, but as soon as it becomes possible.

16. Pre-term termination of the insurance agreement

16.1. The Policyholder shall have the right to terminate the insurance agreement having notified the Insurer in writing thereof no later than 30 days before the date of termination of the insurance agreement.

16.2. If the Policyholder, who is a natural person, terminates the insurance agreement having notified the Insurer thereof within 30 days from the moment when he was informed about the concluded insurance agreement, the Insurer shall return the sum of the paid insurance premiums.

16.3. The Insurer may unilaterally terminate the insurance agreement in cases provided for in paragraphs 10.6, 13.4 and 13.8 of these Insurance Rules and/or cases provided for by laws of the Republic of Lithuania.

16.4. When the insurance agreement is terminated at the Insurer's initiative upon the Policyholder's breach of insurance agreement conditions, the Policyholder shall be returned the surrender value.

16.5. When the insurance agreement is terminated at the Policyholder's initiative, except for cases laid down in paragraph 16.6, the Policyholder shall be returned the surrender value.

16.6. When the insurance agreement is terminated at the Policyholder's initiative upon the Insurer's breach of insurance agreement conditions, the Policyholder shall be returned the value of capital accumulated under the insurance agreement, additionally paying to him a compensation of 1% of the accumulated capital value.

16.7. If the Policyholder has not indicated any other authorized person, the beneficiary shall receive a notice of termination of the insurance agreement after his death. If there is no beneficiary, or locating him is impossible, a notice may be handed in to heirs or successors of the Policyholder.

17. Amending the insurance agreement

17.1. The Policyholder shall notify the Insurer about the desired amendments to the insurance agreement, except for the cases laid down in paragraphs 17.4 and 17.5, in writing or by other means agreed upon with the Insurer no later than 30 days before the planned date of amendment of the insurance agreement.

17.2. The Policyholder may change the beneficiary at any time before the insured event, except for cases provided for in paragraph 17.3 of these Insurance Rules, having informed the Insurer thereof in writing. If the beneficiary was appointed at the Insured's consent, the beneficiary may be changed only at the Insured's consent.

17.3. If the beneficiary was appointed irrevocably, the Policyholder may not reduce the sum insured without the beneficiary's consent. If the insurance coverage is suspended, the Insurer may inform the irrevocably appointed beneficiary thereof.

17.4. Having informed the Insurer in writing or by other means agreed upon with the Insurer and having received the Insurer's consent, the Policyholder shall have the right to change the investment programme. The changed investment programme shall apply solely to insurance premiums paid from the day of change of the investment programme. The Insurer may set limits for the change of investment programmes and apply the fees set in the pricelist of additional insurance agreement administration services.

17.5. During the validity period of the insurance agreement, the Policyholder shall have the right to change the structure of the accumulated capital without breaching the limits of investing in a certain direction set by the Insurer, having informed the Insurer in writing or by other means agreed upon with the Insurer and having received the Insurer's consent. When changing the structure of the accumulated capital, the held investment units shall be converted to investment units of the newly selected investment directions according to the price of the calculation day. At the Insurer's consent, the recalculation shall be made immediately, but no later than within 5 working days. If following these terms is impossible for reasons beyond the Insurer's control, the structure of the accumulated capital shall be changed later on, but immediately when it becomes possible

18. Procedure of assigning rights and duties under the insurance agreement

18.1. The Insurer shall have the right to assign its rights and duties under the insurance agreement to another insurance company, insurance company of another European Union member state or a foreign insurance company branch, established in the Republic of Lithuania or another European Union member state in accordance with the procedure established by laws of the Republic of Lithuania, on the basis on a written agreement and having received a permission of the Bank of Lithuania.

18.2. The Insurer's notice on the intension to assign its rights and duties under the insurance agreement shall indicate a deadline of at least 2 months during which the Policyholder shall have the right to express to the Insurer his objections on the intension to assign rights and duties under the insurance agreement in writing.

18.3. Disagreeing with the assignment of rights and duties under the insurance agreement, the Policyholder shall have the right to terminate the insurance agreement within one month from the day of assignment of rights and duties, having informed the Insurer about the termination of the insurance agreement in writing. The insurance agreement shall be terminated from the day of receipt of the notice on the termination of the insurance agreement. Having terminated the insurance agreement on the basis indicated herein, the Policyholder shall be paid the surrender value.

19. Information on personal data processing

19.1. The Data Subject shall be a natural person, who is the Policyholder, the Insured, the Beneficiary, or the insurance premium payer.

19.2. The Insurer shall process personal data received from the Data Subject for the following purposes:

19.2.1. For the conclusion and administration of life insurance contracts, assessing the insurance risk, investigation of insured events and determination of insurance benefit amounts in accordance with Article 6(1)(a),(b) and Article 9(2)(a) of Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation) (hereinafter – Regulation (EU) 2016/679), for 10 (ten) years after termination of contractual relations;

19.2.2. For direct marketing with the Data Subject's consent;

19.2.3. For making an audio record of a phone call, for obtaining the proof of the conclusion and performance of insurance contracts, for 10 (ten) years after termination of contractual relations.

19.3. If the Data Subject does not provide to the Insurer all necessary personal data, the insurance services may be not provided, and the Insurer shall have the right to refuse concluding the insurance contract according to the conditions of the insurance regulations of the Insurer.

19.4. The personal data of the Data Subject may be provided to and received from:

19.4.1. health care institutions, services authorised under legal acts to establish the disability and capacity for work, for medical examination of the insured person prior to the conclusion or amendment of the insurance contract, for the purpose of assessing the insurance risk when concluding, amending life insurance contracts.

19.4.2. medical specialists, hospitals and other medical treatment, health care and nursing institutions, the National Health Insurance Fund under the Ministry of Health and territorial health insurance funds, the State Social Insurance Fund Board (SODROS), the SE Centre of Registers, services authorised under legal acts to establish the disability and capacity for work, forensic experts, specialists, law enforcement bodies, other natural and legal persons in the territory of the Republic of Lithuania and other countries for the purpose of assessing the circumstances of the occurring insured events and determining the insurance benefit amount.

19.5. The Insurer may provide personal data of the Data Subject to:

19.5.1. courts, law enforcement bodies and other institutions in the cases established by laws;

19.5.2. reinsurers for the purposes of reinsurance both in the Republic of Lithuania and other countries;

19.5.3. banks for the purposes of providing information on administration of the contract;

19.5.4. data processors – companies providing to the Insurer services of customer servicing and other value added (administration) services, document scanning, management and storage of archive documents (archive), maintenance and support of the Insurer's information systems;

19.5.5. enteritis engaged in activities relating to debt collection in recovering from the Policyholder the unpaid insurance premiums, contract administration fees;

19.5.6. other data recipients on the basis of the Data Subject's consent or request.

19.6. The Data Subject shall be informed about his or her right to request from the Insurer the access to his or her personal data, the right to have them rectified or deleted, or to restrict the processing and the right to object to the processing of such data and the right to the portability of data. These rights shall be implemented according to the time limits and procedure set out by Regulation (EU) 2016/679, except where Regulation (EU) 2016/679 establishes otherwise.

19.7. Where personal data are processed according to Article 6(1)(a) and Article 9(2)(a) of Regulation (EU) 2016/679, the Data Subject shall have the right to withdraw his or her consent at any time.

19.8. The Data Subject shall have the right to contact the Data Protection Officer of the Insurer (by e-mail: asmensduomenys@ergo.lt or phone 1887) on all matters concerning processing his or her personal data and exercising his or her rights under Regulation (EU) 2016/679.

19.9. The Insurer may use profiling in respect of personal data of the Data Subject for the purposes specified in paragraph 19.2.
More detailed information on the profiling is provided in the Privacy Policy of ERGO, which is available at www.ergo.lt.

19.10. Where the Data Subject considers that his or her rights established under Regulation (EU) 2016/679 are infringed, he or she shall have the right to lodge a complaint with the supervisory authority, and, in the first instance, with the State Data Protection Inspectorate under Article 77(1) of Regulation (EU) 2016/679, and the right to invoke the judicial remedy under Article 79 of Regulation (EU) 2016/679.

20. Final provisions

20.1. The insurance agreement shall be subject to laws of the Republic of Lithuania.

20.2. All disagreements arising between the Policyholder and the Insurer in respect to the conclusion, performance or termination of the insurance agreement shall be solved by mutual negotiation. Having failed to resolve disagreements by negotiation, a dispute between the Policyholder and the Insurer may be solved in out-of-court procedure pursuant to the rules for resolving disputes between consumers and participants in financial markets set by the Bank of Lithuania, or in court pursuant to laws of the Republic of Lithuania. The Policyholder and the Insured persons shall have the right to refer to the supervisory authority of participants in financial markets, namely, the Bank of Lithuania, for dispute resolution in out-of-court procedure.

20.3. The Insurer shall have the right to amend the insurance rules on the basis whereof the insurance agreement was concluded, if rights and interests of the Policyholder, the Insured and the beneficiary arising out of the insurance agreement are not annulled or restricted by that amendment.

20.4. The Insurer shall have the right to supplement and amend certain paragraphs of the insurance rules on the basis whereof insurance agreements were concluded in the following cases: upon the change or emergence of new legal norms following which insurance rules were drafted, or upon the change of legal norms directly related to the insurance agreement, or in presence of an objective necessity due to economic situation (for example, in case of hyperinflation).

20.5. The Insurer shall familiarize the Policyholder with amendments to the Insurance Rules according to paragraphs 20.3 and 20.4, notifying him in writing or by other agreed means. Amendments to the Insurance Rules shall take effect in 30 days from the day of sending the Insurer's notice about the amendment to the Insurance Rules to the Policyholder, unless the Insurer indicates a different period of time. If the Policyholder disagrees with amendments to the Insurance Rules, he shall have the right to terminate the insurance agreement. In such a case, the Policyholder shall be paid the surrender value.

20.6. Claims arising out of the insurance agreement shall be subject to limitation periods established in the Civil Code of the Republic of Lithuania.

II. Conditions of additional orphan's pension insurance

1. Insured events

1.1. The insured event shall be death of the Insured during the validity of the insurance coverage, except for cases provided for in paragraph 2.1.

1.2. Upon the court's declaration of death of the Insured, this shall be considered an insured event, if the date of death of the Insured declared by an effective court judgement falls within the validity period of the insurance coverage. Where court declares the Insured to be missing, this shall not be treated an insured event.

2. Non-insured events

2.1. Non-insured events, when an insurance benefit shall not be paid, shall include the following:

a) suicide committed by the Insured within the first 3 insurance coverage validity years;

b) death of the Insured related to military actions, introduction of the state of war or emergency, internal unrest and nuclear energy effects;

c) death of the Insured during his engagement in a criminal offense. The existence of a criminal offense shall be proved by investigation material of pre-trial investigation institutions, conclusions, procedural decision or a court judgement;

d) death of the Insured at the time of suspension of insurance coverage;

e) death of the Insured at the intent (acts committed by direct or indirect intent) of the Policyholder, the Insured or the Beneficiary, except for the suicide of the Insured after 3 years of validity of the insurance coverage.

3. Object of insurance

3.1. The object of insurance shall be a property interest related to the life expectancy of the Insured, which is identified as orphan's pension in the insurance agreement.

4. Sum insured and insurance benefits

4.1. At the agreement of the parties to the insurance agreement, the Insured persons may be covered by additional orphan's pension insurance. The Insured persons and terms of validity of their insurance coverage shall be indicated in the insurance policy.

4.2. The amount of the sum insured shall decrease each month and be equal to the sum of orphan's pensions payable in case of an insured event.

4.3. In case of the death of the Insured before the expiry of the insurance term, the orphan's pension shall be paid to the beneficiary specified in the insurance agreement from the beginning of the following month till the end of the insurance term of orphan's pension. The orphan's pension shall be paid on the first day of each month, indicating its amount in the insurance policy. If the expiry of the insurance term is not the first day of the month, the last orphan's pension shall be paid on the first day of the following month after the expiry of the insurance term.

4.4. If the sum insured of the orphan's pension of the Insured was increased, but the Insured has committed a suicide within 3 first years from the increase of the sum insured, except for the case provided for in paragraph 2.1 a), the paid orphan's pension amount shall be equal to the orphan's pension valid before the increase thereof.

5. Procedure of determining insurance benefit amounts

5.1. Death of the Insured shall be reported to the Insurer within 30 days from the death of the Insured or within 30 days from the effective date of the court's judgement to declare the Insured dead.

5.2. The Insurer shall start paying insurance benefits within 30 days from the day of receipt of all information important in determining the fact of an insured event, its circumstances and consequences (including additional information from law enforcement authorities, health care institutions, etc.).

III. Conditions of additional loss of working capacity insurance

1. Insured event

1.1. An insured event shall be irreversible loss of working capacity of the Insured of 75% or more (complete loss of working capacity) caused by disorders of various notable bodily functions emerged during the validity period of the insurance coverage resulting in the Insured's set level of working capacity of 0-25% or the Insured being considered incapacitated. The Ministry of Social Security and Labor of the Republic of Lithuania together with the Ministry of Health of the Republic of Lithuania establish the criteria for determining the level of loss of working capacity and the level of capacity for work.

The fact of complete loss of working capacity shall be confirmed, if such incapacity of the Insured continuously lasts for at least 12 months. The Insurer shall make a decision on declaring the loss of working capacity an insured event.

1.2. In the event of the change of official methodology for determining the level of working capacity in the Republic of Lithuania, when assessing an insured event, the Insurer may follow the amended methodology in accordance with which the fact of complete loss of working capacity is determined and a person is considered incapacitated.

2. Non-insured events

2.1. Loss of working capacity shall be considered a non-insured event, and the Insurer shall not be obliged to pay insurance benefits, when the Insured's loss of working capacity was caused by illnesses and/ or consequences of accidents:

a) that came as a result of events related to military actions, introduction of the state of war or emergency, internal unrest, rebellion, riot, employee strikes, lockouts, arrests and detentions by governmental institutions and officials, military service or participation in a peacekeeping mission;

b) emerged and/or caused at the time of the Insured's engagement in a criminal offense or getting ready to engage therein, and/or other actions in conflict with law (for example, driving a vehicle without having the right to do that). Conclusions, procedural decisions of pre-trial investigation institutions or bodies authorized to examine administrative offense cases and/or court judgements, decisions, resolutions and rulings shall prove signs of criminal offense or preparation to commit a criminal offense or other actions in conflict with law, thus the Insurer may use them as a basis for making a decision on recognising an event to be non-insured event;

c) related to engagement of the Insured in professional sports and/or extreme sports/leisure-time, unless the insurance agreement provides otherwise;

d) diseases intentionally caused by the Insured, intentional injuries or suicide attempts;

e) injury of the Insured by intentional actions (acts committed by direct or indirect intent) of the Policyholder or beneficiary;

f) nuclear energy effects (except for consequences of radiotherapy);

g) influence of alcohol, drugs or toxic, psychotropic or other psychoactive substances or medicines that were not prescribed by a doctor used for intoxication purposes ;

h) AIDS or HIV.

2.2. Loss of working capacity shall not be considered an insured event, if the loss of working capacity was determined in the first 6 months from the start of insurance, except for consequences of accidents having happened during the insurance period and beyond the Insured's control.

2.3. If insurance coverage was suspended or terminated, having restored the validity of the insurance coverage, loss of working capacity shall not be considered an insured event if it happened for reasons that occurred during non-validity period of insurance coverage.

3. Object of insurance

3.1. The object of insurance shall be a property interest related to complete loss of working capacity of the Insured.

4. Sum insured

4.1. At the agreement of the parties to the insurance agreement, the Insured persons may be covered by additional loss of working capacity insurance. The sums insured of loss of working capacity insurance agreed upon by the parties to the insurance agreement shall be indicated in the policy.

4.2. Having declared loss of working capacity of the Insured an insured event, the sum insured for the loss of working capacity of this person shall be paid.

4.3. When the Insurer declares the Insured's loss of working capacity an insured event, the loss of working capacity insurance of this person shall expire.

5. Procedure of determining insurance benefit amounts

5.1. Complete loss of working capacity of the Insured shall be reported to the Insurer within 30 days from the day when working capacity was determined. The Insurer must be presented with a statement on working capacity (copy of the statement) issued by the Disability and Employment Capacity Assessment Office under the Ministry of Social Security and Labor and a comprehensive statement of the treating doctor on reasons for the loss of working capacity, the beginning thereof and its planned long-term presence in the future.

5.2. In case of an insured event the Insurer shall pay an insurance benefit to the Insured, unless the insurance agreement establishes otherwise.

5.3. The Insurer shall pay an insurance benefit within 30 days from the day of receipt of all the information important in determining the fact of an insured event, its circumstances and consequences (including additional information from law enforcement authorities, health care institutions, etc.).

5.4. In order to determine if an insurance benefit must be paid, the Insurer may request to furnish documents and/or additional evidence, question all doctors and treatment institutions where the Insured was treated, order the performance of the necessary medical tests or appoint a doctor's examination.

5.5. If the sum insured of the loss of working capacity was increased, after the declaration of the loss of the Insured's working capacity within the first 6 months from the day of increase of the sum insured, the insurance benefit shall be equal to the sum insured valid before the increase.

5.6. A loss of working capacity insurance benefit shall not be paid if the Insurer was notified of the loss of working capacity after the death of the Insured or more than 12 months after complete loss of working capacity of the Insured.

IV. Conditions of additional critical illnesses insurance

1. Insured event

1.1. An insured event shall be critical illness of the Insured confirmed by medical documents and corresponding to the list of critical illnesses indicated in the insurance agreement and Item 7 of these conditions, and criteria for diagnosing critical illnesses.

2. Non-insured events and non-insured persons

2.1. Non-insured events, when an insurance benefit shall not be paid, shall include the following:

a) the diagnosis did not meet all the criteria for diagnosing a critical illness listed in Item 7;

b) a critical illness occurred within the first 3 months from the beginning of critical illness insurance established in the insurance policy;

c) a critical illness occurred due to the effects of nuclear energy (except for consequences of radiotherapy);

d) a critical illness was caused by the Insured's intentional injury or by him trying to commit a suicide;

e) a critical illness was caused by the injury of the Insured caused by intentional actions (acts committed by direct or indirect intent) of the Policyholder or beneficiary;

f) a critical illness occurred in the course of the Insured's engagement in a criminal offense or preparing to commit it, or another action in conflict with law;

g) a critical illness came as a result of events related to military actions, introduction of the state of war or emergency, military actions, rebellion, riot, employee strikes, lockouts, arrests and detentions by governmental institutions and officials, military service or participation in a peacekeeping mission;

h) a critical illness came as a result of the influence of alcohol, drugs or toxic, psychotropic or other psychoactive substances or medicines that were not prescribed by a doctor used for intoxication purposes;

i) a critical illness came as a result of the engagement of the Insured in professional sports and/or extreme sports/leisure-time, unless the insurance agreement provides otherwise;

j) the Insured was diagnosed with the following malignant tumours: skin malignant tumour, chronic lymphocytic leukaemia, stage I lymphogranulomatosis, stage I prostate cancer, early stage carcinoma in situ malignant tumour;

k) the Insured was diagnosed with any tumour, when the Insured is HIV or AIDS infected;

l) the Insured was diagnosed with a congenital malformation (applicable solely to the person covered under paragraph 7.2 of the list of critical illnesses of children);

m) a critical illness was the reason of death of the Insured within one month from the day when the critical illness was diagnosed.

2.2. An insurance benefit shall not be paid if a critical illness occurred for reasons that happened during non-validity period of insurance coverage. If insurance coverage was suspended or terminated, it shall start applying for critical illness insured events after the period of 3 months from the day of restoration of validity of the insurance coverage.

2.3. The following persons shall not be covered by critical illness insurance:

- persons that suffer or suffered from critical illnesses;
- persons who are AIDS or HIV carriers;
- persons suffering from atherosclerosis, diabetes mellitus, chronic severe blood, liver, kidney or lung diseases;
- mental patients and people with chronic severe nervous disorders;
- persons abusing various stupefying, toxic or narcotic substances, medicines or alcohol;
- persons transferred to a special education institution or those serving a custodial sentence and persons subject to compulsory medical aids.

3. Object of insurance

3.1. The object of insurance shall be a property interest related to a critical illness of the Insured.

3.2. Lists of critical illnesses are presented in Item 7 of these insurance conditions. The insurance policy shall specify, which critical illness insurance option applies to the Insured and for which insurance period. The list of critical illnesses of children presented in paragraph 7.2 shall apply to the Insured till 18 years of age, unless the insurance agreement establishes otherwise. The list of critical illnesses laid down in paragraph 7.1 shall apply to the Insured from 18 years of age, unless the insurance agreement establishes otherwise.

4. Sum insured

4.1. At the agreement of the parties to the insurance agreement, the Insured persons may be covered by critical illness insurance. Critical illness insurance sums insured agreed upon by the parties to the insurance agreement shall be indicated in the insurance policy.

4.2. Having declared the critical illness of the Insured an insured event, the critical illness insurance sum insured of this person shall be paid. The sum insured under insurance of each Insured person shall be paid only once, regardless of the number of critical illnesses and their recurrence. Upon the Insurer's recognition of the Insured's critical illness, critical illness insurance of this person shall expire.

5. Procedure of determining insurance benefit amounts

5.1. The Insurer shall be notified of a critical illness in writing within 30 days from the day when it was diagnosed.

5.2. The Insurer shall pay insurance benefits having submitted a completed report on a critical illness and documents from a health care institution confirming the critical illness: a comprehensive doctor's statement on the illness, its course, tests, treatment and performed surgeries.

5.3. In order to determine if an insurance benefit must be paid, the Insurer may request to furnish documents and/or additional documents and/or evidence, question all doctors and treatment institutions where the Insured was treated, order the performance of the necessary medical tests or appoint a doctor's examination.

5.4. For as long as the Policyholder, the Insured or another person seeking for an insurance benefit intentionally or negligently defaults on the requirements laid down in this Item, the Insurer shall have the right not to recognize an insured event, but this clause shall not apply in cases where such negligent default on duties does not interfere with the determination of the insured event.

5.5. If the critical illness sum insured was increased, having diagnosed the Insured with a critical illness within the first 3 months from the day of increase of the sum insured, an insurance benefit for a critical illness shall be the critical illness insurance sum insured valid till the increase.

5.6. In case of critical illness insurance, the Insurer shall pay an insurance benefit to the Insured, unless the insurance agreement establishes otherwise.

6. Amending the insurance agreement

6.1. In the event of the change of life insurance sum insured of the Insured or the insurance duration, critical illness insurance may be extended in accordance with the conditions set by the Insurer only.

6.2. Considering the development of medical science and changes in morbidity rate, the Insurer shall have the right to unilaterally change definitions of critical illnesses and/or diagnostic criteria. The Insurer shall have the right to amend critical illness insurance conditions warning the Policyholder thereof no later than 30 days before the planned date of change of insurance conditions. If the Policyholder disagrees with these amendments to insurance conditions, critical illness insurance shall be terminated from the planned date of change of insurance conditions.

7. List of critical illnesses and diagnostic criteria

7.1. List of critical illnesses (applicable to the Insured persons 18-65 years of age):

- Cancer
- Myocardial Infarction
- Stroke
- Coronary Artery Bypass Graft Surgery
- Chronic Kidney Disease
- Major Organ, Composite Tissue or Bone Marrow Transplantation
- Heart Valve Surgery
- Surgery of the Aorta
- Paralysis of Limbs
- Profound Vision Loss
- Deafness
- Loss of Speech
- Multiple Sclerosis
- Alzheimer's Disease
- Persistent Vegetative State
- Aplastic Anaemia
- Benign Brain Tumor
- Primary Cardiomyopathy
- Severe Liver Disease
- Chronic Lung Disease
- Coma
- Sporadic Creutzfeldt-Jakob Disease
- Acute Viral Encephalitis
- Fulminant Viral Hepatitis
- Major Head Trauma
- HIV Infection due to Transfusion of Blood Products
- HIV Infection Caught at Work in an Eligible Occupation
- Loss of Limbs
- Third-Degree burns
- Motor Neurone Disease
- Bacterial Meningitis
- Muscular Dystrophy
- Primary Pulmonary Hypertension
- Idiopathic Parkinson's Disease
- Systemic Sclerosis (Scleroderma)
- Systemic Lupus Erythematosus
- Chronic Pancreatitis
- Severe Rheumatoid Arthritis
- Necrotising Fasciitis

7.2. List of critical illnesses of children (applicable to the Insured persons 2-18 years of age):

- Cancer
- Chronic Kidney Disease
- Major Organ, Composite Tissue or Bone Marrow Transplantation
- Paralysis of Limbs
- Profound Vision Loss
- Deafness
- Benign Brain Tumor
- Coma
- Acute Viral Encephalitis
- Major Head Trauma
- Loss of Limbs
- Bacterial Meningitis
- Insulin dependent Diabetes Mellitus (Type I)
- Severe Asthma exacerbation

7.3. Definitions of critical illnesses and their diagnostic criteria for the Insured persons 18-65 years of age:

Cancer

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The diagnosis must be confirmed by a Specialist. Unless not specifically excluded, leukaemia, malignant lymphoma and myelodysplastic syndrome are covered under this definition.

For the above definition, the following are not covered:

- Any tumour histologically classified as pre-malignant, non-invasive or carcinoma in situ (including ductal and lobular carcinoma in situ of the breast and cervical dysplasia CIN-1, CIN-2 and CIN-3);
- Any prostate cancer unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
- Chronic lymphocytic leukaemia unless having progressed to at least Binet Stage B;
- Basal cell carcinoma and squamous cell carcinoma of the skin and malignant melanoma stage IA (T1aN0M0) unless there is evidence for metastases;
- Papillary thyroid cancer less than 1 cm in diameter and histologically described as T1N0M0;
- Papillary micro-carcinoma of the bladder histologically described as Ta;
- Polycythemia rubra vera and essential thrombocythemia;
- Monoclonal gammopathy of undetermined significance;
- Gastric MALT Lymphoma if the condition can be treated with Helicobacter-eradication;
- Gastrointestinal stromal tumour (GIST) stage I and II according to the AJCC Cancer Staging Manual;
- Cutaneous lymphoma unless the condition requires treatment with chemotherapy or radiation;
- Microinvasive carcinoma of the breast (histologically classified as T1mic) unless the condition requires mastectomy, chemotherapy or radiation;
- Microinvasive carcinoma of the cervix uteri (histologically classified as stage IA1) unless the condition requires hysterectomy, chemotherapy or radiation.

Myocardial Infarction

A myocardial infarction is death of heart tissue due to prolonged obstruction of blood flow. Under this definition, myocardial infarction is evidenced by a rise and/or fall of cardiac biomarkers (troponin or CKMB) to levels considered diagnostic of myocardial infarction together with at least two of the following criteria:

- Symptoms of ischaemia (like chest pain);
- Electrocardiogram (ECG) changes indicative of new ischaemia (new ST-T changes or new left bundle brunch block);
- Development of pathological Q waves in the ECG;

The diagnosis must be confirmed by a Consultant Cardiologist.

For the above definition, the following are not covered:

- Acute coronary syndrome (stable or unstable angina);
- Elevations of troponin in the absence of overt ischemic heart diseases (e.g. myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, drug toxicity);
- Myocardial infarction with normal coronary arteries or caused by coronary vasospasm, myocardial bridging or drug abuse;
- Myocardial infarction that occurs within 14 days after coronary angioplasty or bypass surgery.

Stroke

Death of brain tissue due to an acute cerebrovascular event caused by intracranial thrombosis or haemorrhage (including subarachnoid haemorrhage), or embolism from an extracranial source with:

- acute onset of new neurological symptoms;
- new objective neurological deficits[1] on clinical examination.

The neurological deficit must persist for more than 3 months following the date of diagnosis. The diagnosis must be confirmed by a Consultant Neurologist and supported by imaging findings.

For the above definition, the following are not covered:

- Transient Ischaemic Attack (TIA) and Prolonged Reversible Ischaemic Neurological Deficit (PRIND);
- Traumatic injury to brain tissue or blood vessels;
- Neurological deficits due to general hypoxia, infection, inflammatory disease, migraine or medical intervention;
- Incidental imaging findings (CT- or MRI-scan) without clearly related clinical symptoms (silent stroke);
- Death of tissue of the optic nerve or retina or vestibular organ.

Coronary Artery Bypass Graft Surgery

The undergoing of heart surgery to correct narrowing or blockage of two or more coronary arteries with bypass grafts. Heart surgery with full sternotomy (vertical division of the breastbone) and minimally invasive procedures (partial sternotomy or thoracotomy) are covered. The surgery must be determined to be medically necessary by a Consultant Cardiologist or Cardiac Surgeon and supported by coronary angiogram findings.

For the above definition, the following are not covered:

- Bypass surgery to treat narrowing or blockage of one coronary artery;
- Coronary angioplasty or stent-placement.

Chronic Kidney Disease

Chronic and irreversible failure of both kidneys, as a result of which either regular haemodialysis or peritoneal dialysis is instituted or renal transplantation is carried out. The dialysis must be medically necessary and confirmed by a Consultant Nephrologist.

For the above definition, the following are not covered:

- Acute reversible kidney failure with temporary renal dialysis.

Major Organ, Composite Tissue or Bone Marrow Transplantation

The undergoing as a recipient of an allograft or isograft transplant of one or more of the following:

- Heart;
- Kidney;
- Liver (including split liver and living donor liver transplantation);
- Lung (including living donor lobe transplantation or single-lung transplantation);
- Bone marrow (allogeneic hematopoietic stem cell transplantation preceded by total bone marrow ablation);
- Small bowel;
- Pancreas.

Partial or full face, hand, arm and leg transplantation (composite tissue allograft transplantation) is covered under this definition, too. The condition leading to transplantation must be deemed untreatable by any other means, as confirmed by a Specialist.

For the above definition, the following are not covered:

- Transplantation of other organs, body parts or tissues (including cornea and skin);
- Transplantation of other cells (including islet cells and stem cells other than hematopoietic).

Heart Valve Surgery

The undergoing of surgery to replace or repair one or more defective heart valves. Including minimally invasive and catheter-based procedures. The following procedures are covered under this definition:

- Heart valve replacement or repair with full sternotomy (vertical division of the breastbone), partial sternotomy or thoracotomy;
- Ross-Procedure;
- Catheter-based valvuloplasty;
- Transcatheter aortic valve implantation (TAVI).

The surgery must be determined to be medically necessary by a Consultant Cardiologist or Cardiac Surgeon and supported by echocardiogram or cardiac catheterisation findings.

For the above definition, the following are not covered:

- Transcatheter mitral valve clipping.

Surgery of the Aorta

The undergoing of surgery to treat narrowing, obstruction, aneurysm or dissection of the aorta. Minimally invasive procedures like endovascular repair are covered under this definition. The surgery must be determined to be medically necessary by a Consultant Surgeon and supported by imaging findings.

For the above definition, the following are not covered:

- Surgery to any branches of the thoracic or abdominal aorta (including aortofemoral or aortoiliac bypass grafts);
- Surgery of the aorta related to hereditary connective tissue disorders (e.g. Marfan syndrome, Ehlers–Danlos syndrome);
- Surgery following traumatic injury to the aorta.

Paralysis of limbs

Total and irreversible loss of muscle function to the whole of any 2 limbs as a result of injury to, or disease of the spinal cord or brain. Limb is defined as the complete arm or the complete leg. Paralysis must be present for more than 3 months, confirmed by a Consultant Neurologist and supported by clinical and diagnostic findings.

For the above definition, the following are not covered:

- Paralysis due to self-harm or psychological disorders;
- Guillain-Barré-Syndrome;
- Periodic or hereditary paralysis.

Profound Vision Loss

Profound vision loss of both eyes resulting from either disease or trauma that cannot be corrected by refractive correction, medication, or surgery. Profound vision loss is evidenced by either a visual acuity of 3/60 or less (0.05 or less in the decimal notation) in the better eye after best correction or a visual field of less than 10° diameter in the better eye after best correction. The diagnosis must be confirmed by a Consultant Ophthalmologist.

Deafness

A definite diagnosis of a permanent and irreversible loss of hearing in both ears as a result of sickness or accidental injury. The diagnosis must be confirmed by a Consultant ENT specialist and supported by an average auditory threshold of more than 90 db in the better ear using a pure tone audiogram.

Loss of Speech

A definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease. The condition has to be present for a continuous period of at least 6 months. The diagnosis must be confirmed by a Consultant ENT Specialist.

For the above definition, the following are not covered:

- Loss of speech due to psychiatric disorders.

Multiple Sclerosis

Definite diagnosis of multiple sclerosis, which must be confirmed by a Consultant Neurologist and supported by all of the following criteria:

- Current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months;
- Magnetic resonance imaging (MRI) showing at least two lesions of demyelination in the brain or spinal cord characteristic of multiple sclerosis.

For the above definition, the following are not covered:

- Possible multiple sclerosis and neurologically or radiologically isolated syndromes suggestive but not diagnostic of multiple sclerosis;
- Isolated optic neuritis and neuromyelitis optica.

Alzheimer's Disease

A definite diagnosis of Alzheimer's disease evidenced by all of the following:

- Loss of intellectual capacity involving impairment of memory and executive functions (sequencing, organizing, abstracting, and planning), which results in a significant reduction in mental and social functioning;
- Personality change – Gradual onset and continuing decline of cognitive functions;
- No disturbance of consciousness;
- Typical neuropsychological and neuroimaging findings (e.g. CT scan).

The disease must require constant supervision (24 hours daily). The diagnosis and the need for supervision must be confirmed by a Consultant Neurologist.

For the above definition, the following are not covered:

- Other forms of dementia due to brain or systemic disorders or psychiatric conditions.

Persistent Vegetative State

A vegetative state is absence of responsiveness and awareness due to dysfunction of the cerebral hemispheres, with the brain stem, controlling respiration and cardiac functions, remaining intact. The definite diagnosis must be evidenced by all of the following:

- Complete unawareness of the self and the environment;
- Inability to communicate with others;
- No evidence of sustained or reproducible behavioural responses to external stimuli;
- Preserved brain stem functions;
- Exclusion of other treatable neurological or psychiatric disorders with appropriate neurophysiological or neuropsychological tests or imaging procedures.

The diagnosis must be confirmed by a Consultant Neurologist and the condition must be medically documented for at least one month without any clinical improvement.

Aplastic Anaemia

A definite diagnosis of aplastic anaemia resulting in severe bone marrow failure with anaemia, neutropenia and thrombocytopenia. The condition must be treated with blood transfusions and, in addition, with at least one of the following:

- Bone marrow stimulating agents;
- Immunosuppressants;
- Bone marrow transplantation.

The diagnosis must be confirmed by a Consultant Haematologist and evidenced by bone marrow histology.

Benign Brain Tumor

A definite diagnosis of a benign (non-malignant) brain tumour, located in the cranial vault and originating from tissue of the brain, meninges or cranial nerves. The tumour must be treated with at least one of the following:

- Complete or incomplete surgical removal;
- Stereotactic radiosurgery;
- External beam radiation.

If none of the treatment options is possible due to medical reasons, the tumour must cause a persistent neurological deficit[1] which has to be documented for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a Consultant Neurologist or Neurosurgeon and supported by imaging findings.

For the above definition, the following are not covered:

- The diagnosis or treatment of any cyst, granuloma, hamartoma or malformation of the arteries or veins of the brain;
- Tumours of the pituitary gland.

Primary Cardiomyopathy

A definite diagnosis of one of the following primary cardiomyopathies:

- Dilated Cardiomyopathy;
- Hypertrophic Cardiomyopathy (obstructive or non-obstructive);
- Restrictive Cardiomyopathy;
- Arrhythmogenic Right Ventricular Cardiomyopathy.

The disease must result in at least one of the following:

- Left ventricular ejection fraction (LVEF) of less than 40% measured twice at an interval of at least 3 months;
- Marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain (Class III or IV of the New York Heart Association classification) over a period of at least 6 months;

- Implantation of an Implantable Cardioverter Defibrillator (ICD) for the prevention of sudden cardiac death.

The diagnosis must be confirmed by a Consultant Cardiologist and supported by echocardiogram or cardiac MRI. The implantation of an Implantable Cardioverter Defibrillator (ICD) must be determined to be medically necessary by a Consultant Cardiologist.

For the above definition, the following are not covered:

- Secondary (ischaemic, valvular, metabolic, toxic or hypertensive) cardiomyopathy;
- Transient reduction of left ventricular function due to myocarditis;
- Cardiomyopathy due to systemic diseases;
- Implantation of an Implantable Cardioverter Defibrillator (ICD) due to primary arrhythmias (e.g. Brugada or Long-QT-Syndrome).

Severe Liver Disease

A definite diagnosis of severe liver disease evidenced by a Child-Pugh score of at least 7 points (Child-Pugh Class B or C).

The score must be calculated by all of the following variables:

- Total bilirubin levels;
- Serum albumin levels;
- Severity of ascites;
- International normalized ratio (INR);
- Hepatic encephalopathy.

The diagnosis must be confirmed by a Consultant Gastroenterologist and supported by imaging findings.

For the above definition, the following are not covered:

- Severe liver disease secondary to alcohol or drug use (including hepatitis B or C infections acquired by intravenous drug use).

Chronic Lung Disease

A definite diagnosis of severe lung disease resulting in chronic respiratory failure and evidenced by all of the following:

- FEV1 (Forced Expiratory Volume at 1 second) being less than 40% of predicted on 2 measurements at least 1 month apart;
- Treatment with oxygen therapy for at least 16 hours per day for a minimum of three months;
- Persistent reduction in partial oxygen pressures (PaO2) below 55mmHg (7.3 kPa) in arterial blood gas analysis measured without administration of oxygen.

The diagnosis must be confirmed by a Specialist.

Coma

A definite diagnosis of a state of unconsciousness with no reaction or response to external stimuli or internal needs, which:

- results in a score of 8 or less on the Glasgow coma scale for at least 96 hours,
- requires the use of life support systems, and
- results in a persistent neurological deficit1 which must be assessed at least 30 days after the onset of the coma.

The diagnosis must be confirmed by a Consultant Neurologist.

For the above definition, the following are not covered:

- Medically induced coma;
- Any coma due to self-inflicted injury, alcohol or drug use.

Sporadic Creutzfeldt-Jakob Disease

A diagnosis of sporadic Creutzfeldt-Jakob disease (sCJD), which has to be classified as "probable" by all of the following criteria:

- Progressive dementia;
- At least two out of the following four clinical features: myoclonus, visual or cerebellar signs, pyramidal/extrapyramidal signs, akinetic mutism;
- Electroencephalogram (EEG) showing sharp wave complexes and/or the presence of 14-3-3 protein in the cerebrospinal fluid;
- No routine investigations indicate an alternative diagnosis.

The diagnosis must be confirmed by a Consultant Neurologist.

For the above definition, the following are not covered:

- Iatrogenic or familial Creutzfeldt-Jakob disease;
- Variant Creutzfeldt-Jakob disease (vCJD).

Acute Viral Encephalitis

A definite diagnosis of acute viral encephalitis resulting in a persistent neurological deficit[1] documented for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a Consultant Neurologist and supported by typical clinical symptoms and cerebrospinal fluid or brain biopsy findings.

For the above definition, the following are not covered:

- Encephalitis in the presence of HIV;
- Encephalitis caused by bacterial or protozoal infections;
- Myalgic or paraneoplastic encephalomyelitis.

Fulminant Viral Hepatitis

A definite diagnosis of fulminant viral hepatitis evidenced by all of the following:

- Typical serological course of acute viral hepatitis;
- Development of hepatic encephalopathy;
- Decrease in liver size;
- Increase in bilirubin levels;
- Coagulopathy with an international normalized ratio (INR) greater than 1.5;
- Development of liver failure within 7 days of onset of symptoms;
- No known history of liver disease.

The diagnosis must be confirmed by a Consultant Gastroenterologist.

For the above definition, the following are not covered:

- All other non-viral causes of acute liver failure (including paracetamol or aflatoxin intoxication);
- Fulminant viral hepatitis associated with intravenous drug use.

Major Head Trauma

A definite diagnosis of a disturbance of the brain function as a result of traumatic head injury. The head trauma must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

Activities of Daily Living are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances;
- Feeding oneself – the ability to feed oneself when food has been prepared and made available;

- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function;
- Getting between rooms – the ability to get from room to room on a level floor;
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist or Neurosurgeon and supported by typical imaging findings (CT scan or brain MRI).

For the above definition, the following are not covered:

- Any major head trauma due to self-inflicted injury, alcohol or drug use.

HIV Infection due to Transfusion of Blood Products

A definite diagnosis of an infection with the Human Immunodeficiency Virus (HIV) resulting from transfusion of blood products. The HIV infection must be evidenced by all of the following:

- The infection is caused by a medically necessary transfusion of blood products received after commencement of the policy;
- The institution or transfusion service, which provided the transfusion of blood products, is officially registered with and recognised by the health authorities;
- The institution or transfusion service which provided the transfusion of blood products admits liability;
- HIV seroconversion must occur within 12 months of transfusion;
- The transfusion of the contaminated blood product must have been carried out within the European Union or Switzerland.

For the above definition, the following are not covered:

- HIV infection resulting from any other means of transmission, including sexual activity or drug use;
- HIV infection resulting from transfusion of blood products due to haemophilia or thalassaemia major.

HIV Infection Caught at Work in an Eligible Occupation

A definite diagnosis of an infection with the Human Immunodeficiency Virus (HIV) resulting from an incident occurring during normal duties of employment from the following eligible occupations:

- Medical doctor or dentist;
- Nurse or midwife;
- Physician's assistant or dental assistant;
- Laboratory worker or laboratory technician;
- Member of the fire service;
- Member of the ambulance service;
- Hospital housekeeper or hospital maintenance worker;
- Police officer;
- Prison officer.

The HIV infection must be evidenced by all of the following:

- The incident must have taken place after commencement of the policy;
- The incident must have been reported, investigated and documented in accordance with current guidelines of appropriate authorities (for example, workers' compensation board);
- A HIV-negative blood test taken within 5 days of the incident;
- HIV seroconversion must occur within 12 months of the incident;
- The incident must have occurred while performing an occuption within the European Union or Switzerland;

For the above definition, the following are not covered:

- HIV infection resulting from any other means of transmission, including sexual activity or drug abuse.

Loss of Limbs

A definite diagnosis of complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis has to be confirmed by a Specialist.

For the above definition, the following are not covered:

- Loss of limbs due to self-inflicted injury.

Third-Degree Burns

Burns that involve destruction of the skin through its full depth to the underlying tissue (third-degree burns) and covering at least 20% of the body surface as measured by "The Rule of Nines" or the "Lund and Browder Chart". The diagnosis must be confirmed by a Specialist.

For the above definition, the following are not covered:

- Third-degree burns due to self-inflicted injury;
- Any first- or second-degree burns.

Motor Neurone Disease

A definite diagnosis of one of the following motor neurone diseases:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease);
- Primary lateral sclerosis (PLS);
- Progressive muscular atrophy (PMA);
- Progressive bulbar palsy (PBP).

The disease must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

Activities of Daily Living are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances;
- Feeding oneself – the ability to feed oneself when food has been prepared and made available;
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function;
- Getting between rooms – the ability to get from room to room on a level floor;
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist and supported by nerve conduction studies (NCS) and electromyography (EMG).

For the above definition, the following are not covered:

- Multifocal motor neuropathy (MMN) and inclusion body myositis;
- Post-polio syndrome;
- Spinal muscular atrophy;
- Polymyositis and dermatomyositis.

Bacterial Meningitis

A definite diagnosis of bacterial meningitis resulting in a persistent neurological deficit[1] documented for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a Consultant Neurologist and supported by growth of pathogenic bacteria from cerebrospinal fluid culture.

For the above definition, the following are not covered:

- Aseptic, viral, parasitic or non-infectious meningitis.

Muscular Dystrophy

A definite diagnosis of one of the following muscular dystrophies:

- Duchenne Muscular Dystrophy (DMD);
- Becker Muscular Dystrophy (BMD);
- Emery-Dreifuss Muscular Dystrophy (EDMD);
- Limb-Girdle Muscular Dystrophy (LGMD);
- Facioscapulohumeral Muscular Dystrophy (FSHD);
- Myotonic Dystrophy Type 1 (MMD or Steinert's Disease);
- Oculopharyngeal Muscular Dystrophy (OPMD).

The disease must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

Activities of Daily Living are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances;
- Feeding oneself – the ability to feed oneself when food has been prepared and made available;
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function;
- Getting between rooms – the ability to get from room to room on a level floor;
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist and supported by electromyography (EMG) and muscle biopsy findings.

For the above definition, the following are not covered:

- Myotonic Dystrophy Type 2 (PROMM) and all forms of myotonia.

Primary Pulmonary Hypertension

A definite diagnosis of primary pulmonary hypertension evidenced by all of the following:

- Marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain (Class III or IV of the New York Heart Association classification) over a period of 6 months;
- Mean pulmonary artery pressure of more than 25 mmHg at rest measured by right heart catheterisation.

The diagnosis must be confirmed by a Consultant Cardiologist or Lung Specialist.

For the above definition, the following are not covered:

- Pulmonary hypertension secondary to lung, heart, or systemic disease;
- Chronic thromboembolic pulmonary hypertension (CTEPH);
- Drug- or toxin-induced pulmonary hypertension.

Idiopathic Parkinson's Disease

A definite diagnosis of primary idiopathic Parkinson's disease, which is evidenced by at least two out of the following clinical manifestations:

- Muscle rigidity;
- Tremor;
- Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses).

Idiopathic Parkinson's disease must result [before age 65] in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months despite adequate drug treatment.

Activities of Daily Living are:

- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances;
- Feeding oneself – the ability to feed oneself when food has been prepared and made available;
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function;
- Getting between rooms – the ability to get from room to room on a level floor;
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis must be confirmed by a Consultant Neurologist.

The implantation of a neurostimulator to control symptoms by deep brain stimulation is, independent of the Activities of Daily Living, covered under this definition. The implantation must be determined to be medically necessary by a Consultant Neurologist or Neurosurgeon.

For the above definition, the following are not covered:

- Secondary parkinsonism (including drug- or toxin-induced parkinsonism);
- Essential tremor;
- Parkinsonism related to other neurodegenerative disorders.

Systemic Sclerosis (Scleroderma)

A definite diagnosis of systemic sclerosis evidenced by all of the following:

- Typical laboratory findings (e.g.anti-Scl-70 antibodies);
- Typical clinical signs (e.g. Raynaud's phenomenon, skin sclerosis, erosions);
- Continuous treatment with corticosteroids or other immunosuppressants.

Additionally, one of the following organ involvements must be diagnosed:

- Lung fibrosis with a diffusing capacity (DCO) of less than 70% of predicted;
- Pulmonary hypertension with a mean pulmonary artery pressure of more than 25 mmHg at rest measured by right heart catheterisation;
- Chronic kidney disease with a glomerular filtration rate of less than 60 ml/min (MDRD-formula);
- Echocardiographic signs of significant left ventricular diastolic dysfunction.

The diagnosis must be confirmed by a Specialist.

For the above definition, the following are not covered:

- Localized scleroderma without organ involvement;
- Eosinophilic fasciitis;
- CREST-Syndrome.

Systemic Lupus Erythematosus

A definite diagnosis of systemic lupus erythematosus evidenced by all of the following:

- Typical laboratory findings, such as presence of antinuclear antibodies (ANA) or anti-dsDNA antibodies;
- Symptoms associated with lupus erythematosus (butterfly rash, photosensitivity, serositis);
- Continuous treatment with corticosteroids or other immunosuppressants.

Additionally, one of the following organ involvements must be diagnosed:

- Lupus nephritis with proteinuria of at least 0.5 g/day and a glomerular filtration rate of less than 60 ml/min (MDRD formula);
- Libman-Sacks endocarditis or myocarditis;
- Neurological deficits[1] or seizures over a period of at least 3 months and supported by cerebrospinal fluid or EEG findings. Headaches, cognitive and psychiatric symptoms are not seen as typical neurological deficits in this context.

The diagnosis must be confirmed by a Specialist.

For the above definition, the following are not covered:

- Discoid lupus erythematosus or subacute cutaneous lupus erythematosus;
- Drug-induced lupus erythematosus.

Chronic Pancreatitis

A definite diagnosis of severe chronic pancreatitis evidenced by all of the following:

- Exocrine pancreatic insufficiency with weight loss and steatorrhoea;
- Endocrine pancreatic insufficiency with pancreatic diabetes;
- Need for oral pancreatic enzyme substitution.

These conditions have to be present for at least 3 months. The diagnosis must be confirmed by a Consultant Gastroenterologist and supported by imaging and laboratory findings (e.g. faecal elastase).

For the above definition, the following are not covered:

- Chronic pancreatitis due to alcohol or drug use;
- Acute pancreatitis.

Severe Rheumatoid Arthritis

A definite diagnosis of rheumatoid arthritis evidenced by all of the following:

- Typical symptoms of inflammation (arthralgia, swelling, tenderness) in at least 20 joints over a period of 6 weeks at the time of diagnosis and significantly increased CRP levels;
- Rheumatoid factor positivity (at least twice the upper normal value) and/or presence of anti-citrulline antibodies;
- Continuous treatment with corticosteroids;
- Treatment with a combination of “Disease Modifying Anti-Rheumatic Drugs” (e.g. methotrexate plus sulfasalazine/ leflunomide) or a TNF inhibitor over a period of at least 6 months.

The diagnosis must be confirmed by a Consultant Rheumatologist.

For the above definition, the following are not covered:

- Reactive arthritis;
- Psoriatic arthritis;
- Activated osteoarthritis.

Necrotising Fasciitis

A definite diagnosis of necrotising fasciitis evidenced by all of the following:

- Progressive, rapidly spreading bacterial infection located in the deep fascia, with secondary necrosis of the subcutaneous tissues of the limbs or trunk;
- Fever and rapid increase in C-reactive protein (CRP) levels;
- Surgical resection of all necrotic tissue.

Fournier’s gangrene is covered under this definition. The diagnosis must be confirmed by a Consultant Surgeon and evidenced by microbiological or histological findings.

For the above definition, the following are not covered:

- Gas gangrene;
- Gangrene caused by diabetes, neuropathy or vascular diseases.

[1] Neurological deficit

Symptoms of dysfunction in the nervous system that are present on clinical examination. Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, lethargy, dementia, delirium and coma.

For the above definition, the following are not covered:

- An abnormality seen on CT- or MRI-scans or other imaging techniques without definite related clinical symptoms;
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms;
- Symptoms of psychological or psychiatric origin.

7.4. Definitions of critical illnesses and their diagnostic criteria for the Insured persons 2-18 years of age:

Cancer

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The diagnosis must be confirmed by a Specialist.

Leukaemia, malignant lymphoma, myelodysplastic syndrome, polycythemia rubra vera, essential thrombocythaemia are covered under this definition.

For the above definition, the following are not covered:

- Any tumour histologically classified as pre-malignant, non-invasive or carcinoma in situ (including CIN-1, CIN2 and CIN 3);
- Papillary thyroid cancer less than 1 cm in diameter and histologically described as T1N0M0;
- Basal cell carcinoma and squamous cell carcinoma of the skin and malignant melanoma stage IA (T1aN0M0) unless there is evidence for metastases;
- Gastric MALT Lymphoma if the condition can be treated with Helicobacter-eradication;
- Gastrointestinal stromal tumour (GIST) stage I and II according to the AJCC Cancer Staging Manual;
- Wilms tumour stage I and favourable histology (no anaplasia).

Chronic Kidney Disease

Chronic and irreversible failure of both kidneys, as a result of which either regular haemodialysis or peritoneal dialysis is instituted or renal transplantation is carried out. The dialysis must be medically necessary and confirmed by a Consultant Nephrologist.

For the above definition, the following are not covered:

- Acute reversible kidney failure with temporary renal dialysis;
- Chronic kidney disease (kidney failure) due to congenital renal and/or congenital urinary tract abnormalities;
- Chronic kidney disease (kidney failure) due to impaired renal perfusion at perinatal stage.

Major Organ, Composite Tissue or Bone Marrow Transplantation

The undergoing as a recipient of an allograft or isograft transplant of one or more of the following:

- Heart;
- Kidney;
- Liver (including split liver and living donor liver transplantation);
- Lung (including living donor lobe transplantation or single-lung transplantation);
- Bone marrow (allogeneic hematopoietic stem cell transplantation preceded by total bone marrow ablation);
- Small bowel;
- Pancreas.

Partial or full face, hand, arm and leg transplantation (composite tissue allograft transplantation) is covered under this definition, too. The condition leading to transplantation must be deemed untreatable by any other means, as confirmed by a Specialist.

For the above definition, the following are not covered:

- Transplantation of other organs, body parts or tissues (including cornea and skin);
- Transplantation of other cells (including islet cells and stem cells other than hematopoietic);
- Transplantation due to congenital malformations or abnormalities.

Paralysis of Limbs

Total and irreversible loss of muscle function to the whole of any 2 limbs as a result of injury to, or disease of the spinal cord or brain. Limb is defined as the complete arm or the complete leg. Paralysis must be present for more than 3 months, confirmed by a Specialist and supported by clinical and diagnostic findings.

For the above definition, the following are not covered:

- Paralysis due to self-harm or psychological disorders;
- Paralysis due to congenital abnormalities of the brain and/or spinal cord including brain tumours and spinal cord tumours;
- Guillain-Barré-Syndrome;
- Periodic or hereditary paralysis.

Profound Vision Loss

Profound vision loss of both eyes resulting from either disease or trauma that cannot be corrected by refractive correction, medication, or surgery. Profound vision loss is evidenced by either a visual acuity of 3/60 or less (0.05 or less in the decimal notation) in the better eye after best correction or a visual field of less than 10° diameter in the better eye after best correction. The diagnosis must be confirmed by a Specialist. The diagnosis needs to be supported by appropriate testing.

In children < 3 years of age, objective tests (e.g. visual evoked potential) are needed.

For the above definition, the following is not covered:

- Any form of blindness or profound vision disturbance that is congenital or hereditary including blindness/profound vision disturbance due to infection during pregnancy.

Deafness

A definite diagnosis of a permanent and irreversible loss of hearing in both ears as a result of sickness or accidental injury, which cannot be sufficiently compensated by hearing aids to allow normal communication (auditory threshold of more than 90dB). The diagnosis must be confirmed by a Consultant ENT specialist and supported by objective audiometry (e.g. Auditory brain stem response).

For the above definition, the following is not covered:

- Any form of deafness that is congenital or hereditary including deafness due to infection during pregnancy.

Benign Brain Tumour

A definite diagnosis of a benign brain tumour, which is defined as a non-malignant growth of tissue located in the cranial vault and limited to the brain, meninges or cranial nerves. The tumour must be treated with at least one of the following:

- Complete or incomplete surgical removal;
- Stereotactic radiosurgery;
- External beam radiation.

If none of the treatment options is possible due to medical reasons, the tumour must cause a persistent neurological deficit, which has to be documented for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a Specialist and supported by imaging findings.

For the above definition, the following are not covered:

- The diagnosis or treatment of any cyst, granuloma, hamartoma or malformation of the arteries or veins of the brain;
- Tumours of the pituitary gland;
- Congenital tumours.

Coma

A definite diagnosis of a state of unconsciousness with no reaction or response to external stimuli or internal needs, which:

- results in a score of 8 or less on the Glasgow coma scale for at least 96 hours, requires the use of life support systems, and results in a persistent neurological deficit1 which must be assessed at least 30 days after the onset of the coma.

The diagnosis must be confirmed by a Consultant Neurologist.

For the above definition, the following are not covered:

- Medically induced coma;
- Any coma due to child abuse or assault;
- Any coma due to intentional injury, alcohol or drug use;
- Any coma due to birth complications or congenital malformations.

Acute Viral Encephalitis

A definite diagnosis of acute viral encephalitis resulting in

- a persistent neurological deficit1 documented for at least 3 months following the date of diagnosis. (applies to every age) or
- a complete cessation/stagnation of motor-, cognitive- and language-development for at least 12 months (applies to ages below 6 years only).

The diagnosis must be confirmed by a Consultant Neurologist and supported by typical clinical symptoms and cerebrospinal fluid or brain biopsy findings.

For the above definition, the following are not covered:

- Encephalitis in the presence of HIV;
- Encephalitis caused by bacterial or protozoal infections;
- Myalgic or paraneoplastic encephalomyelitis.

Major Head Trauma

A definite diagnosis of a disturbance of the brain function as a result of traumatic head injury. The head trauma must result in a score of 3-5 on the Paediatric Glasgow Coma Scale (PGCS) and in

- a persistent neurological deficit1 documented for at least 3 months following the date of diagnosis. (applies to every age) or
- a complete cessation/stagnation of motor-, cognitive- and language-development for at least 12 months (applies to ages below 6 years only).

The diagnosis and neurological deficit, with no reasonable chance of recovery must be confirmed by a Specialist and supported by typical imaging findings (CT scan or brain MRI).

For the above definition the following is not covered:

- Any major head trauma due to child abuse or assault;
- Any major head trauma due to intentional injury, alcohol or drug use.

Loss of Limbs

A definite diagnosis of complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis has to be confirmed by a Specialist.

For the above definition, the following are not covered:

- Loss of limbs due to self-inflicted injury.

Bacterial Meningitis

A definite diagnosis of bacterial meningitis resulting in:

- a persistent neurological deficit1 documented for at least 3 months following the date of diagnosis. (applies to every age) or
- a complete cessation/stagnation of motor-, cognitive- and language-development for at least 12 months (applies to ages below 6 years only)

The diagnosis must be confirmed by a Specialist and supported by growth of pathogenic bacteria from cerebrospinal fluid culture.

For the above definition, the following is not covered:

- Aseptic, viral, parasitic or non-infectious meningitis.

Insulin dependent Diabetes Mellitus (Type 1)

A definite diagnosis of diabetes type 1 characterised by the pancreas´s failure to produce enough insulin, hence resulting in a lifelong dependence on exogenous insulin.

The diagnosis must be confirmed by a specialist and supported by typical clinical characteristics and laboratory testing.

The laboratory testing should show at least one of the following:

- Pancreatic autoantibodies;
- Insulin and C-peptide levels leading to the diagnosis of Diabetes type 1.

For the above definition, the following is not covered:

- Diseases of the exocrine system (e.g. Cystic fibrosis, hereditary hemochromatosis, chronic pancreatitis);
- Endocrine abnormalities in glucose regulation (e.g. Cushing syndrome);
- Drug-induced diabetes;
- Diabetes mellitus type 2.

Severe Asthma exacerbation

A definite diagnosis of acute severe asthma exacerbation leading to at least 2 hospital admissions within the last 12 months and evidenced by a Pulmonary Index Score (PIS) ≥12 or the equivalent in alternative scores.

For the above definition, the following is not covered:

- Asthma caused by Gastrooesophageal reflux disease (GERD);
- Asthma caused by medication;
- Asthma as complication of respiratory infection.

[1] Neurological deficit

Symptoms of dysfunction in the nervous system that are present on clinical examination. Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, lethargy, dementia, delirium and coma.

For the above definition, the following are not covered:

- An abnormality seen on CT- or MRI-scans or other imaging techniques without definite related clinical symptoms;
- Neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms;
- Symptoms of psychological or psychiatric origin.

V. Conditions of additional accident insurance

1. Insured event

1.1. An insured event shall be an accident laid down in the insurance agreement (except for non-insured events listed in Item 2) upon the occurrence of which a beneficiary shall acquire the right to an insurance benefit.

1.2. A case when the body of the Insured is suddenly, beyond his control, affected from outside, or his health is impaired, shall be considered an accident.

1.3. The Insurer shall provide insurance coverage in cases of those accidents that may happen to the Insured during the insurance coverage validity period all day long and throughout the world. Injuries that may be recognized insured events are listed in tables on accident insurance benefits of these insurance conditions.

2. Non-insured events and non-insured persons

2.1. Non-insured events, when an insurance benefit shall not be paid, shall include the following:

2.1.1. accidents occuring due to:– a chronic, congenital or degenerative disease;

- a non-traumatic mental or consciousness disorder;
- a non-traumatic effusion of blood in cranial cavity;
- an epileptic or other convulsive jerks affecting the whole body of the Insured, provided that such jerking was caused not by an external impact on the Insured's body.

2.1.2. accidents directly or indirectly related to introduction of the state of war or emergency, military actions, rebellion, riot, internal unrest, terror acts of any nature, employee strikes, lockouts, arrests and detentions by governmental institutions and officials, unless the insurance agreement establishes otherwise. Damage and expenses caused by or related to response to actions and events indicated herein, their prevention or suppression shall not be reimbursed either;

2.1.3. accidents caused at the intent (acts committed by direct or indirect intent) of the Policyholder or the beneficiary;

2.1.4. accidents related to intentional self-injury of the Insured or his attempt to commit a suicide, participation in a fight or domestic conflicts, also those suffered by the Insured when committing or preparing to commit a criminal offense and/or committing other actions in conflict with law. Signs of a criminal offense, preparation to commit an offense or other actions in conflict with law, action or omission may be proven by and the Insurer may use the following in making a decision on the declaration of an incident a non-insured event or a refusal to pay an insurance benefit: conclusions, procedural decisions of pre-trial investigation institutions or bodies authorized to examine administrative offense cases and/or court judgements, decisions, resolutions and rulings.

2.1.5. Accidents having happened in the Insured's:

a) use of motorless aircrafts, motorized airplanes, light aircrafts, spacecrafts, also his engagement in parachuting;

b) driving a vehicle under the influence of alcohol (exceeding alcohol concentration in the blood established by legal acts), drugs, toxic, psychotropic and other psychoactive substances or potent medicines used for intoxication purposes;

c) flying means of air transport or being its crew member;

d) serving in an army or another similar association, participating in a peacekeeping mission;

e) participation in vehicle racing as a driver of a motor vehicle, a second driver or a passenger , also in trainings where high speed is involved;

f) engagement in professional sports and/or extreme sports/ leisure-time, unless the insurance agreement establishes otherwise;

2.1.6. accidents caused by direct or indirect nuclear energy effects and health impairments by any radiation (radioactive, electromagnetic, heat, light, etc.) effects, also the use of chemical and biological substances for non-peaceful purposes;

2.1.7. health impairments caused by treatment procedures, surgeries or other medical procedures. If a surgery or treatment was necessary for an accident, this shall be treated as an insured event;

2.1.8. infections, except for those, whose pathogens get into the body of the Insured, when the Inured is injured at the time of the insured event provided for in these insurance conditions. Minor injuries to the skin or mucous membrane (scraping, scratching) shall not be considered insured events, even if pathogens get into the body through the injuries immediately or at some time. In case of rabies, tetanus, Lyme disease or tick-borne encephalitis, this restriction shall not apply. Infections caused during treatment shall be subject to paragraph 2.1.7;

2.1.9. when an acute illness indicated in Table No. 4 for determining additional assistance occurs during the first 30 days from the beginning of application of the additional insurance coverage.

2.1.10. death and/or disability caused by the illness specified in Table No. 4 for determining additional assistance.

2.1.11. accidents the occurrence whereof was affected by the use of alcohol, drugs or toxic, psychotropic or other psychoactive substances or potent medicines used for intoxication purposes. The Insurer shall not pay an insurance benefit if the Insured used alcohol or other stupefying substances after an accident before a medical examination, or avoided a sobriety or intoxication check;

2.1.12. abdominal hernia;

2.1.13. health disorders due to mental disorders (in affective state) regardless of the reason of their occurrence;

2.1.14. accidents the occurrence whereof was affected by an illness (trauma) of the Insured, which formed the basis for the determination of the level of working capacity (incapacity) of the Insured by state institutions, or a mental illness;

2.1.15. pathologocial bone fractures, intervertebral disk impairments, intervertebral hernia, pathological dislocations, recurrent joint dislocations, degenerative tears, harm to the teeth done while eating;

2.1.16. procedure of removal of osteosynthesis structures, fracture and/or dislocation of osteosynthesis structures, fracture and/or dislocation of joint prosthesis;

2.1.17. upon the court's declaration of a person being missing.

2.1.18. accidents incurred during the suspension or invalidity of insurance coverage.

2.2. Non-insured persons:

2.2.1. mental patients and persons that require long-term care shall not be insured, and even though an insurance benefit has been paid to them, insurance coverage shall not apply to them. A person requiring care is such a person, which needs continuous care of others in his daily life;

2.2.2. persons transferred to a special education institution or those serving a custodial sentence and persons subject to compulsory medical aids. Insurance coverage shall not be provided during pre-trial detention (custody) or arrest.

2.2.3. Insurance coverage shall expire than the Insured becomes no longer insured under paragraphs 2.2.1 and 2.2.2.

3. Object of insurance

3.1. The object of insurance shall be a property interest related to accidents.

4. Types of insurance benefits and sums insured

Types of insurance benefits and sums insured shall be set for each of the insured by an agreement of the parties to the insurance agreement. The agreed types of insurance benefits and sums insured shall be indicated in the insurance policy.

4.1. Insurance benefit in case of death

If the Insured having suffered from an insured event dies within one year after the accident, the right of claim to an insurance benefit provided for in the insurance policy in case of death of the Insured caused by an accident shall emerge.

Where the court declares the Insured dead, an insurance benefit shall be paid only in cases where a court decision indicates that the Insured went missing for such circumstances, which allow believing that he died as a result of an insured event, and that the Insured went missing and presumably died during the validity period of the insurance coverage.

4.2. Insurance benefit in case of a disability

A disability is a long-term and permanent loss of physical or mental capacity of the Insured caused by an accident, when a person is completely or partially unable to take care of his personal or social life, implement his rights and perform his duties. If an accident caused a permanent loss of physical or mental capacity (disability) of the Insured, the Policyholder shall have the right to request for an insurance benefit paid from the sum insured agreed for a disability in accordance with the conditions laid down in this paragraph. Disability and its degree shall be set pursuant to medical documents and conclusions of medical experts of the Insurer.

An insurance benefit in case of a disability shall be paid if all the below conditions are met:

- a disability was caused by an accident which was declared an insured event;
- a disability shall persist at least 12 months after the accident, which shall be confirmed by a respective medical statement issued no later than within 3 months after the expiry of the 12-month period from the day of the accident. A disability shall manifest no later than within 2 years from the date of diagnosing Lyme disease or tick-borne encephalitis;
- a disability shall be confirmed by medical documents and conclusions of medical experts of the Insurer.

4.3. Insurance benefit in case of bone fractures

If the parties to the insurance agreement agreed thereon, an insurance benefit shall be paid from the sum insured agreed upon in case of bone fractures in proportion to bone fractures diagnosed by medical experts for those bone fractures, which the Insured has suffered due to an insured event.

An insurance benefit for bone (joint) fracture shall be paid, if the condition was substantiated with objective instrumental tests (X-ray, computer tomography or magnetic resonance imaging or their descriptions).

4.4. Insurance benefit in case of a temporary disability

A temporary disability is injury of the Insured impairing the integrity of his body tissues (organs) and a brief disruption of their functions.

If the parties to the insurance agreement agreed thereon, a one-time benefit for temporary disability shall be paid in proportion to the disability level diagnosed by medical experts of the Insurer from the sum insured agreed upon in case of a temporary disability caused by the following:

4.4.1. Dislocation (partial dislocation) of joints (bones)An insurance benefit in case of dislocation (partial dislocation) of joints (bones) shall be paid when the condition was confirmed by X-ray or other objective test methods, when treatment or immobilisation was prescribed for uninterrupted period of time of at least 14 days, and the dislocation (partial dislocation) was diagnosed in a personal health care institution. If the initial dislocation (partial dislocation) happened before the effective date of the insurance coverage, recurring dislocations (partial dislocations) shall not be insured events, and insurance benefits shall not be paid therefor.

4.4.2. Soft tissue injury

An insurance benefit shall be paid in case of an impairment of soft tissue or muscle integrity, multiple hematomas, periostal inflammation, ear drum or penetrative eyeball injuries, chest injuries that caused pneumothorax, hemothorax, exudative pleuritis, subcutaneous emphysema, having led to pustular complications: osteomyelitis, phlegmons, abscesses, hemarthrosis (where a joint had to be aspirated).

4.4.3. Tear (partial tear) of menisci, muscles, tibia or tendons

An insurance benefit shall be paid in case of a tear (partial tear) of menisci when the condition was treated by surgery or confirmed by magnetic resonance imaging.

Tear (partial tear) of menisci, muscles, tibia or tendons shall be confirmed by objective radiological tests and treatment period lasting for at least 14 consecutive days applying immobilisation, or by a surgical treatment.

4.4.4. Burns (at least second degree burns) or an inflammatory illness.

4.4.5. Frostbites (at least third degree frostbites).

4.4.6. Brain and spinal cord trauma

This is a haemorrhage (hematoma), commotion or contusion of the head or spinal cord.

Commotion or contusion of the head or spinal cord shall be diagnosed by a medical specialist (neurologist or neurosurgeon) treated in an inpatient or outpatient care institution for at least 14 days, when medically justified objective loss of working capacity lasted for at least 14 days.

4.4.7. Traumatic injury of internal body organs, when a surgery had to be performed on the injured organ.

4.4.8. Random acute medium or severe degree poisoning of the Insured with medicines, chemical substances, gas, steam, poisonous plants or mushrooms, except for the cases listed in paragraph 2.1.11.

Poisoning of the Insured shall be considered an insured event, if the Insured was treated at the hospital for at least 3 days.

4.4.9. miscarriage caused by an accident or other reasons under in Table no. 2 defined conditions.

4.5. Ordinary medical assistance

If the insurance agreement provides for insurance benefits in case of death, disability, bone fractures and temporary disability for the Insured, the Insured shall also become entitled to the insurance benefits listed in paragraphs 4.5.1 – 4.5.3, if the conditions laid down in the said paragraphs have been met. Before receiving medical services, shall approve amounts of expenses of medical assistance with the Insurer.

4.5.1. The Insured shall become eligible to the insurance benefit for expenses incurred for cosmetic plastic surgery in order to remove cosmetic defects or disfigurements within 5 years after the accident, provided that such surgery was necessary for removal of consequences of injuries suffered during the accident. The insurance benefit shall not exceed EUR 1500.

4.5.2. The Insured shall become entitled to an insurance benefit for the reimbursement of expenses incurred for rehabilitation in a personal health care institution, for prosthetizing limbs, joints or organs, or acquiring prosthetics and orthopaedic aids, if these expenses were incurred as a result of disability of at least 15% determined according to paragraph 4.2, and they have not been covered from compulsory health insurance fund budget or voluntary health insurance funds, or have been reimbursed only in part. The insurance benefit shall not exceed EUR 1000.

Rehabilitation expenses shall comprise sums of money paid by the Insured for the following medical services: physiotherapy procedures, kinesiotherapy sessions and 10 massage sessions.

4.5.3. The Insured shall become entitled to reimbursement of expenses for psychological assistance (consultations of a psychologist, psychiatrist or psychotherapist), if the said assistance was provided to the Insured for disability of at least 15% determined according to paragraph 4.2. The insurance benefit shall not exceed EUR 1000.

4.6. Additional assistance

4.6.1. Where the parties to the insurance agreement have so agreed and this is specified in the insurance policy, additional assistance costs shall be indemnified. The amount of all benefits in respect of one insured event may not exceed the sum insured for additional assistance specified in the insurance policy.

4.6.2. The insurance cover provided according to the additional assistance insurance clauses shall enter into force after 30 days from the beginning of the additional assistance insurance.

4.6.3. The insurance cover in respect of acute diseases listed in Table No. 4 for determining additional assistance shall apply when such diseases have not been diagnosed for the Insured before the beginning of the insurance cover.

4.6.4. The insured's death or disability caused by acute diseases listed in Table No. 4 shall not be treated as accidents and insurance benefits shall not be paid according to Table No. 1 for determining disability caused by accidents (excluding disability caused by tick-borne encephalitis).

4.6.5. In the case of the Insured who has several valid insurance agreements provided with additional assistance the amount of insurance compensations for incurred expenses may not exceed the amount of expenses actually incurred by the Insured.

4.7. Daily allowance

4.7.1. Where the parties to the insurance agreement have so agreed, daily allowance shall be paid: when due to an accident which is recognised to be the insured event according to paragraphs 4.2–4.4 the injured Insured becomes temporarily incapable to work or when a minor covered by accident insurance was injured during an accident and a certificate of incapacity for work because of nursing of the injured minor is issued to one of the parents insured under the same insurance agreement against accident insurance with the selected daily allowance insurance cover.

4.7.2. The insurance benefit amount for each day of incapacity shall be set in the insurance policy. The payment of daily allowance shall start from the first day of incapacity. The first and the last day of incapacity shall be considered one day. The basis for paying daily allowance shall be a medically justified objective duration of incapacity and a statement on incapacity issued in the procedure prescribed by legislation.

4.7.3. No more than 30 days of incapacity shall be paid for one insured event.

4.7.4. Daily allowance for incapacity caused by injuries unprovided for in tables for accident insurance benefits of these insurance conditions or injuries provided for in Table No. 3 for determining temporary disability, for which an insurance benefit for temporary disability shall be up to 2% inclusive, shall be paid for no more than 14 calendar days.

4.7.5. Daily allowance for all insured events having taken place in one year of insurance validity shall be paid for no more than 100 days of incapacity.

5. Rights and duties of the parties to the insurance agreement during the validity of the insurance

5.1. The Policyholder and the Insured shall follow legal norms, departmental or other established security measures and follow commonly accepted safe conduct rules acceptable to all in order to avoid an accident.

5.2. In case of a material change of circumstances provided for in the insurance agreement which may lead to increased or potentially increased insurance risk, the Policyholder shall inform the Insurer thereof as soon as he discovered about the change of insurance risk, but no later than within 14 calendar days from the day of discovery. An increase of the insurance risk shall be cases when the nature of work has changed in life or activities of the Insured, or any of the circumstances indicated in the Policyholder's application has changed for other reasons. The Insurer, who was notified on the increase of the insurance risk, shall have the right to amend insurance agreement conditions or increase insurance risk deductible.

5.3. If during the validity of the insurance agreement circumstances laid down in the insurance agreement, which lead to decreased or potentially decreased insurance risk, change substantially, the Policyholder may inform the Insurer thereof, and shall have the right to present an application for amending insurance agreement conditions or reducing an insurance risk deductible.

5.4. The Insurer shall have the right to change additional accident insurance conditions having warned the Policyholder thereof no later than 30 days before the planned date of change of insurance conditions. If the Policyholder disagrees with these amendments to the insurance conditions, accident insurance shall be terminated from the planned date of change of insurance conditions.

6. Procedure of determining insurance benefit amounts

6.1. In case of an accident, the Policyholder (the Insured) shall:

a) immediately, but no later than within 48 hours, refer to a personal health care institution;

b) indicate to the treating doctor an accurate date and circumstances of an accident;

c) follow doctor's orders and reduce consequences of an accident to the extent possible;

d) report the each insured event to the Insurer immediately, but no later than within 30 days. In case of delayed reporting of an insured event, the Insurer may request the Policyholder to compensate expenses necessary for determining an insured event;

e) correctly complete an accident report presented by the Insurer and immediately send it to the Insurer;

f) prevent losses from forming or reduce them following orders of the Insurer, also provide information requested by the Insurer;

g) try to have reports and conclusions necessary for the Insurer prepared without any undue delay;

h) undergo medical examination prescribed by the Insurer, if medical documents are insufficient and accurately determining the degree of health impairment suffered during the accident is impossible based thereon. The Insurer shall cover expenses necessary therefor;

i) give a written consent conferring the Insurer with the right to get familiar with his medical documents, allow the Insurer to conduct investigation of the reason of losses and the amount, provide the Insurer with all correct information, also furnish it with all the requested documents;

j) substantiate the losses incurred with documents, if a claim for paying an insurance benefit for medical assistance has been filed, also in other cases established by the insurance agreement.

6.2. The Policyholder, the Insured and the beneficiaries shall follow provisions of Article 6.

6.3. The Policyholder and/or the Insured shall respond to questions of a questionnaire presented by the Insurer as comprehensively as possible and return it to the Insurer; he shall also furnish all other available documents and information on the circumstances and consequences of an insured event necessary to determine the insurance benefit amount. The Policyholder and/or the Insured shall have the right to acquire these documents in accordance with the procedure prescribed by laws and other legal acts.

6.4. Having received the initial information, the Insurer shall conduct an investigation of the insured event filing inquiries with respective law enforcement authorities, treatment and medical examination institutions, also institutions that keep lists of psycho-neurological, toxicological, narcological patients, etc. The Insurer may hire institutions, experts, specialists in the respective field and scientists to examine an insured event.

6.5. Medical experts of the Insurer shall set the insurance benefit amount pursuant to insurance benefit tables of these insurance conditions and considering conclusions, treatment applied, consultations and proposals of doctors having treated the suffered person and effectiveness of rehabilitation of the suffered person.

6.6. The necessity for a cosmetic plastic or reconstructive surgery shall be determined according to requirements of paragraph 6.5 after the end of the injury healing process, considering health condition of the suffered person before the accident and ruling out consequences and cosmetic defects of previous traumas, or congenital anomalies.

6.7. In case of filing a claim for reimbursement of expenses of psychological assistance, a referral for a psychologist's, psychiatrist's or psychotherapist's consultation issued by a personal health care institution shall be presented to the Insurer.

6.8. In case of usual medical assistance and additional assistance insurance, the Insurer shall be presented with original invoices substantiating expenses. In case of filing a claim for covering expenses incurred for the search and rescue of the Insured, a document issued by the search and rescue service substantiating the fact of search and/or rescue works, and an invoice substantiating such expenses shall be presented. In case of the transportation of the suffered insured to his permanent place of residence, a doctor's statement on the necessity to transport him to his permanent place of residence for further treatment shall be presented.

6.9. The Insurer may assess and determine long-term and permanent loss of physical or mental capacity (disability) of the Insured and its degree in at least 12 months after an accident provided that disability was confirmed by a respective medical statement issued no later than within 3 months after the expiry of the 12-month period from the date of an accident. If non-curable loss of physical or mental capacity (disability) is undoubted, the Insurer shall have the right to pay an insurance benefit without following the deadlines laid down in this paragraph.

7. Calculating insurance benefits

7.1. The insurance benefit amount shall depend on the degree of disability. When determining the degree of disability, exacerbations of past diseases, lack of provision of medical assistance or reconstructive-plastic surgeries shall be disregarded.

7.2. In case of complete loss of a part of the body or an organ, or manifestation of functional impairment, the degree of disability shall be determined according to Table No. 1 for determining disability in case of an accident presented in these conditions.

7.3. Decrease (loss) of working capacity of the suffered person and/or determination of this decrease, when the Disability and Employment Capacity Assessment Office has set for the suffered person a fixed-term or permanent decrease of working capacity (disability) may not be considered a basis for calculating (determining) the insurance benefit amount.

7.4. In case of a partial loss or incurable impairment of functions of body parts or sensory organs, the degree of disability shall be determined as a percentage expression of the complete loss or impairment of body parts or sensory organs.

7.5. If a body part, internal or sensory organs, the loss whereof has not been provided for in insurance benefit tables of these insurance conditions, were injured due to an accident, the physical or mental degree of impairment of bodily functions shall be determined medically according to other criteria laid down in paragraph 6.5.

7.6. If several physical or mental functions were impaired due to an accident, the degree of disability shall be determined according to paragraph 7.2 adding up degrees of impairment of these functions, but this sum may not exceed 100%. The insurance benefit paid for all injuries of one body part may not exceed the insurance benefit paid for the loss of that body part.

7.7. If a mental or physical function, which was permanently impaired due to an illness or experienced trauma before an insured event, is impaired due to an accident, the degree of impairment of the functions (disability) shall be calculated according to paragraph 7.2, deducting the respective former degree of loss of organ function.

7.8. If the Insured covered with accident insurance in case of death dies within one year from the accident due to that same accident, the right of claim to a benefit for disability, bone fractures and temporary disability shall be lost, i.e. the share of the benefit, which was already paid to the Policyholder for disability, bone fracture or temporary disability, shall be deducted from the insurance benefit provided for according to paragraph 4.1 in case of death.

7.9. If the Insured dies within one year from the day of the accident but for reasons other than the effects of the accident, or dies in more than a year regardless of the reason, and the right of claim for a benefit in case of disability according to paragraph 4.2 has been filed, a benefit for disability shall be paid according to the degree of the disability determined according to the last medical examination data.

7.10. If the parties to the insurance agreement agreed on insurance in case of bone fractures, insurance benefits shall be set according to Table No. 2 for determining bone fractures presented in these conditions, calculating as a percentage from the sum insured in case of bone fractures.

7.11. If the parties to the insurance agreement agreed on insurance in case of a temporary disability, insurance benefits shall be set according to Table No. 3 for determining temporary disability presented in these conditions, calculating as a percentage from the sum insured in case of a temporary disability.

7.12. An insurance benefit for expenses of usual medical assistance or additional assistance to the Insured shall not be paid in cases when these expenses were compensated by persons liable for the damage, or they have been compensated under compulsory or voluntary insurance. If the said expenses have been reimbursed only in part, the Policyholder shall become entitled to an insurance benefit for non-reimbursed part.

7.13. If the parties to the insurance agreement agreed on additional assistance insurance, insurance benefits shall be determined according to Table No. 4 for determining additional assistance included in these conditions.

7.14. The Insurer shall pay insurance benefits for expenses of usual medical assistance or additional assistance, if the Insured receives services of such assistance within 2 years from the date of an accident. Insurance benefits for the said assistance services received having missed this term shall not be paid.

8. Procedure of paying insurance benefits

8.1. Insurance benefits shall be paid to the Insured, unless the insurance agreement establishes otherwise. In case of the death of the Insured, insurance benefits shall be paid to beneficiaries. If a beneficiary has not been indicated in the insurance agreement, insurance benefits shall be paid to successors of the Insured upon his death.

8.2. If the Insured is a minor or incapacitated person, benefits shall be paid solely to the bank account opened on behalf of this person. In case of the death of the insured minor or incapacitated person, the insurance benefit shall be paid to his legitimate successors.

8.3. In case of an accident, an insurance benefit may be paid in parts considering conclusions of doctors having treated the Insured and effectiveness of rehabilitation.

8.4. If an event is an insured event, but the Policyholder and the Insurer fail to reach an agreement on the insurance benefit amount, the Insurer shall pay the sum equal to the insurance benefit amount undisputed by the parties to the insurance agreement, if more than 3 months are needed to determine exact damage amount.

9. Reducing an insurance benefit and bases for non-payment thereof

9.1. If health disorders caused by an accident or their consequences were affected by illnesses or ailments, or consequences of previous traumas, an insurance benefit shall be reduced according to the share of the illness or ailment.

9.2. The Insurer shall have the right not to pay an insurance benefit or to pay a lower benefit amount, if when concluding an insurance agreement, the Policyholder and/or the Insured presented data about the Insured which the Insurer knows to be false, or concealed them, if the Insured does not allow or interferes with accessing medical documentation of the Insured and/or checking his health.

9.3. The Insurer shall have the right not to pay an insurance benefit or to pay a lower benefit amount, if in case of an accident the Policyholder defaults on requirements provided for in parts a), c), d) or f) of paragraph 6.1 of these insurance conditions, except when evidence is furnished that the Insurer found out about the insured event on time, and when a failure to report an insured event had no impact on the duty of the Insurer to pay an insurance benefit.

9.4. The Insurer shall have the right not to pay an insurance benefit or to pay a lower benefit amount, if:

a) when riding in a motor vehicle equipped with seatbelts as a driver or a passenger the Insured had not buckled the seatbelts;

b) the Insured has driven a motor vehicle without having the right to drive this type of vehicle;

c) the Insured has not followed legitimate orders of police officers and incurred damage as a result thereof;

d) the damage has occurred due to the fact that the Policyholder or the Insured deliberately did not take measures available to them to avoid or reduce this damage.

9.5. The Insurer shall make a decision on non-payment of an insurance benefit or payment of a lower benefit amount; he shall give a reasoned explanation of the reasons therefor and inform thereof persons entitled to insurance benefits under the insurance agreement in writing.

Table No. 1 for determining disability due to an accident

Item No.	Injury	Insurance benefit (%)
	I. Central nervous system	
1.	**Residual effects after brain and spinal cord injury:**	
1.1.	Paralysis of upper and lower limbs (tetraplegia); extensive damage to cerebral cortex and cerebellum; dementia; disturbance of consciousness; impaired function of pelvic organs	100
1.2.	Paralysis of lower limbs with impaired function of pelvic organs	70
1.3.	Hemiplegia; extremely severe restriction of movement, sensation and muscle strength of two limbs; extremely apparent coordination disorder; extreme hypertonia of limb muscles; severe cognitive impairment (10 points or lower); dementia; epileptic seizures at least once per month	50
1.4.	Severe restriction of movement, sensation and muscle strength of two limbs; apparent organic damage to the brain; coordination disorder; severe hypertonia of limb muscles; impaired function of pelvic organs; apparent cognitive impairment (20 points or lower); epileptic seizures at least once a month	40
1.5.	Monoplegia; speech impairment; apparent coordination impairment; hypertonia of limb muscles and decreased muscle strength and sensation; epileptic seizures of average frequency (5-10 times per year); parkinsonism.	30
1.6.	Coordination and movement impairment; speech impairment; minor cognitive impairment; minor hypertonia of limb muscles and decreased muscle strength; rare epileptic seizures (3-4 times per year).	15
1.7.	Apparent facial asymmetry; autonomic (vegetative) symptoms; cerebellar function and speech impairments, vasomotor disorders, sporadic epileptic seizures (1-2 times per year).	7
Note: Residual effects shall be attributed to a particular group when at least two characteristics of that group are determined. If the Insured experiences at least one injury provided for in Item 1 of this Table and at least one injury of torso and/or limb bones provided for in Items 44-87 of this Table due to the same external impact, an insurance benefit shall not be paid for injuries provided for in Items 44-87 of this Table.		
	II. Peripheral nervous system	
2.	**Traumatic injury of cranial nerves:** *Note: An insurance benefit shall be paid in presence of symptoms of neuropathy, irrespective of the number of damaged nerves.*	
2.1.	Unilateral	5
2.2.	Bilateral	10
3.	**Injury of neck and shoulder, lumbar region and sacral plexus or respective nerves.** *Note: An insurance benefit shall be paid if movement, muscle strength, sensation are impaired, also in presence of muscular dystrophy and trophic skin disorder.*	10
4.	**Impairment of the integrity of peripheral nerves:** *Note: An insurance benefit shall be paid in presence of symptoms of neuropathy. If several nerves are injured in one limb, an insurance benefit shall be paid for the injury of one nerve only. When the right hand of right-handed people or the left hand of left-handed people is injured, the insurance benefit shall be increased by 10%.*	
4.1.	Nerve damage in forearm, wrist, shin and tarsus areas	5
4.2.	Nerve damage in upper arm, elbow, thigh and knee areas	10
	III. Organs of vision	
5.	**Paralysis of accommodation of one eye**	10
6.	**Significant visual field reduction; concentric narrowing of the field of vision**	15
7.	**Vision impairment, when an intraocular lens or lens (in both eyes) was implanted because of sustained trauma:** 0.4 0.3–0.1 below 0.1.	 10 20 25
8.	**Eyelid ptosis, eye muscle paralysis, eyelid defect preventing the eyes from closing.**	5
9.	**Unilateral bulging of the eye (exophthalmos)**	20
10.	**Consequences of injuring the organs of vision:** eye ball dislocation, tear duct injury, strabismus, retinal detachment (as a result of direct eye injury).	10
11.	**Post-traumatic eye diseases (except conjunctivitis); haemorrhage; iridal defect; pupil shape changes; lens dislocation** *Note: If the Insured suffered at least one of the injuries provided for in Items 5-14 of this Table due to an external impact on his body, an insurance benefit for injuries provided for in Item 11 shall not be paid.*	5

Item No.	Injury	Insurance benefit (%)
12.	**Complete loss of vision in one or both eyes**	100
13.	**Complete loss of vision in one eye**	45
14.	**Visual acuity reduction after eye injury** *Note: Visual acuity shall be determined according to the Table presented below, separately for each eye.*	

Visual acuity		Insurance benefit (%)	Visual acuity		Insurance benefit (%)
Before injury	**After injury**		**Before injury**	**After injury**	
1,0	0,7 0,6 0,5 0,4 0,3 0,2 0,1 <0,1 0,0	1 3 5 7 10 15 20 30 45	0,6	0,4 0,3 0,2 0,1 <0,1 0,0	1 3 10 15 20 30
0,9	0,7–0,6 0,5 0,4 0,3 0,2 0,1 <0,1 0,0	1 3 5 10 15 20 30 45	0,5	0,4–0,3 0,2 0,1 <0,1 0,0	1 5 10 15 25
0,8	0,6–0,5 0,4–0,3 0,2 0,1 <0,1 0,0	2 7 15 20 30 45	0,4	0,3–0,2 0,1 <0,1 0,0	2 7 10 20
			0,3	0,1 <0,1 0,0	5 10 20
0,7	0,5–0,4 0,3 0,2 0,1 <0,1 0,0	2 7 15 20 25 40	0,2	0,1 <0,1 0,0	5 10 20
			0,1	<0,1 0,0	10 20
			<0,1	0,0	10

Notes:
1. Complete blindness – when visual acuity is below 0.01 (inability to count fingers at a distance of 2 meters) to light perception.
2. When visual acuity of the injured eye before the day of the accident is not known, it shall be considered to be the same as the visual acuity on the non-injured eye.
3. In case of impaired visual acuity of both eyes, each eye shall be evaluated separately.

Item No.	Injury	Insurance benefit (%)

IV. Organs of hearing

15.	**Severe disorders of the vestibular function:** multiple, unremitting bouts of dizziness with vegetative reactions and hesitant walk.	30
16.	**Loss of the entire auricle**	5
17.	**Hearing impairment in one ear:** *Note: Audiogram and impedancemetry data and the ability to hear speech shall be assessed*	
17.1.	**Whispered words heard at up to 1 meter, conversation heard at a distance of 1 to 3 meters** (audiogram shows hearing decrease to 30-50 db).	5
17.2.	**Whispered words not heard at the auricle, conversation heard at a distance of up to 1 meter** (audiogram shows hearing decrease to 60-80 db).	10
18.	**Complete deafness in one ear** (conversation not heard at all, audiogram shows less than 91 db).	15
19.	**Complete deafness in both ears**	60

Item No.	Injury	Insurance benefit (%)
V. Respiration system		
20.	**Loss of nasal bones, cartilages and soft tissues**	30
21.	**Loss of nose wings and tip**	15
22.	**Loss of nose tip or wing (wings)**	10
23.	**Impairment of breathing through the nose.** The insurance benefit amount shall depend on the degree of impairment and sides (evaluated by rhinomanometry, norm: inhale and exhale 380–400 ml/second): a) severe unilateral (less than 100 ml/second) or apparent bilateral (less than 200 ml/second); b) complete bilateral (0 ml/second).	 5 10
24.	**Loss of olfaction and taste**	15
25.	**Loss of olfaction**	10
26.	**Post-traumatic chronic inflammation of paranasal sinuses**	2
27.	**Function impairment of larynx or trachea:**	
27.1.	Permanently inserted tracheostomy tube	40
27.2.	Dysphonia	10
27.3.	Aphonia	30
27.4.	Disorders of articulation	15
28.	**Lesions of respiratory organs causing:**	
28.1.	Stage I respiratory failure	10
28.2.	Stage II respiratory failure	40
28.3.	Stage III respiratory failure	60
29.	**Thoracic deformations after rib or sternal fractures in the presence of severe respiratory movement restriction**	10
Note: If the Insured suffered at least one of the injuries provided for in Item 28 of this Table and at least one of injuries provided for in Item 29 of this Table due to an external impact on his body, an insurance benefit for injuries provided for in Item 29 shall not be paid		
VI. Cardiovascular system		
30.	**Heart and blood vessel failure because of an injury to heart blood vessels or major blood vessels:** *Note: symptoms of failure of heart and blood vessels shall be evaluated according to NYHA classification, ECG, cardiac* stress tests, ultrasound imaging or long-term ECG and blood pressure monitoring	
30.1.	Functional class II – when heart failure symptoms are observed during difficult physical load.	15
30.2.	Functional class III – when heart failure symptoms are observed during average physical load.	40
30.3.	Functional class IV – when heart failure symptoms are observed at rest and sometimes persist	70
31.	**Blood flow disorder because of injury to major peripheral blood vessels:**	
31.1.	Minor – swelling, weaker pulse	5
31.2.	Significant – swelling, cyanosis, extremely weak pulse	10
31.3.	Severe – swelling, cyanosis, lymphoedema, trophic disturbances	15
Note: Residual effects shall be attributed to a particular group when at least two characteristics of that group are identified.		
VII. Gastrointestinal tract		
32.	**Chewing disorder because of facial bones fracture or lower jaw injury:**	
32.1.	Significant bite and chewing disorder	7
32.2.	Severe bite and mouth opening disorder, jaw deformation	25
33.	**Loss of lower jaw:** *Note: In case of loss of the jaw, an insurance benefit for injuries provided for in Item 32 shall not be paid*	
33.1.	Part of the jaw	15
33.2.	The entire jaw	50
34.	**Loss of the tongue:**	
34.1.	Up to the middle third	15
34.2.	From the middle third and more	30
34.3.	Complete loss	50
35.	**Severe narrowing of oral cavity, salivary fistula formation**	15

Item No.	Injury	Insurance benefit (%)
36.	**Oesophageal or pharyngeal narrowing as a result of burns or trauma:** *Note: The narrowing must be confirmed by objective tests.*	
36.1.	Difficulty while swallowing soft food	10
36.2.	Difficulty while swallowing liquid food	30
36.3.	Complete obstruction (gastrostomy)	80
37.	**Residual effects after gastrointestinal tract injury:**	
37.1.	Dumping syndrome	40
37.2.	Partial bowel obstruction	15
37.3.	Colostomy	30
37.4.	Disorder of pancreatic endocrine function	30
37.5.	Disorder of pancreatic exocrine function	5
37.6.	Stage II liver failure	45
37.7.	Stage III liver failure	80
38.	**Traumatic gastrointestinal tract injury, which led to the excision of:**	
38.1.	Part of liver	15
38.2.	Spleen	15
38.3.	Part of stomach, pancreas or intestine	25
38.4.	Entire stomach	40
Note: If the Insured suffered traumatic injury of internal organs in case of a temporary disability due to an external impact on his body, when a surgery on the organ had to be performed, and at least one of the injuries provided for in Item 38 of this Table, an insurance benefit shall not be paid according to paragraph 4.4.7 of the insurance conditions for a traumatic injury of internal organs when a surgery on the organ had to be performed. If the Insured suffered at least one of injuries provided for in Item 38 of this Table and at least one of injuries provided for in Item 37 of this Table due to an external impact on his body, an insurance benefit for injuries provided for in Item 37 of this Table shall not be paid.		

VIII. Urinary and reproductive system

39.	Kidney removal *Note: If the Insured suffered an injury provided for in Item 39 of this Table due to an external impact on his body, and a traumatic injury of internal organs in case of a temporary disability when a surgery on the organ had to be performed, an insurance benefit shall not be paid according to paragraph 4.4.7 of the insurance conditions for a traumatic injury of internal organs when a surgery on the organ had to be performed.*	25
40.	**Disorders of urine excretion functions:**	
40.1.	Kidney function disorder: a) Stage II failure; b) Stage III failure. *Note: Having suffered an injury provided for in Item 39 of this Table, and at least one of the injuries provided for in paragraph 40.1, an insurance benefit for an injury provided for in Item 39 of this Table shall not be paid.*	 40 80
40.2.	Significant narrowing of ureters or urethra, urinary bladder volume reduction	20
40.3.	Complete obstruction of ureter or urethra, fistula of reproductive organs	30
41.	**Consequences of injury of reproductive organs:**	
41.1.	Ovary, fallopian tube or testicle removed	15
41.2.	Penis part removed	25
41.3.	Entire penis removed	40
41.4.	Either both ovaries or both fallopian tubes, or uterus removed: a) when a woman is under 50 years of age, inclusive; b) when a woman is over 50 years of age.	 40 20

IX. Soft tissue injury

42.	**Very noticeable scars of the front or side surfaces of the face and neck that interfere with facial expressions (remaining after a plastic surgery) caused by burns, frostbite or injury.** An insurance benefit shall be paid in accordance with provisions of paragraph 4.5.1 of the insurance conditions. If an insurance benefit is paid for treatment expenses performing cosmetic plastic surgeries, in case of scars remaining after a cosmetic surgery, the difference between these insurance benefits shall be paid.	10
43.	**Hypertrophic, keloidal scars of the skin of torso and limbs that deform soft tissue and interfere with wearing clothes or footwear:**	
43.1.	Scars take up less than 1% of total body surface area	1
43.2.	Scars take up 1-2% of total body surface area	2
43.3.	Scars take up 3-4% of total body surface area	4

Item No.	Injury	Insurance benefit (%)
43.4.	Scars take up 5-10% of total body surface area	5
43.5.	Scars take up more than 10% of total body surface area	8
43.6.	Scars take up more than 15% of total body surface area	10
Note: A palm of the Insured shall correspond to 1% of the body's surface area. Scars shall be evaluated after at least one year after the injury. If the Insured has paid at least one insurance benefit indicated in Item 43 of this Table, the Insured shall lose the right of claim to reimbursement of plastic surgery expenses, except for plastic surgeries for removing cosmetic defects or deformities in the area of the face or the neck.		

X. Injuries to the bones of the torso and the extremities

Spine		
44.	**Spine function disorders after a spinal injury.** Injuries and percentage shares of benefits set therefor are presented in Items 1 and 2 of the Table.	
Shoulder girdle; shoulder joint		
45.	**Complete shoulder joint immobility after resection of humerus head**	40
46.	**Complete shoulder joint immobility**	30
47.	**Limited mobility of the shoulder joint**	10
Note: when the right hand of right-handed people or the left hand of left-handed people is injured, the insurance benefit shall be increased by 10%.		
Arm		
48.	**Loss of arm and scapula (or part thereof)**	75
49.	**Loss of arm after disarticulation at the shoulder joint or stump in the middle part of the arm**	70
50.	**Loss or arm – stump at the lower third of the arm**	65
51.	**Loss of forearm after disarticulation at the elbow joint**	65
52.	**Loss of forearm under the elbow joint**	60
Note: when the right hand of right-handed people or the left hand of left-handed people is injured, the insurance benefit shall be increased by 10%.		
Shoulder joint		
53.	**Complete immobility of shoulder joint**	20
54.	**Limited mobility of the shoulder joint**	7
Note: when the right hand of right-handed people or the left hand of left-handed people is injured, the insurance benefit shall be increased by 10%.		
Wrist joint; hand		
55.	**Loss of hand from the wrist or metacarpus**	55
56.	**Complete immobility of the wrist joint**	20
57.	**Limited mobility of the wrist joint**	5
58.	**Hand function disorder** *Note: If the Insured suffered at least one of the injuries provided for in Item 4 of this Table and an injury provided for in Item 58 due to an external impact on his body, insurance benefits for injuries provided for in Item 4 of this Table shall not be paid*	10
Note: when the right hand of right-handed people or the left hand of left-handed people is injured, the insurance benefit shall be increased by 10%.		
59.	**First finger (thumb):**	
59.1.	Partially amputated distal phalange	5
59.2.	Completely amputated distal phalange	8
59.3.	Partially amputated intermediate phalange	15
59.4.	Loss of finger	20
59.5.	Loss of finger and metacarpus or a part thereof	25
60.	Immobility of thumb joint	5
61.	Immobility of thumb palm joint	10
Note: when the right hand of right-handed people or the left hand of left-handed people is injured, the insurance benefit shall be increased by 10%.		

Item No.	Injury	Insurance benefit (%)
62.	**Second (index) finger:**	
62.1.	Partially amputated distal phalange	3
62.2.	Completely amputated distal phalange	4
62.3.	Completely amputated intermediate phalange	8
62.4.	Partially amputated proximal phalange	10
62.5.	Loss of finger	12
62.6.	Loss of finger and metacarpus or a part thereof	15
62.7.	Finger contracture in half-bent state and ankylosis of proximal finger joint or palm and finger joint	4
62.8.	Finger contracture while fully bent or extended and ankylosis two finger joints	8
Note: when the right hand of right-handed people or the left hand of left-handed people is injured, the insurance benefit shall be increased by 10%.		
63.	**Third (middle), fourth (ring) or fifth (pinky) fingers:**	
63.1.	Partially amputated distal phalange	2
63.2.	Stump of intermediate or proximal phalange	5
63.3.	Loss of finger and metacarpus or a part thereof	15
63.4.	Finger contracture in half-bent state and ankylosis of first finger joint or palm and finger joint	1
63.5.	Finger contracture while fully bent or extended or ankylosis of two and three finger joints	3
64.	Loss of two fingers of the same hand:	
64.1.	First and second fingers	35
64.2.	First and third, first and fourth or first and fifth (1+3), (1+4), (1+5)	25
64.3.	Second and third, second and fourth or fifth (2+3), (2+4), (2+5)	15
64.4.	Third and fourth or third and fifth (3+4), (3+5)	10
65.	**Loss of three fingers of the same hand:**	
65.1.	First, second and third, fourth or fifth (1+2+3), (1+2+4), (1+2+5)	40
65.2.	First, third and fourth or fifth (1+3+4), (1+3+5)	35
65.3.	Second, third and fourth or fifth (2+3+4), (2+3+5)	30
65.4.	Third, fourth and fifth (3+4+5)	25
66.	**Loss of four fingers of the same hand**	40
Note: In other cases of loss of fingers or their function, an insurance benefit shall be calculated summing up the benefits determined in cases of loss of function of individual fingers		
67.	**Loss of all fingers of the same hand**	45
Note: when the right hand of right-handed people or the left hand of left-handed people is injured, the insurance benefit shall be increased by 10%.		
Leg		
68.	**Loss of a leg or a stump at the upper third:**	
68.1.	Loss of leg after disarticulation at hip joint or stump at the upper third	70
68.2.	Loss of leg after disarticulation at hip joint or stump at the upper third, if before the injury it was the only one leg	90
69.	**Thigh stump at the middle or lower third**	60
70.	**Leg function impairment because of leg shortening by more than 2.5 cm**	5
71.	**Loss of shin or a stump at the upper third**	
71.1.	Loss of shin after disarticulation at the knee joint or a stump at the upper third	50
71.2.	Loss of shin of the only leg	80
72.	**Stump at the middle or upper third of the shin**	45
Hip joint		
73.	**Complete immobility of hip joint**	35
74.	**Limited mobility of hip joint**	10
Knee joint		
75.	**Complete joint immobility**	30
76.	**Pathological joint mobility because of the tear of ligaments (persisting after surgical treatment)**	8
77.	**Limited movement of the knee joint**	5

Item No.	Injury	Insurance benefit (%)
Tarsal joint; foot		
78.	**Complete immobility of tarsal joint**	20
79.	**Limited movement of the tarsal joint**	5
80.	**Loss of foot after disarticulation at the tarsal joint or foot amputation at tarsal bones**	40
81.	**Loss of distal part of the foot because of amputation at the level of metatarsus**	30
82.	**Disorder of foot function because of deformation or unhealed fracture** *Note: if the Insured suffered at least one of the injuries provided for in Item 4 of this Table and an injury provided for in Item 82 of this Table due to an external impact on his body, an insurance benefit shall not be paid for injuries provided for in Item 4 of this Table*	5
Toes		
83.	**Loss of all toes after disarticulation at sole and toe joints or amputation at the level of proximal phalanges**	20
84.	**Loss of the first toe and the metatarsal bone or a part thereof**	15
85.	**Loss of the first toe after disarticulation at sole and toe joint or a stump at the level of proximal phalange**	5
86.	**Loss of the distal phalange of the first toe**	2
87.	**Loss of the second, third, fourth or fifth toes:**	
87.1.	After disarticulation at the sole and toe joint or a stump at the proximal phalange	2
87.2.	Loss including a metatarsal bone or a part thereof	5
87.3.	Toe function disorder because of joint immobility	1
Note: in case of a loss of toes or their function in cases unprovided for in Items 83-87 of this Table, an insurance benefit shall be paid by summing up benefits provided for in case of the loss of the function of separate toes.		

XI. Disorders of other functions

88.	**Loss of speech**	50

Table No. 2 for diagnosing bone fractures

Item No.	Injury	Insurance benefit (%)
1. Skull bones:		
1.1.	Bones of the calvaria	10
1.2.	Bones of the base of the skull	15
1.3.	Bones of the calvaria and the base of the skull	20
2. Facial bones:		
2.1.	Cheekbone and the upper jaw	7
2.2.	Lower jaw	6
2.3.	Eye orbit (any of the walls)	5
2.4.	Nasal bones, ethmoid bone	3
2.5.	Larynx, thyroid cartilage, hyoid bone	4
Note: fracture of dental alveolus of the jaw shall not be considered a jaw fracture		
3. Traumatic teeth injury resulting in loss of tooth and/or root:		
3.1.	Loss of a milk-tooth before the age of 5 years. *Note: the insurance benefit per one event may not exceed 5%*	2
3.2.	Loss of 1 permanent tooth	4
3.3.	Loss of 2-3 permanent teeth	7
3.4.	Loss of 4-5 permanent teeth	10
3.5.	Loss of 6 and more permanent teeth	14
Note: in case of a fracture of prostheses or bridges, an insurance benefit shall be paid only for the loss of supporting teeth due to an accident. In all other cases of traumatic injury of permanent teeth (tooth dislocation, punching it into the alveolus, breakage of at least ¼ of the teeth), 1% for one injured tooth, but no more than 3%, shall be paid. In case of loss of a tooth affected by parodontosis, caries or another dental pathology, an insurance benefit of traumatic injury shall be reduced by 50%.		
4. Spine:		
4.1.	Fractures of vertebral bodies and arches in cervical, thoracic or lumbar regions:	
4.1.1.	When treated in a hospital for at least 6 days. *Note: in case of a fracture of three or more vertebrae, an insurance benefit shall not exceed 24%.*	12
4.1.2.	*When treated outpatiently or in a hospital for less than 6 daysNote: in case of a fracture of three or more vertebrae, an insurance benefit shall not exceed 16%.*	8
4.2.	Transverse or spinous processes of a vertebra *Note: in case of a fracture of three or more processes of vertebrae, an insurance benefit shall not exceed 8%.*	3
4.3.	Sacrum	5
4.4.	Coccyx	3
5. Sternum and rubs:		
5.1.	Sternum	5
5.2	Ribs (1-2)	3
5.3.	Ribs (3 and more)	4
5.4.	Fracture of ribs (3 and more) on both sides of the thorax	6
6. Arm:		
6.1.	Scapula, clavicle	5
6.2.	Humeral head impression fracture after shoulder joint dislocation	3
6.3.	Tubercle of the humerus	4
6.4.	Upper extremity of the humerus	9
6.5.	Body of the humerus	10
6.6.	Proximal humerus fracture	
6.7.	One bone of the forearm	5
6.8.	Distal end of one bone of the forearm and styloid process of another bone	7
6.9.	Fractures of two bones of the forearm	10
6.10.	Styloid processes of the ulna or the radius	2
6.11.	Wrist bones (except for scaphoid bone)	3
6.12	Scaphoid bone	5
6.13.	Metacarpal bone fractures *Note: an insurance benefit shall be paid for each bone fracture, but shall not exceed 8%.*	3
6.14.	Base phalanx of the thumb	3
6.15.	Distal phalanx of the thumb	2

Item No.	Injury	Insurance benefit (%)
6.16.	Fracture of II-V fingers (proximal, intermediate phalanx) *Note: an insurance benefit shall be calculated for the fracture of each finger bone, but shall not exceed 5%.*	2
6.17.	Fracture of II-V fingers (distal phalanx) *Note: an insurance benefit shall be calculated for the fracture of each finger bone, but shall not exceed 3%.*	1
Note: the fracture of several phalanxes of a single finger shall be treated as a single fracture. An insurance benefit shall be paid according to the paragraph providing for the largest benefit.		
7. Pelvic bones (ilium, ischium, hip bone, pubis):		
7.1.	Fracture of acetabulum;	12
7.2.	Tear of symphyses and bone fractures	13
7.3.	Fracture of two or more bones	8
7.4.	Tear of symphysis	7
7.5.	Fracture of one bone	5
8. Thigh:		
8.1.	Trochanters of the femur	8
8.2.	Head and/or neck of the femur	14
8.3.	Body of the femur	10
8.4.	Intraarticular fractures of the femur or tibia (at the knee joint)	10
8.5.	Patella	8
8.6.	Tibia (except for posterior margin and medial malleolus)	8
8.7.	Posterior margin and medial malleolus of tibia	5
8.8.	Fibula, external malleolus	5
8.9.	Tibia and fibula	10
8.10.	Tibia and fibula with tear of syndesmosis	12
8.11.	Calcaneus, talus	7
8.12.	Other ankle and foot bones (metatarsus bones) *Note: an insurance benefit shall be paid for the fracture of each bone, but it shall not exceed 10%.*	4
8.13.	Big toe	2
8.14.	Toe bones of toes II-V of the foot *Note: an insurance benefit shall be calculated for the fracture of each bone, but it shall not exceed 3%.*	1
8.15.	Sesamoid bones	1
Note: the fraction of several toe bones of one toe shall be treated as a single fracture.		
9. Other:		
9.1.	Compound bone fractures or where osteosynthesis was performed to fixate bone fractures (fixation with a metal plate, nails, wire and a fixation machine from the outside), an insurance benefit shall be increased by 50%, but not more than once for the same insured event.	
9.2.	Where an artificial joint had to be implanted during acute trauma period, an insurance benefit shall be increased by 100%.	
9.3.	Avulsion bone fractures, bone splits, bone infractions, bone impression fractures, stress fractures and other changes in the bone structure which do not extend only to partial and not full bone thickness.	1
Note: the fraction of one bone in several spots for the same insured event shall be treated as a single fracture.		
In case of a repeated bone fraction at the place of internal fixation or callus of the bone an insurance benefit for the fracture of that bone shall be reduced by 50%. *If several bones fractured at the time of an insured event, insurance benefits shall be summed up, but the sum shall not exceed 100% of the sum insured for bone fractures.* *When the injury provided for in this Table is sustained by the Insured person diagnosed with pregnancy at the time of the accident, the insurance benefit shall be doubled.*		

Table No. 3 for determining temporary disability

Item No.	Injury	Insurance benefit (%)
1. Brain and spine cord injuries:		
1.1.	Cerebrovascular haemorrhage (hematoma).	10
1.2.	Cerebrovascular haemorrhage with opening of the cranial cavity.	18
1.3.	Brain concussion treated for at least 3 days in a hospital and then outpatiently.	6
1.4.	Brain concussion treated outpatiently for at least 14 days or in a hospital for 1-2 days and then outpatiently.	4
1.5.	Cerebral contusion.	8
1.6.	Spinal cord concussion treated for at least 3 days in a hospital and then outpatiently.	5
1.7.	Spinal cord concussion treated outpatiently for at least 14 days or in a hospital for 1-2 days and then outpatiently.	4
1.8.	Spinal cord contusion	7
1.9.	Cerebral and spinal cord compression	15
Note: if the insured suffered several cerebral and/or spinal cord injuries due to an external impact on his body, an insurance benefit shall be paid according to the Item providing for the greatest insurance benefit. The first and the last day of hospital treatment shall be treated as one day.		
2. Dislocation of joints (bones):		
2.1.	Dislocation of joints – shoulder, elbow, hip, knee	5
2.2.	Dislocation of joints – shoulder, elbow, hip, knee, if a surgery had to be performed thereon	7
2.3.	Dislocation of wrist, ankle joints	3
2.4.	Dislocation of wrist, ankle joints, if a surgery had to be performed thereon	5
2.5.	Lower jaw	3
2.6.	Lower jaw, if a surgery had to be performed thereon	5
2.7.	Dislocation of phalanges	1
2.8.	Dislocation of phalanges with impaired integrity of tendons/ ligaments or capsule, if a surgery had to be performed thereon	3
Note: dislocation of several phalanges of one finger shall be treated as a single dislocation		
2.9.	Dislocation of the patella	4
2.10.	Dislocation of a vertebra of the cervical spine	5
2.11.	Dislocation of two and more vertebrae of the cervical spine	7
Note: if the insured has suffered a dislocation, a tear of soft tissues, muscles, tendons or ligaments, an insurance benefit shall be paid according to the Item providing for the largest insurance benefit. In case of a partial dislocation of joints (bones), an insurance benefit shall be reduced by 50%.		
3. Tear of tendons, ligaments, muscles, menisci		
3.1.	Tear of knee menisci *Note: In case of the tear of both menisci of one knee joint due to an injury, an insurance benefit shall be paid for the tear of one meniscus only*	4
3.2.	Tear of menisci and lateral/ cruciate ligaments of the knee	6
3.3.	Tear of tendons, ligaments, muscles of the hand, wrist, ankle, feet, fingers, toes (without a surgical treatment)	2
3.4.	Tear of tendons, ligaments, muscles of the hand, wrist, ankle, feet, fingers, toes (with a surgical treatment)	3
3.5.	Tear of tendons, ligaments, muscles of the shoulder, elbow, hip, knee or tear of vertebral ligaments (without a surgical treatment)	3
3.6.	Tear of tendons, ligaments, muscles of the shoulder, elbow, hip, knee or tear of vertebral ligaments (with a surgical treatment)	5
3.7.	Achilles tendon rupture	5
3.8.	Achilles tendon rupture (with a surgical treatment)	7
3.9.	Sprain of ligaments, muscles, tendons of the neck, shoulder, elbow, wrist, hip, knee, ankle, foot joints (an insurance benefit shall not be paid for repeated sprains of muscles, tendons or ligaments of the same joint within one year from the previous event).	1
Note: in cases of a partial tear of ligaments, tendons, muscles and when the injuries laid down in Item 3 of this table were suffered in limbs with degenerative changes, an insurance benefit shall be reduced by 50%. In case of a tear of the same meniscus, ligament, tendon and/or muscle for the second time, and insurance benefit for meniscus, ligament, tendon or muscle shall be reduced by 50%, and in case of each subsequent tear an insurance benefit shall not be paid. If the Insured has suffered a dislocation, tears of soft tissue, muscles, tendons or ligaments in the same limb due to an external impact on his body, an insurance benefit shall be paid according to the Item providing for the largest insurance benefit.		

Item No.	Injury	Insurance benefit (%)
4. Traumatic injury of internal organs, soft tissues:		
4.1.	Traumatic impairment of internal organs, when a surgery had to be performed on the impaired organ	6
4.2.	Chest injury having led to pneumothorax, hemothorax, exudative pleuritis, hypodermic emphysema	2
4.3.	Chest injury having led to pneumothorax, hemothorax, exudative pleuritis, hypodermic emphysema (when a surgical intervention was needed to treat these conditions)	4
4.4.	Eyeball penetrating injury	5
4.5.	Corneal abrasion, lenticular dislocation	2
4.6.	Erosion of tunica conjuctive, cornea of the eye with foreign objects, iris splitting, when the insured was treated outpatiently for at least 6 days	1
4.7.	Traumatic rupture of drum of one ear when hearing was not impaired	3
4.8.	Soft tissue damage greater than 10 cm, which required stitching the tissues	5
4.9.	3–10 cm soft tissue damages, which required stitching the tissues	2
4.10.	Injuries of soft tissues having led to impaired integrity of tissues less than 3 cm, which required stitching the tissues	1
4.11.	Finger wound with torn nail, when the nail was torn by direct impact of external force at the time of an accident	2
4.12.	Stab wounds, when one stab has led to damaged skin, hypoderma and muscular layers	1
4.13.	Multiple bite injuries with soft tissue defects, when more than one spot on the body is injured and one injury covers 0.25% or more of the body surface	5
4.14.	Soft tissue injuries having led to multiple hematomas; posttraumatic osteomyelitis, phlegmon, abscess (that were treated surgically), crushed, scalped wounds. *Note: in case of multiple hematomas, an insurance benefit shall be paid if non-resorbed hematomas persist in more than 3 weeks after the trauma, the area of each of them exceeds 5 cm2 and there are no less than 3 of them*	3
4.15.	Deep skin abrasions (reaching stratum papilare and deeper), which are localized in different parts of the body. *Note: an insurance benefit shall be paid if skin abrasions are localized in different anatomical structures, with their total area covering at least 2% of the surface of the body, and a person was incapacitated for more than 6 days.*	3
4.16.	Haemarthrosis (if a joint has to be aspirated)	2
Note: if the Insured has suffered a dislocation, a tear of soft tissues, muscles, tendons or ligaments, an insurance benefit shall be paid according to the Item providing for the largest insurance benefit.		
5. Poisoning, bites of poisonous animals, natural or technical electrical effects or other injuries unprovided for in this Table (when the Insured was treated in a hospital):		
5.1.	Up to 2 days	1
5.2.	3 to 6 days	2
5.3.	7 to 15 days	4
5.4.	More than 15 days	7
5.5.	Traumatic, post-hemorrhagic, anaphylactic shock, fat embolism	10
Note: The first and the last day of hospital treatment shall be treated as one day.		
6. Burns, frostbites:		
6.1.	Second degree burns covering at least 1% of the surface of the body	3
6.2.	Second degree burns covering at least 4% of the surface of the body	5
6.3.	Third degree burns up to 2% of the surface of the body	4
6.4.	Third degree burns covering at least 2% of the surface of the body	6
6.5.	Third degree eye burns	4
6.6.	Wide first degree burn causing an inflammatory illness	6
6.7.	Third degree frostbite	5
Note: 1% of the total body surface shall correspond to the size of a handprint (including the palm and fingers) of the Insured		
7. Tick-borne diseases		
7.1.	Tick-borne encephalitis or Lyme disease *Note: the disease shall be supported by serological tests, the appearance of the first symptoms of the disease after at least 30 days from the first day of application of the additional insurance coverage. Side effects may be assessed according to disorders specified in Table No 1 (paragraph 4.2 of the insurance conditions).*	1

Item No.	Injury	Insurance benefit (%)
8. Miscarriage:		
8.1.	An insurance benefit shall be paid when pregnancy of more than 22 weeks ends or must be ended artificially due to an external impact (trauma).	20
8.2.	The insurance benefit shall be disbursed when pregnancy is lost or artificially terminated for other reasons from week 14 (The insurance benefit under this paragraph shall be paid once time during the entire insurance agreement validity period).	10
Common note for Items 2, 3 and 4 of Table No. 3 (for determining temporary disability): if the Insured has suffered a dislocation of joints (bones), a tear of soft tissues, muscles, tendons or ligaments in the same extremity due to an external impact on his body, an insurance benefit shall be paid according to the Item providing for the largest insurance benefit. *When the injury provided for in clauses 1–7 of this Table is sustained by the Insured person diagnosed with pregnancy at the time of the accident, the insurance benefit shall be doubled.*		

Table No. 4 for determining additional assistance

Item No.	Injury, condition	Insurance benefit
1. Additional assistance when the insured person suffers an accident recognised to be the insured event. The insurer shall indemnify the necessary expenses:		
1.1.	a) Measures of search and rescue of the injured insured person by public or private services; b) The injured insured person's delivery by special transport to the nearest medical institution when such need is confirmed by a doctor; c) The injured insured person's transportation to the permanent place of residence when such need is confirmed by a treating doctor's decision; d) In the event of death of the insured person caused by an accident abroad, transportation of the dead person's body to the permanent place of residence or necessary costs of burying abroad without exceeding the costs of transportation.	Up to EUR 10 000
1.2.	Costs of purchase or rent of medical assistance and orthopaedic technical aids (splints, sticks, crutches, rehabilitation equipment, wheelchair)	Up to EUR 200 per one year of insurance for all events
1.3.	Diagnostic/radiological tests necessary for confirmation or treatment of injuries *Note: The doctor's consultation is not indemnified.*	Up to EUR 200 per one year of insurance for all events
1.4.	Suture, dressing of wounds, injections, infusions	Up to EUR 100 per one year of insurance for all events
1.5.	In the case of the insured person's disability/loss of capacity for work – costs of adaptation of the place of residence for the disabled insured person	Up to EUR 600 per one event
1.6	In the case of the insured person's death, disability/loss of capacity for work – costs of a psychologist's assistance to the injured person or to insured persons who are close relatives (parents/legal guardians, children, brothers, sisters or spouse).	Up to EUR 300 per one year of insurance for all events
1.7.	In the case of the insured person's death – costs of burying/cremation.	Up to EUR 600 per one event
General comment for Item 1 of Table No 4: Costs incurred not in the currency of the insurance agreement shall be indemnified converting into the currency of the insurance agreement at the exchange rate of the day on which they were incurred. Costs must be supported by the invoice detailing the acquired goods/services.		
2. Additional assistance in the cases of acute diseases:		
2.1. 2.2. 2.3. 2.4. 2.5. 2.6. 2.7. 2.8. 2.9. 2.10. 2.11. 2.12. 2.13. 2.14. 2.15.	Ebola virus, malaria, diphtheria, whooping cough, tetanus, botulism Acute appendicitis Meningococcal infection Gas gangrene Pneumococcal infection Hospital infection, sepsis Ectopic pregnancy surgery Brittle bone disease (for children) diagnosed for the first time during the insurance agreement validity period Tick-borne encephalitis, tick-borne myelitis, tick-borne encephalomyelitis Trichinosis, legionelosis Perforated gastric or duodenal ulcer Systemic lupus diagnosed for the first time during the insurance agreement validity period Gallstones due to which the gallbladder removal surgery was performed Kidney stones due to which stones were removed by lithrotripsy or surgical procedure not more than 2 times during the insurance agreement validity period Tuberculosis for persons younger than 18 years diagnosed for the first time during the insurance agreement validity period	EUR 500 per one event, without exceeding EUR 1 000 during one year of insurance
General comment for Item 2 of Table No 4: in the cases of acute diseases the insurance benefit shall be disbursed when the insured person due to his (her) health condition was hospitalised and the disease was confirmed by the doctor's conclusion and medical tests. *The insurance benefit shall not be disbursed for diseases indicated in points 2.8–2.15 of this Table and exacerbations of such diseases diagnosed before the beginning of the insurance agreement or during the first 30 days from the beginning of this insurance cover.*		

Managing Director
Bogdan Benczak