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ERGO Life Insurance SE

ERGO Universal Life Insurance Rules No 027



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Information under Article 116 of the Republic of Lithuania Law on Insurance for the policyholder concluding ERGO Universal Life Insurance Contract

Insurer

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ERGO Universal Life Insurance

Universal Life Insurance belongs to the life insurance group related to investment funds. Under this Insurance Contract insurance premiums are converted into investment units of investment directions chosen. The Policyholder must assess that return on investment is not guaranteed and therefore, the amount of insurance benefit at the end of the Insurance Contract is not known. It might be both higher and lower than expected. The Policyholder shall bear the losses incurred due to the investment risk. A part of the insurance premiums paid shall be used to cover the costs of conclusion and administration of the insurance contract as well as costs of the insurance cover chosen.

Upon conclusion of ERGO Universal Life Insurance Contract, in case of insured event the insurance company undertakes to pay the insurance benefit to the persons referred to in the insurance contract and the policyholder undertakes to pay insurance premiums in due time.

Insurance contract conclusion

ERGO Universal Life Insurance Rules No 027 (as amended on 01 09 2025) shall apply to the Insurance Contract.

A person who wishes to conclude an ERGO Universal Life Insurance Contract shall provide the Insurer with the specific format application. The Policyholder and the insured persons shall complete the survey questionnaires established by the Insurer if the Insurer so requests. The application and the survey questionnaires provided by the Policyholder become an integral part of the Contract upon its conclusion together with the insurance rules.

Provision of the application and payment of the premium shall not obligate the Insurer to conclude the Insurance Contract. The Insurer, having assessed the insurance risk, may refuse to conclude the Insurance Contract without giving the reasons for the refusal. Key factors influencing the insurance risk and the increase of the insurance risk shall be: the occupational or trade activity, leisure activities and hobbies and health status.

If the Insurer has agreed to conclude the insurance contract, an insurance policy confirming conclusion of the Insurance Contract shall be issued to the Policyholder. The insurance policy shall be delivered to the Policyholder in the manner chosen by the latter.

The Insurance Contract shall enter into force upon issuing the insurance policy by the Issuer and paying the whole first insurance premium by the Policyholder. Payment of the first periodic (and an additional premium, if agreed upon) or of a single insurance premium shall mean that the Policyholder agrees with the terms and conditions of the Insurance Contract and expresses his willingness to conclude the Insurance Contract. The Insurance Contract shall remain valid even without the Policyholder's signature on the insurance policy. The Policyholder shall have the right at the latest 30 days after the date when he was informed about conclusion of the Insurance Contract to submit to the Insurer objections to the content of the Insurance Contract in writing and / or withdraw from it.

Upon conclusion of an insurance contract, the insurance distributor shall be paid a commission fee, which is an integral part of the insurance premium, and additional remuneration may be paid depending on the results of work, without violating the requirements set out in the Republic of Lithuania Law on Insurance.

A recommendation shall be provided to the Policyholder regarding the insurance products distributed by the insurer.

Insurance premiums and sums insured

The minimum amount of the monthly periodic insurance premium shall be EUR 50.00.

The Policyholder shall have the right to choose indexation of the periodic premium from 5% – the amount agreed upon by the Policyholder and the Insurer is indicated in the insurance policy (the premium shall be increased by the amount agreed upon by the parties from the beginning of each insurance year).

The minimum single insurance premium when it is paid for the whole contract period shall be EUR 3 000.00. The minimum additional insurance premium shall be EUR 150.00. Insurance premium rates set out for the Insurance Contract are provided for in the insurance policy. The Policyholder shall have the right to pay additional insurance premiums which are not provided for in the insurance policy after the prior submission of the specific format application to the Insurer.

Insurance premiums shall be paid on the terms chosen by the Policyholder to the bank account of the Insurer. The minimum sum insured of the main or supplementary life insurance of the insured person shall be EUR 3 000.00. The Insurer may also set out other minimum and/or maximum sums insured. The rates of the sums insured agreed between the Policyholder and the Insurer shall be indicated in the insurance policy.

The procedure and methods of payment of insurance premiums are provided for in Articles 7 and 9 of the Insurance Rules.

Insurance benefits

Upon conclusion of an ERGO Universal Life Insurance Contract, the Policyholder may choose one of the two following insurance options:

- Insurance option A, when in case of death of the principal insured person the larger of the following amounts is paid: the sum insured of the life insurance or the accrued capital value;
- Insurance option B, when in case of death of the principal insured person both the sum insured of the life insurance and the accrued capital value are paid.

The insurance benefit calculation option applied to the Insurance Contract shall be specified in the insurance policy.

The determination of the amount of insurance benefits and the procedure and methods of payment of insurance benefits are specified in Articles 5 and 7 of the Special Life Insurance Conditions of the insurance rules and in the special conditions of the selected insurances.

Insurance covers

The Policyholder may choose the following insurance covers for the principal insured person and other insured persons under the conditions provided by the Insurer:

- life insurance;
- insurance against partial or total disability (loss of participation);
- cancer and other critical illness insurance;
- accident insurance.

Insurance contract validity period

The minimum validity period of the Insurance Contract shall be 1 (one) year. The maximum age of the principal insured person at the end of insurance shall be 99 years.

The age of insured persons at the beginning of insurance shall be as follows:

- 0–98 years for life insurance of the principal insured person;
- 0–74 years for life insurance of other insured persons;
- 18–64 years for insurance against partial or total disability (loss of participation);
- 2–64 years for cancer and other critical illnesses insurance;
- 0–69 years for accident insurance.

Insurance contract deductions

A part of the insurance premiums paid shall be used to cover the costs of conclusion and administration of the insurance contract as well as costs of the insurance cover chosen. Insurance deductions and the procedure for their application are provided for in the Insurer's pricelist and are also described in Article 8 of the Insurance Rules.

Investment directions and programmes

The Policyholder shall have the right to choose an investment direction from the list proposed by the Insurer. The investment directions chosen by the Policyholder and the percentage distribution of insurance premiums invested in them form the investment programme. Investment objects of the investment directions and historical return on investment are provided for in the descriptions of the investment directions. Descriptions of the investment directions are available on the website of the Insurer and might be provided to the Policyholder upon his request.

The Policyholder shall have the right during the insurance contract validity period to change the investment programme and the structure of the capital accrued without prejudice to the restrictions imposed by the Insurer on investment in the directions. The amended investment programme shall apply only to the insurance premiums paid from the date of the investment programme amendment.

More information is available in Articles 10 and 14 of the Insurance Rules.

Information on sustainability of ERGO Universal Life Insurance Product

ERGO Universal Life Insurance is a financial product that promotes environmental and social characteristics, but does not achieve a sustainable investment purpose. Promoting these characteristics means that ERGO Universal Life Insurance product invests in at least one light green investment direction and has at least one of the light green investment directions for the entire financial product. More information about these investment directions characteristics can be found in the information below.

Information on sustainability risk assessment in funds

In this financial product, you can choose one or several investment directions from the offered list of investment directions yourself or you can choose one of the ERGO investment programmes offered to you, considering your risk tolerance and sustainability priorities. This financial product will be invested accordingly in the investment objects specified in the table below, i.e., investment funds or exchange-traded funds..

Taking into account the focus on sustainability risks, the directions can be divided into three categories (according to Regulation (EU) 2019/2088 of the European Parliament and Council on sustainability-related disclosures in the financial services sector (hereinafter – the SFDR) requirements):

Main directions (Article 6 of the SFDR) – investment directions that have integrated sustainability risk into their investment strategy. Investing in this financial product does not take into account the criteria for environmentally sustainable economic activities according to the EU.

ESG directions (Article 8 of the SFDR or light green) – investment directions that have integrated sustainability risk into their investment strategy and actively contribute to sustainable investments.

ESG impact directions (Article 9 of the SFDR or dark green) – investment directions that only invest sustainably and advertise it.

Please note that the financial product does not invest directly in companies but invests in them indirectly through funds. Thus, the proportion of light green funds and sustainable investments in the financial product directly depends on the chosen investment directions and sustainability priorities.

Information about the focus on sustainability risks for your chosen directions can be found in the table below.

Investment direction (fund name)	ISIN	Direction category	Does the fund promote environ mental and social (E/S) characteristics?	Does the fund have a sustain able investment goal?	Does the fund undertake to invest a minimum share of funds in sustainable investments?	Does the fund consider principle adverse impact on sustainability factors?[2]
Bond investment directions						
Short-term investments (Evli Euro Liquidity B)	FI0008804463	Light green	Yes[1]	No	No	Yes[3]
Bonds (BGF Euro Bond I2)	LU0368229703	Light green	Yes[1]	No	No	Yes[3]
Stock index investment directions						
World stock index (iShares Core MSCI World ETF)	IE00B4L5Y983	Main	No	No	No	No
USA stock index (iShares Core S&P 500 ETF)	IE00B5BMR087	Main	No	No	No	No
European stock index (Xtrackers Stoxx Europe 600 ETF)	LU0328475792	Main	No	No	No	No
Japan stock index (Amundi MSCI Japan ETF)	LU1781541252	Main	No	No	N	N
World ESG stock index (BNPP MSCI World SRI PAB ETF)	LU1615092217	Light green	Yes[1]	No	Yes, 40%	Yes[3]
Stock investment directions						
Global emerging markets shares (Nordea 1 – Emerging Sustainable Stars Equity BI)	LU0602539271	Light green	Yes[1]	No	Yes, 50%	Yes[3]
European emerging markets shares (TRIGON – New Europe A)	LU1687402393	Light green a	Yes[1]	No	No	Yes[3]
Global shares (Evli Global IB)	FI4000301312	Light green	Yes[1]	No	N	Yes[3]
European shares (Comgest Growth Europe Smaller Companies I)	IE00BHWQNP08	Light green	Yes[1]	No	Yes, 10%	Yes[3]
U.S. shares (T. Rowe Price US Smaller Companies Equity Q1)	LU1737526100	Light green	Yes[1]	No	Yes, 10%	Yes[3]
Asian shares (Schroder ISF Asian Opportunities C)	LU0248183658	Light green	Yes[1]	No	Yes, 25%	Yes[3]
Alternative investments						
Gold (iShares Physical Gold ETC)	IE00B4ND3602	Raw materials	N/A	N/A	N/A	N/A

[1] More information about the environmental and social characteristics of the fund within the meaning of Article 8 of the SFDR can be found in the current fund prospectus in the pre-contractual information disclosure annex "Environmental and / or social characteristics" on the fund manager's website (see the table below).

[2] More information about the principal adverse impacts on sustainability factors (PAI statement) can be found in the current fund prospectus on the fund manager's website (see the table below).

[3] More information about the principal adverse impact on the fund's sustainability factors will be provided in the financial statements of the fund and published on the fund manager's website (see the table below).

Investment direction (fund name)	Current prospectus of the fund and sustainability-related information is available here:
Short-term investments (Evli Euro Liquidity B)	https://www.evli.com/en/products-and-services/funds/elik
Bonds (BGF Euro Bond I2)	https://www.blackrock.com/lu/intermediaries/products/228385/
World stock index (iShares Core MSCI World ETF)	https://www.blackrock.com/lu/intermediaries/products/251882/
U.S. stock index (iShares Core S&P 500 ETF)	https://www.blackrock.com/lu/intermediaries/products/253743/
European stock index (Xtrackers Stoxx Europe 600 ETF)	https://etf.dws.com/en-lu/LU0328475792-stoxx-europe-600-ucits-etf-1c/
Japan stock index (Amundi MSCI Japan ETF)	https://www.amundietf.lu/en/professional/products/equity/amundi-msci-japan-ucits-etf-acc/lu1781541252
World ESG stock index (BNPP MSCI World SRI PAB ETF)	https://www.bnpparibas-am.com/en-lu/professional-investor/fundsheet/equity/bnp-paribas-easy-msci-world-sri-s-series-pab-5-capped-track-classic-eur-c-lu1615092217
Global emerging markets shares (Nordea 1 – Emerging Sustainable Stars Equity BI)	https://www.nordea.lu/en/professional/funds/
European emerging markets shares (TRIGON – New Europe A)	https://trigoncapital.com/asset-management/trigon-new-europe-fund/
Global shares (Evli Global IB)	https://www.evli.com/en/products-and-services/funds/glob
European shares (Comgest Growth Europe Smaller Companies I)	https://www.comgest.com/en/lu/professional-investor/funds/comgest-growth-europe-smaller-companies-eur-i-acc
U.S. shares (T. Rowe Price US Smaller Companies Equity Q1)	https://www.troweprice.com/financial-intermediary/lu/en/funds/sicav/us-smaller-companies-equity-fund.html
Asian shares (Schroder ISF Asian Opportunities C)	https://www.schroders.com/en-lu/lu/professional/fund-centre/#/fund/SCHDR_F0GBR06O27/schroder-international-selection-fund-asian-opportunities-c-accumulation-eur/LU0248183658/profile
Gold (iShares Physical Gold ETC)	https://www.blackrock.com/lu/intermediaries/products/258441/

More detailed information on investment directions is available here:
https://www.ergo.lt/privatiems/gyvybes-draudimas-ir-taupymas/investiciniu-vienetu-kainos/

How is sustainability risk integrated into investment decision-making and how does sustainability risk affect the financial product return?

ERGO Life Insurance SE takes sustainability criteria into account when selecting funds. In addition to sustainability criteria, fund ratings, risk categories, past performance, and other qualitative and quantitative criteria are considered when selecting and monitoring investment life insurance product funds. The selection and verification of funds also take into account ESG (Environmental, Social, and Governance) ratings.

Investments meeting sustainability criteria may also be associated with opportunities and risks. These risks can have a negative impact on the development of investments. Below we provide more detailed information on this.

Sustainability risk refers to events or situations arising from environmental, social, or corporate governance areas, whose occurrence may have or potentially have a negative impact on the company's assets, financial and profit position, as well as its reputation, and thus the value of investments.

Since sustainability risk is intertwined with classical risk categories in various ways, we do not separate it into a distinct risk category.

In the decisions of ERGO Life Insurance SE related to investments, all associated risks, including sustainability risk, are considered when selecting funds. During this process, risks are mitigated by purposefully choosing investments and providing the client with matching and diversification opportunities.

Integration of sustainability risks into insurance advice provided

The sustainability risk is integrated into the insurance advisory processes by including questions in the customer needs assessment questionnaire that help determine his/her sustainability priorities, as stipulated by Commission Delegated Regulation (EU) 2017/2359 (as amended by Delegated Regulation (EU) 2021/1257), i.e., the customer can choose whether he/she wishes for one or more funds to be included in his/her investments where a certain minimum percentage of funds must be invested in environmentally sustainable investments within the meaning of Regulation (EU) 2020/852 of the European Parliament and Council, or investments as defined by Regulation (EU) 2019/2088 of the European Parliament and of the Council, or whether the customer wishes for one or more funds to be included in his/her investments that take into account the principal adverse impacts on sustainability factors. Firstly, the customer's general investment objectives and individual circumstances are assessed, then the customer is asked to specify possible sustainability priorities, and considering the customer's knowledge, experience and risk tolerance, as well as sustainability priorities, investment directions or programmes are recommended.

Amendment to the Insurance Contract

The Policyholder shall inform the Insurer of the requested amendments to the Insurance Contract in writing or in another manner agreed with the Insurer. The amendments to the Insurance Contract shall enter into force from the date specified on the amendment of the Insurance Contract issued by the Insurer.

By agreement of the parties to the insurance contract, the valid Insurance Contact may include the insurance covers or the insurance covers might be changed under the terms and conditions of the Insurance Rules.

More information is provided in Article 14 of the Insurance Rules.

Withdrawal from, and early termination of, the insurance contract

The Policyholder – a natural person – shall have the right to withdraw from the Insurance Contract within 30 days from the date when the Policyholder was informed of the Insurance Contract concluded. In that case, the Insurer shall reimburse the insurance premium paid during the Insurance Contract validity period recalculated according to the investment result (termination of the Insurance Contract on concessionary terms according to Article 124 of the Law on Insurance). In order to withdraw from the insurance contract, the policyholder must submit to the insurer a completed model form of withdrawal from the contract or a clear statement of the decision to withdraw from the insurance contract. The completed form of withdrawal from the contract or statement shall be submitted by email: info@ergo.lt or to the address Lvivo str. 37, Vilnius. The cancellation of the insurance contract shall be carried out in accordance with the applicable legal acts of the Republic of Lithuania.

Where the Insurance Contract is terminated on initiative of the Policyholder or due to the latter's breach of the terms and conditions of the Insurance Contract, surrender value shall be refunded to the Policyholder. Examples of surrender values shall be provided with the insurance offer. Insurance Contract termination fee is provided for in the price list.

The terms and conditions of the termination of the Insurance Contract termination are provided for in Article 15 of the Insurance Rules.

Resolution of Disputes

The insurance agreement is governed by the laws of the Republic of Lithuania.

According to laws of the Republic of Lithuania, any disputes arising out of the Insurance Contract shall either be settled before court or according to the out-of-court procedure prescribed by the Republic of Lithuania Law on the Bank of Lithuania. The out-of-court procedure for settlement of disputes between the insurer and the consumer is established by Resolution No 03-23 of the Bank of Lithuania of 26 January (as amended by Resolution No 03-11 of 28 January 2016) and posted on www.lb.lt/gincu_nagrinejimas.

ERGO Universal Life Insurance Rules No 027, investment direction descriptions, price lists and the report on solvency and financial performance of the Policyholder are available at www.ergo.lt.

Upon occurrence of an insured event, please contact ERGO insurance by phone 1887 or register the event in self-service at https://mano.ergo.lt/.

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Essential information for policyholders (residents) about taxation procedure applicable to life insurance contracts concluded on or after 1 January 2003

Prepared in accordance with the version and comments of the Republic of Lithuanian Law on Personal Income Tax (hereinafter – the LPIT), the Republic of Lithuanian Law on Accumulation of Occupational Pensions (hereinafter – the LAOP), the Republic of Lithuanian Law on State Social Insurance (hereinafter – the LSSI), and the Republic of Lithuanian Law on Health Insurance (hereinafter – the LHI) as of 1 January 2026, as well as the official explanations and letters from the State Tax Inspectorate.

I. Personal income tax relief for payers of life insurance contributions

A permanent resident of Lithuania may deduct from his/her income life insurance premiums paid:
- for his/her own benefit,
- for the benefit of the spouse,
- for the benefit of minor children (adoptive children, foster children, rated as requiring permanent nursing (care) in the family),
- for the benefit of disabled children under 18 years of age and older (adoptive children, foster children, rated as requiring permanent nursing (care) in the family), rated as requiring permanent nursing care in the family, adults rated as requiring permanent nursing (care) in the family before reaching the full age), for whom the need for compensation of first or second level individual assistance provision costs has been determined, as well as children under 18 years of age and older (adoptive children, foster children, rated as requiring permanent nursing (care) in the family), rated as requiring permanent nursing care in the family, adults rated as requiring permanent nursing (care) in the family before reaching the full age), who were rated as totally disabled before 30 June 2005),

before 31 December 2034, under a life insurance contract concluded before 31 December 2024 which provides that the insurance benefit shall be paid not only upon occurrence of an insured event but also upon expiry of the insurance contract validity period. The personal income tax relief shall not apply to premiums paid under a life insurance contract concluded after 1 January 2025 (Article 21(1)(1) of the LPIT).

The total amount of expenses deducted from the resident's income, specified in Article 21(1) of the LPIT may not 25% of the taxable income for the tax period, to which the 15%, 20%, 25%, and 32% income tax rates apply. Also, the total amount of deductible life insurance premiums under life insurance contracts concluded before 31 December 2024, and contributions to pension funds, associations of participants of occupational pension funds, and/or equivalent entities operating in the country of the European Economic Area to pension funds held under pension accumulation agreements concluded before 31 December 2024, as well as additional accumulated pension contributions paid according to the provisions of Article 8(3) of the Law on Pension Accumulation (exceeding 3% of the resident's income from which state social insurance contributions are calculated), may not exceed EUR 1 500 per tax period (Article 21(3) of the LPIT).

Expenses shall be deducted only from the income of a permanent resident of Lithuania for the purpose of calculating income tax for the tax period and filing an annual income tax return (Article 21(4) of the LPIT).

II. Insurance benefit due to an insured event (other than expiry of a life insurance contract validity period)

The insurance benefit payable in the case of the insured person's death, health injury, or illness, shall not be taxable. (Article 17(1)(13) of the LPIT).

III. Insurance benefit payable upon expiry of validity period of a life insurance contract or amount payable upon its full or partial termination

1. The total amount of the insurance benefit upon expiry of the insurance contract validity period or the amount payable upon full or partial termination of the insurance contract shall be non-taxable, if:

1.1. under a life insurance contract concluded for a term of not less than 10 years or terminated not earlier than 10 years after its conclusion, insurance premiums were paid only by residents and were not deducted from income in accordance with the procedure established by Article 21 of the LPIT (Article 17(1)(11) and (12) of the LPIT);

1.2. under a life insurance contract, premiums were paid by residents and were deducted from income according to the procedure established in Article 21 of the LPIT, or premiums were paid by legal entities, or by residents and legal entities, and the beneficiary specified in the insurance contract has not changed from the date of conclusion of the insurance contract, except in cases where the beneficiary has changed due to the death of the beneficiary or the end (beginning) of marriage, or if the beneficiary – own child (adoptive child, foster child) was replaced by another own child (adoptive child, foster child), also if the beneficiary had changed before 31 December 2016 (Article 17(6) of the LPIT), and at least one of the following conditions is met:
- the contract term is not less than 10 years or the contract is terminated no earlier than 10 years after its conclusion, and at the time of receiving the benefit, the beneficiary is younger than 26 years old (Article 17(1)(10) of the LPIT); or
- the contract term is not less than 5 years or the contract is terminated no earlier than 5 years after its conclusion, and at the time of receiving the benefit, the beneficiary has reached the age of 55 (for contracts concluded between 1 January 2003 and 31 December 2012) (Article 17(1)(9) of the LPIT); or
- the contract term is not less than 5 years or the contract is terminated no earlier than 5 years after its conclusion, and at the time of receiving the benefit not more than 5 years remain until the beneficiary reaches the retirement age specified in the Republic of Lithuania Law on Social Insurance Pensions, which was in effect at the time of the conclusion of the life insurance contract (for contracts concluded from 1 January 2013) (Article 17(1)(9^1) of the LPIT); or
- the contract term is not less than 5 years or the contract is terminated no earlier than 5 years after its conclusion, and at the time of receiving the benefit the beneficiary has an established participation level of 0–40% (until 31 December 2023, the working capacity level of 0–40% had been established), or the beneficiary is a disabled child with the established need for compensation for the costs of providing the first or second level individual assistance (a special need for permanent care has been established before 31 December 2023,) (Article 17(1)(9),(9^1) of the LPIT).

2. If the life insurance contract does not meet the conditions specified in paragraph 1, the life insurance benefit at the end of the insurance contract term or the amount payable upon termination or partial termination of the insurance contract shall be taxed in the following manner:

2.1. the portion equal to the life insurance premiums paid by residents and deducted from income according to the procedure established by the LPIT, shall be subject to a 15% personal income tax (Article 6(4) of the LPIT);

2.2. the portion equal to the life insurance premiums paid by residents and not deducted from income according to the procedure established by the LPIT shall be non-taxable (Article 17(1)(12) of the LPIT);

2.3. The portion equal to the life insurance contributions paid by legal entities shall be subject to progressive personal income tax rates (Article 6(1) and (2) of LPIT):
- the portion not exceeding 12 average national salaries (hereinafter – ANS) shall be taxed at a rate of 15%;
- the portion exceeding 12 ANS but not exceeding 36 ANS shall be taxed at a rate of 20%;
- the portion exceeding 36 ANS but not exceeding 60 ANS shall be taxed at a rate of 25%;
- the portion exceeding 60 ANS shall be taxed at a rate of 32%.

2.4. the portion exceeding the life insurance premiums paid shall be non-taxable if the term of the life insurance contract is not less than 10 years or the contract is terminated not earlier than 10 years after its conclusion (Article 17(1)(11) of the LPIT). If the term of the life insurance contract is less than 10 years or the contract is terminated earlier than 10 years after its conclusion, this portion of the personal income tax shall be taxed at progressive personal income tax rates (Article 6(1) and (2) of the LPIT):
- the portion not exceeding 12 ANS shall be taxed at a rate of 15%;
- the portion exceeding 12 ANS but not exceeding 36 ANS shall be taxed at a rate of 20%;
- the portion exceeding 36 ANS but not exceeding 60 ANS shall be taxed at a rate of 25%;
- the portion exceeding 60 ANS shall be taxed at a rate of 32%.

Contributions of the state social insurance and of the compulsory health insurance from benefits received by a resident paid upon expiry or termination of a life insurance contract shall not be payable (Article 10 of the LSSI and Article 17 LHI).

Notes

1. When paying an insurance benefit upon the expiry of a life insurance contract or upon the termination or partial termination thereof, the insurer shall apply the relevant personal income tax rate and withhold the tax taking into account the amount payable. Where the amount payable consists of a portion equal to the life insurance contributions paid by legal entities and a portion exceeding the total life insurance contributions paid, these portions shall be aggregated for the purpose of determining the applicable personal income tax rate (Article 23(7) of the LPIT).

2. The taxable portion of the insurance benefit paid upon the expiry, termination or partial termination of a life insurance contract, i.e. the portion equal to the contributions paid by legal entities and the portion exceeding the total life insurance contributions paid, shall be included in the taxpayer's total taxable annual income for the purpose of calculating the final personal income tax liability. Non-taxable amounts shall not be included in total income. Any additional personal income tax calculated upon annual declaration shall be payable by the individual (Article 27(1) and (5) of the LPIT).

3. Insurance benefits received by a non-permanent resident of Lithuania shall not be subject to income tax, therefore, they shall be neither declared nor taxed (Articles 4 and 5 of the LPIT).

4. Where, during the tax period, a non-taxable income amount (NPD) was applied to income derived from employment or relationships equivalent thereto, and the individual receives a benefit under an expired, terminated or partially terminated life insurance contract, the annual NPD shall be reduced by taking into account (by adding to annual income) the portion of the benefit exceeding the contributions paid under the contract, provided that such portion was subject to personal income tax (Article 20(7) of the LPIT).

5. A life insurance contract shall be partially terminated when fewer insurance premiums are returned than would be returned upon full termination of the contract, and the contract remains valid after the repayment of premiums (STI interpretation No KM0829, 22 11 2018).

6. The amount of the average national salary shall be determined annually in the Law approving the indicators of the State Social Insurance Funds' budgets for the respective year.

A more detailed interpretation of provisions of the LPIT regarding the taxation rules applicable to life insurance contracts can be found on the State Tax Inspectorate's website. www.vmi.lt.

IV. Regarding amendment to the terms and conditions of life insurance contracts and possibility of abuse

In cases where certain amendments are made to the terms and conditions of the insurance contract according to the provisions of legal acts regulating insurance activities, but the rights established in those legal acts are used to seek tax benefits (e.g., to receive a benefit not taxed with a personal income tax), the tax administrator shall have the competence to qualify such cases as abuse and, applying the principle of substance over form established by Articles 10 and 69 of the Republic of Lithuania Law on Tax Administration, the benefit received by a resident shall be taxed at the personal income tax rate established by the PITL.

ERGO Universal Life Insurance Rules No 027

1. Structure of the Insurance Rules

ERGO universal life insurance is life insurance linked to investment funds. The ERGO Universal Life Insurance Rules consist of the general part and special conditions of insurance. The special conditions of insurance 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 not provided for in the special conditions. The insurance contract shall be subject to the conditions of the general part of the Insurance Rules and special conditions of insurance included in the insurance contract as well as amendments and supplements to the terms and conditions of the insurance contract made according to the procedure established by the Insurer.

2. Main terms used in the Insurance Rules

2.1. **Insurer** – ERGO Life Insurance SE.

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

2.3. **Parties to the insurance contract** – the Insurer and the Policyholder.

2.4. **Insured person** – a person indicated by the Policyholder and named in the insurance contract under which, should an insured event occur in the life of this person, the Insurer must pay an insurance benefit. There may be several persons insured under one insurance contract. The term "insured person" used in the Insurance Rules shall apply to any person covered under the insurance contract.

2.5. **Principal insured person** – a person whose life is always insured, and the accumulated capital is linked to the sum insured of his/her life insurance. The term "principal insured person" used in Insurance Rules shall apply to the sole person insured under the insurance contract.

2.6. **Additional insured person** – a person covered by any additional insurance according to the special conditions of insurance conditions of these Insurance Rules and named in the insurance contract.

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

2.8. **Insurance cover** – the Insurer's commitment to pay an insurance benefit in case of an insured event.

2.9. **Indexation** – the recalculation (increase) of periodic insurance premiums from the beginning of each insurance year. The indexation amount shall not be linked to the country's inflation, consumer price index, or other official economic indicators of the country, and it is the amount agreed upon by the parties to the insurance contract, which is specified in the insurance contract.

2.10. **Investment direction** – one of directions of investment of the Policyholder's funds offered by the Insurer.

2.11. **Investment object** – investment funds managed by management companies or other investment vehicles to which funds of the investment direction are allocated.

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

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

2.14. **Accumulated capital structure** – distribution of the accumulated capital (expressed in investment units) in investment directions.

2.15. **Accumulated capital value** – the sum of values of investment units under the insurance contract calculated as the product of the number of investment units and the price of investment units.

2.16. **Surrender value** – the sum paid in case of the termination of the insurance contract. The surrender value shall be calculated deducting the insurance contract termination fee specified in the pricelist certificate from the accumulated capital value.

2.17. **Price of the calculation day** – the price of investment units used for the performance of the operation according to the procedure for the administration of investment insurance contracts established by the Insurer (published on the Insurer's website www.ergo.lt). If the price of the day required for calculation is not determined, the last known price of the investment unit shall be applied.

2.18. **Pricelist** – deductions and their terms and conditions set by the Insurer according to these Insurance Rules.

2.19. **Pricelist for additional insurance contract administration services** – fees for contract administration services set by the Insurer according to these Insurance Rules. The valid pricelist shall be posted on the Insurer's website www.ergo.lt and is an integral part of the insurance contract.

2.20. **One year of insurance** – begins on the start date of the insurance each year and lasts for 12 months, but not longer than the end date specified in the insurance policy.

2.21. **Self-service** – the Insurer's electronic system is intended for communication between the parties to an insurance contract, exchange of documents, information and messages, and provision and storage of data related to insurance contracts. This system is considered an official means of communication through which the Policyholder and the Insurer can provide, receive and store information related to the insurance contract.

2.22. **Sports activities** – individual exercise of the Insured in sports clubs, regular amateur practicing of any type of individual or team sports, including participation in training and competitions between amateur teams.

2.23. **Professional sports** – the Insured person's training and participation in national or international competitions held by the federation or union of the respective sport, also individual or team sports, where athletes receive any remuneration (under an employment or civil law contract), sponsorship or scholarship for participation.

2.24. **Extreme sports / leisure** – activities associated with a risk higher than in other sports, which require special physical and mental abilities, special equipment and clothing. Extreme sports shall be activities listed below or those similar to them by nature and equipment used:

2.24.1. car, motorcycle and motor vehicle sports, BMX, HD, FR and specialized mountain biking, skateboarding and skateboarding on ramps, paragliding, skydiving (including BASE jumping), bungee jumping, gliding and flying a non-motorized aircraft, light and ultralight aircraft, horseback riding, equestrian sports, and shooting.
Exception – parachuting in a dome-shaped and rectangular parachute jumping, tandem parachute jumps with instructor; licensed hunting, shooting and/or horse riding under the supervision of an instructor; road, cross-country, track cycling; charter recreational aircraft flights, if these activities are carried out under the supervision of companies who hold a respective license and are a way of spending free time of the Insured, without engaging in these activities periodically in pursuit of sports results or qualification for standards.

2.24.2. kayaking and canoeing, surfing in sparkling waters, long-distance swimming in ice water, mountain river swimming, swimming in rapids and waves, sailing at sea, diving > 40 meters deep, diving at great depths without any diving equipment, rock jumping into the water, water-boarding, windsurfing and surfing, jet skiing, power kiting;
Exception – leisure diving (up to 40 meters deep), sailing and motorless rowing/swimming in stagnant water and plain rivers, where these activities are a way of spending free time of the Insured without pursuing sports results or qualification for standards.

2.24.3. snow kite skiing, ski jumping or snowboard jumping, off-piste skiing, helicopter or paragliding skiing.
Exception – leisure cross-country skiing, in specially adapted downhill and other designated trails.

2.24.4. mountaineering, rock climbing, caving and canyoning, climbing frozen waterfalls, rocks, boulders, mountain ultramarathons, parkouring, expeditions and hiking in extreme climatic conditions, such as the polar zone, jungle, desert, open sea, etc.
Exception – leisure jogging, except for trainings held in extreme conditions and areas.

2.24.5. martial arts and contact sports such as boxing, wrestling, karate, judo, fencing, etc.
Exception – children under the age of 14, who practice these sports activities

3. Insurance contract conclusion

3.1. The insurance contract may be concluded in person or by means of remote communication.

3.2. In order to conclude an insurance contract, a person shall submit to the Insurer an application of the set form, indicate the desired insurance risks under special insurance conditions, and sums insured for each insured person. The Policyholder and the Insured persons shall complete questionnaires in the form set by the Insurer, if requested by the Insurer.

3.3. The submission of the application and the payment of a premium shall not obligate the Insurer to conclude an insurance contract. If the insurance premium on the basis of the submitted application was paid before the insurance risk assessment and the Insurer's refusal to conclude the insurance contract, such premium shall be refunded to the person who has paid. If the insured event provided for in these Insurance Rules occurs during this period, the Insurer shall not be required to pay the insurance benefit.

3.4. An application for concluding an insurance contract shall expire, if the Policyholder is not issued an insurance policy within 3 months from the day of signing of this application.

3.5. If the Insurer agrees to enter into an insurance contract, the Policyholder shall be issued an insurance policy, which confirms the conclusion of the insurance contract. The date of conclusion of the insurance contract shall be the day of issuing an insurance policy.

3.6. The insurance contract shall enter into force on the first day of the insurance period, which is specified in the insurance policy, but not earlier than the day after the first insurance premium is received to the Insurer's account.

3.7. The insurance contract shall comprise the following documents:

3.7.1. an application for concluding ERGO universal life insurance contract and the agreement to conclude it;

3.7.2. questionnaires of the Policyholder and insured persons;

3.7.3. insurance policy and annexes thereto;

3.7.4. ERGO Universal Life Insurance Rules;

3.7.5. Procedure for the administration of investment insurance contracts;

3.7.6. pricelist and other documents issued by the Insurer;

3.7.7. other documents and applications submitted by the Policyholder affecting the conclusion, amendment and performance of the insurance contract.

4. Insurance object and sums insured

4.1. The insurance object shall be the property interest related to the insured person's life expectancy and the accumulation of capital.

4.2. Depending on the special conditions of insurance applicable to a particular contract, the insurance object may also be a property interest related to accidents and / or the health of the insured person.

4.3. Sums insured for each insurance cover and for each insured person under special conditions of insurance shall be determined by agreement between the parties to the insurance contract and indicated in the insurance policy.

5. Insured event

5.1. Expiry of the insurance contract if the principal insured person lives until its expiry.

6. Time limits of payment of the insurance benefit and part of the capital

6.1. The application submitted by the Policyholder, the beneficiary for payment of the benefit shall be considered to be received when all the information requested by the Insurer is submitted in the form established by the Insurer.

6.2. The procedure for determining the insurance benefits is provided for in the special conditions of insurance.

6.3. The Insurer shall convert the investment value into money not later than within 5 working days from the date of receipt of the application. If it is impossible to calculate the investment unit price of any investment direction for reasons that do not depend on the Insurer or the accumulated capital part cannot converted into monetary funds, the conversion of such part shall be carried out when it becomes possible. At that time, the already converted part of the capital to be refunded may be retained in the accumulated capital as monetary funds.

6.4. After recognizing the event to be an insured event under the special conditions of insurance, insurance benefits shall be paid within 30 days from the date on which all information relevant to the fact of the insured event,

circumstances, consequences and the amount of benefit (including additional information from law enforcement bodies, health care institutions, etc.). If the insurance benefit has not been paid within 30 days of reporting the insured event, the Insurer must inform the Policyholder (insured person, beneficiary) in writing in detail about the progress of investigation of the insured event.

6.5. If a criminal or administrative case has been opened for an insured event or a legal dispute is under way according to civil procedure in respect of the insurance contract, the Insurer shall have the right to defer the payment insurance benefit until the completion of the case.

6.6. When collecting information relevant to the determination of the fact, circumstances, consequences of the insured event and the amount of the benefit, the Insurer shall have the right to request from applicants for benefits, the documents issued by doctors, hospitals and other treatment, health care and nursing institutions, law enforcement agencies, other natural and legal persons in the territory of the Republic of Lithuania and other states, the inheritance documents, the personal identification documents, the documents demonstrating kinship, medical reports, diagnoses, other medical documents, documentary evidence of the insured person's death issued in accordance with the procedure prescribed by laws of the Republic of Lithuania, explanations, conclusions, and all other verbal and written information, which, in the opinion of the Insurer, is necessary for the investigation of the event and the determination of the benefit.

6.7. **Insurance benefit payable upon expiry of the insurance period**

6.7.1. Where the principal insured person has survived until expiry of the insurance period – the value of the capital accumulated on the last day of the period shall be paid to the beneficiary, in his/her name, within 7 working days after submission by the beneficiary of a written application for payment of the insurance benefit (depending on which date is later).

6.7.2. Insurance benefits shall be subject to taxation in accordance with the procedure established by laws.

6.8. **Payment of part of the accumulated capital without terminating the insurance contract**

6.8.1. The Policyholder may withdraw part of the accumulated capital by submitting a request in the form established by the Insurer.

6.8.2. The accumulated capital remaining after payment of the part of the accumulated capital must be not smaller than the minimum amount set by the Insurer indicated in the pricelist of additional insurance contract administration services.

6.8.3. The paid part of the accumulated capital shall be reduced by the capital withdrawal fee indicated in the pricelist of additional insurance contract administration services.

6.8.4. The amount paid shall be subject to taxation if the procedure prescribed by laws so provide.

6.8.5. The share of the accumulated capital shall be paid not later than within 8 working days according to the time limits provided for in paragraph 6.3.

6.9. Insurance benefits shall be transferred to the beneficiary's account. If benefits are paid to the account held outside the EU, the related risks and the premium crediting or conversion fees shall be borne by the beneficiary at the rates charged by the customer's bank.

7. Insurance premiums

7.1. Insurance premium amounts shall be indicated in the insurance policy and the responsibility for their payment shall rest upon the Policyholder. Insurance premiums shall be paid within the time limits specified in the insurance policy.

7.2. The insurance premium may be paid as:

7.2.1. a lump sum;

7.2.2. a periodic premium;
7.2.3. a periodic premium with annual indexation;
7.2.4. an additional premium.

7.3. The Policyholder shall have the right to pay additional insurance premiums not specified in the insurance policy by informing in writing the Insurer or indicating in the purpose of the payment order: the additional premium and the insurance contract number. If there is no reference to the payment of an additional premium, the amount received shall be credited to periodic premiums. Payment of an additional insurance premium shall not relieve the Policyholder of the obligation to pay periodic insurance premiums provided for in the insurance contract.

7.4. Separate payments of premiums may not be smaller than the minimum insurance premium amounts. The minimum amount of the insurance premium shall be set by the Insurer.

7.5. The share of insurance premiums paid by the Policyholder, which remains after deductions established by the Insurer and applicable to insurance premiums, shall be used proportionately to acquire investment units in investment directions chosen by the Policyholder.

7.6. 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 contract, 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 policy indicates otherwise. Insurance premiums paid till the day of issuance of the insurance policy shall be converted to investment units immediately, but not later than within 5 working days from the day of issuance of the insurance policy. If it is not possible to observe these time limits for reasons beyond the Insurer's control, the share of the insurance premiums paid shall be recalculated into investment units later, but as soon as possible.

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

8. Insurance deductions

8.1. A premium deduction shall apply to the insurance premiums paid in a lump sum and additional insurance premiums.

8.2. On the last day of each month, the accumulated capital value may be reduced by following insurance contract deductions in the amount established by the Insurer:

a) **deduction for contract conclusion** to cover the costs of conclusion of the insurance contract. This deduction shall not apply if the insurance contract was concluded with a lump sum insurance premium only;
b) **deduction for contract administration** to cover the administration costs of the insurance contract. This deduction may consist of a variable and a fixed component;
c) **deductions for insurance risks** to cover the costs of the selected insurance cover.

8.3. The rates of deductions applicable to the insurance contract and their application procedure shall be indicated in the insurance policy and the pricelist. The Insurer shall have the right to change the rates of deductions applicable to the insurance contract by changing the pricelist according to the procedure laid down in subparagraph 12.2.5.

8.4. The insurance risk deduction tariffs shall be approved by the Insurer. The rates of these deductions shall be calculated according to the applicable Insurer's tariffs and individual data of the Insured persons. Insurance risk deductions may be increased in light of the degree of the insurance risk of the Insured person.

8.5. In case of the change of statistical data on insured events and insurance benefits, the Insurer may unilaterally change the insurance risk deduction 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 contract conditions that affect the rates of these deductions free of charge before the enforcement of the new tariffs, or terminate the insurance contract according to paragraph 15.5.

8.6. If the insurance option A was chosen in the insurance contract, the deduction for life insurance risk of the principal insured person:

8.6.1. shall be calculated according to the tariff for life insurance risk specified in the insurance policy from the difference between the accumulated capital value and the sum insured chosen by the customer.

8.6.2. subparagraph 8.6.1 shall not apply when:
- the value of the accumulated capital is equal to or larger than the sum insured of life insurance of the principal insured person;
- the sum insured of life insurance of the principal insured person is EUR 1.00.

8.7. The deduction for the insurance risk of the life insurance and supplementary insurances shall not apply to the insured person from the date on which the Insurer receives a notification of the insured person's death and for insurance covers under special conditions of insurance – from the day on which an event is declared to be the insured event in the cases where, after payment of the benefit, the insurance cover for the insured person is terminated.

9. Non-payment of, and exemption from, payment insurance premium, insurance cover suspension and renewal

9.1. In the case of the failure to pay in full the first premium (and the first additional premium, if applicable) within 3 months of the contract issue the date the contract shall be considered not enforced and shall be terminated by the Insurer. The Insurer shall notify the Policyholder in writing of the termination. The contract may be renewed only with the consent of the Insurer and under the agreed terms and conditions.

9.2. If the Policyholder delays payment of a periodic insurance premium or a part thereof for more than 30 days after the time agreed in the insurance contract, the Insurer shall inform the Policyholder thereof in writing. The insurance cover shall be valid until the value of the accumulated capital is sufficient for applicable deductions for risks, contract conclusion and administration.

9.3. If the value of capital accumulated during validity of the insurance contract becomes lower than the amount of applicable of deductions of the insurance contract, the insurance cover shall be suspended. In that case:

9.3.1. the Insurer shall notify the Policyholder in writing about the suspension of insurance cover, indicating in the notice the amount of the minimum insurance premium necessary to restore the validity of the insurance cover and the time limit of up to 30 days for payment of the premium. The amount due shall comprise:
- the amount of an additional premium so that the value of the contract is sufficient for deductions before the insurance cover suspension month;
- the deduction for the contract due for 3 months.

9.3.2. If within 30 days of the day of sending the notice to the Policyholder the insurance premium is not paid or a smaller insurance premium is paid which is insufficient for the restoration of the insurance cover, the insurance cover shall remain suspended and an additional notice to the Policyholder shall not be sent;

9.3.3. If the suspension of the insurance cover lasts for more than 6 months, the Insurer shall have the right to unilaterally terminate the insurance contract and it shall be considered that the Policyholder has breached the terms and conditions of the insurance contract;

9.3.4. During suspension of the insurance cover, the insurance risk deductions shall not apply, while insurance contract conclusion and administration deductions shall be calculated and the amount of accumulated capital shall be reduced by their amount;

9.3.5. The insurance cover shall be renewed on the next day after the date of payment of the amount specified in the notice of its suspension, provided that the Policyholder pays the insurance premium according to the terms and conditions of subparagraph 9.3.1 not later than within 6 months from the date of suspension of the insurance cover;

9.3.6. If the Policyholder pays the premium later than within 6 months of the date of suspension of the insurance cover and (or) after the termination of the insurance contract, the contributions shall be returned to the payer's account.

9.4. On agreement of the parties, the Policyholder may be relieved of the obligation to pay insurance premiums by submitting to the Insurer an application of the established form and maintaining the insurance cover agreed under the insurance contract; however, during this period, the value of the capital accumulated must be sufficient to cover the risk and administration deductions. If the value of the accumulated capital becomes less than the amount of the applicable deductions under the insurance contract, paragraph 9.3 shall apply.

10. Investment directions and programmes

10.1. The investment programme shall be chosen by the Policyholder by specifying the investment directions from the proposed list and the proportions for the distribution and investment of the insurance premiums. The Insurer may determine the permitted number of investment directions and the proportions.

10.2. The Insurer shall have the right to change the list of the proposed investment directions by adding or removing investment directions.

10.3. If the investment direction selected under the investment programme is eliminated or its investment strategy is changed, the Insurer shall notify the Policyholder thereof at least 30 days in advance. The Policyholder shall provide his decision in writing before the day of the respective change and if the Policyholder fails to provide his decision the Insurer shall change the investment programme and/or distribute the capital among other investment directions at its own discretion. The Insurer shall have the right to unilaterally change those investment objects of the investment direction that match the investment direction strategy.

10.4. The Policyholder may not bring claims regarding 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 has failed to provide the Insurer with such information within the set deadlines and in the specified ways.

10.5. Descriptions of investment directions, investment strategy and investment unit prices shall be posted on the Insurer's website at www.ergo.lt. At the request of the Policyholder, the Insurer shall provide the Policyholder with the descriptions of investment directions chosen by the Policyholder.

11. Insurance contract validity terms

11.1. The start of insurance indicated in the Policyholder's application for concluding an insurance contract 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 contract shall be specified in the insurance policy. The insurance contract 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 contract effective in the absence of all the listed conditions.

11.2. By paying the first periodic insurance premium or paying it in a lump sum, the Policyholder confirms the acceptance of the terms and conditions of the insurance contract and concludes the insurance contract. The insurance contract shall also be valid without the signature of the Policyholder in the insurance policy.

11.3. The insurance cover shall take effect on the following day after the day of payment of first periodic insurance premium or of a lump sum, but not earlier than the conclusion of the insurance contract and the start of insurance indicated in the insurance policy.

11.4. The insurance contract shall expire when:

11.4.1. the principal insured person dies and/or the accumulated capital is paid out. If the principal insured person's death is not an insured event according to provisions of these Insurance Rules, the insurance contract may be extended upon the Insurer's consent having received the Policyholder's request for the change of the principal insured person;

11.4.2. the Policyholder – a natural person – dies or is declared missing by a court and there is no successor of his rights and obligations. In such a case, the Insurer shall pay the surrender value to the heirs of the deceased Policyholder;

11.4.3. the Policyholder – a legal person – is being liquidated and there are no successors of its rights and obligations. In that case, the Insurer shall pay the surrender value to the legal person being liquidated;

11.4.4. all insurance benefits have been paid;

11.4.5. the insurance contract is terminated;

11.4.6. the insurance contract validity period has expired.

11.5. If the insured person dies, the full insurance cover applicable to that person under the insurance contract shall expire.

11.6. After the death of the principal insured person, the insurance cover of the additional insured person may be continued by concluding a new contract under the terms and conditions agreed by the parties (unless it is agreed to continue the insurance cover in the case described in subparagraph 11.4.1). The consent to extend the contract should be submitted by the insured person or the representative of the minor insured person within 2 months of the death of the Policyholder or after learning about the contract expiry due to the Policyholder's death and the interruption of the insurance cover of the insured person.

11.7. Notwithstanding other provisions of the insurance contract, the insurance cover shall only be valid until it is not in conflict with any trade and economic sanctions, prohibitions or restrictions under United Nations resolutions, and any laws or regulations of the European Union, United Kingdom or United States. If the sanctions, prohibitions or restrictions mentioned directly or indirectly prevent us from providing services under this contract, we shall have the right to terminate this insurance contract (or insurance cover in respect of sanctioned insured persons) unilaterally, notifying the Policyholder about this in writing.

12. Rights and duties of the parties to the insurance contract and liability for the non-fulfilment of its terms and conditions

12.1. The Insurer undertakes:

12.1.1. to familiarize the Policyholder with these Insurance Rules, special conditions of insurance, descriptions of investment directions proposed by the Insurer, insurance premium amounts, and provide other insurance contract-related information, which the Insurer is obligated to provide according to laws of the Republic of Lithuania.

12.1.2. upon conclusion of the insurance contract – to issue an insurance policy, Insurance Rules, special conditions of insurance;

12.1.3. to pay all the insurance benefits due provided for in the insurance contract if there is a basis for payment of the insurance benefit;

12.1.4. to inform the Policyholder each year of the value of his accumulated capital, the amount of the surrender value and provide the Policyholder with other information provided for by legal acts in the manner agreed between the parties and / or the Insurer's self -service;

12.1.5. to introduce amendments to the Insurance Rules and pricelist in accordance with subparagraphs 12.2.5 and 12.2.6 not later than 30 days before the date of the expected changes using the communication method agreed by the parties;

12.1.6. as soon as possible, but not later than within 30 days of the day of receiving the application for termination of the insurance contract, to pay the surrender value to the Policyholder. If the fulfilment of the obligation is subject to restrictions established by legal acts, the Insurer shall inform the beneficiary of the reasons for non-payment.

12.1.7. to properly fulfil other duties established in the insurance contract and legal acts.

12.2. The Insurer shall have the right to:

12.2.1. terminate the insurance contract or reduce the insurance benefit or refuse to pay if after conclusion of the insurance the Insurer has established that the Policyholder or the insured person when concluding the insurance contract or during its validity did not fulfil the duty to disclose information and deliberately or because of negligence provided the Insurer with incomplete, not compliant with reality information about the Policyholder, the insured person or the circumstances that may have an essential influence on the assessment of the insurance risk, the probability of the insured event, the determination of the rates of deductions of the insurance contract or of other circumstances relevant for the insurance contract, excluding the cases when the circumstances concealed by the Policyholder and/or the insured person had ceased before the insured event or had no impact thereon;

12.2.2. propose to change the insurance contract according to the risks of the insured person and to determine insurance deductions corresponding to the risks for supplementary insurances if, after the conclusion of the insurance contract, it is found that the Policyholder or the insured person has not sufficiently identified the circumstances of leisure and sports or the circumstances have changed during the contract and the Insurer's investigation of insured events revealed that the activity of the insured person should be attributed to professional or extreme sports / leisure. If the parties to the insurance contract fail to reach agreement regarding the amendment, it shall be considered that the insurance contract does not provide cover for continuing to engage in professional and/or extreme sports / leisure.

12.2.3. avoid concluding and/or terminate the insurance contract in accordance with paragraph 15.5 if the insurance contract participant objects to his personal data processing.

12.2.4. assess the insurance risk of the Policyholder or insured person and for that purpose:

12.2.4.1. require that the insured person, before concluding an insurance contract, undergoes a medical check-up. The medical check-up costs shall be covered by the Insurer, unless agreed otherwise;

12.2.4.2. in view of the information provided in the health questionnaire of the insured person, ask the insured person additional questions about his state of health and/or circumstances related to insurance risk assessment;

12.2.4.3. propose to enter into an insurance contract under the terms and conditions other than those specified in the application for concluding an insurance contract, if the conditions specified in the application cannot be met due to the risk of the insured person, but the proposed contract must be concluded in the best interests of the Policyholder / insured person and in order to meet the customer's true interests and expectations;

12.2.4.4. refuse to conclude an insurance contract without stating the reason;

12.2.4.5. determine the minimum and maximum sum insured, the minimum or maximum age of the insured person, the shortest or longest duration of the insurance contract.

12.2.5. change the pricelist of the Insurer and the pricelist of additional insurance contract administration services posted on the website at www.ergo.lt informing about the changes in accordance with the procedure established by laws.

12.2.6. unilaterally supplement and/or amend certain paragraphs of the Insurance Rules and conditions on the basis of which insurance contracts are concluded in the following cases: upon change of the rules of law or in the event of new legal provisions according to which the Insurance Rules have been drawn up or

adjust the rates respectively where due to changes regulated by the government the criteria for determining the insured risks under special conditions of insurance are expanded resulting in the change of insurance risk for the Insurer or in the event of an objective necessity due to economic or market situation (such as hyperinflation) and also at the request of the authority supervising the Insurer's activities. The Insurer may unilaterally change the insurance conditions if such changes do not violate the rights or interests of the Policyholder and/or of the insured persons or for the extension of the rules with new risks or special conditions and notifying the Policyholder in writing not later than 30 calendar days in advance of the envisaged date of changes. The Insurer shall have the right to unilaterally amend the investment insurance contracts' administration procedure necessary for administration of the insurance contract in accordance with requirements of laws and ensuring the legitimate interests of the parties to the contract.

12.2.7. refuse the payment of insurance or other benefits if the payment of such benefit results in the violation by the Insurer of the requirements for the compliance with international sanctions in the Republic of Lithuania and their implementation.

12.2.8. implement other rights provided for in the legal acts of the Republic of Lithuania.

12.3. The Policyholder undertakes to:

12.3.1. inform the insured person and/or beneficiary about the concluded insurance contract and its amendments, familiarize them with their rights and obligations laid down in the insurance contract.

12.3.2. pay insurance premiums in due time. Insurance premiums for the Policyholder may be paid by other persons and/or the insured person, without any rights to the insurance contract;

12.3.3. notify about changes in contact details of the Policyholder / insured persons, the Policyholder's name, forename and surname, changes in the list of insured persons not later than within 30 days from the change (unless otherwise agreed in the contract).

12.4. The Policyholder shall have the right to:

12.4.1. receive the insurance policy, Insurance Rules and special conditions of insurance;

12.4.2. be provided with additional insurance contract administration services upon payment of the fee established by the Insurer according to the pricelist of additional insurance contract administration services;

12.4.3. obtain all information related to the insurance contract during the validity of the contract;

12.4.4. apply to the Insurer for change of the terms and conditions of the insurance contract by filling in the application of the form established by the Insurer and the survey questionnaires necessary for the assessment of the insurance risk and the information requested by the Insurer required for the change. When changing the terms and conditions of the insurance contract that affect risk deductions the tariffs valid at the time of the change shall be applied;

12.4.5. upon receipt of information on changes of the pricelist which provides for larger deductions, except for mandatory deductions prescribed by laws, the Policyholder shall have the right to terminate the insurance contract in accordance with the procedure laid down in paragraph 15.5 of these Insurance Rules. Upon receipt of the Policyholder's request to terminate the insurance contract, the Insurer must, within 30 days from the date of receipt of the request, pay to the Policyholder the surrender value;

12.4.6. upon receipt of information on changes in the Rules in accordance with subparagraph 12.2.6, the Policyholder shall have the right to terminate the insurance contract before enforcement of such changes in accordance with the procedure established in paragraph 15.5 of these Insurance Rules. Upon receipt of the Policyholder's request to terminate the insurance contract, the Insurer must, within 30 days from the date of receipt of the request, pay to the Policyholder the surrender value. If the Policyholder does not apply to the Insurer in writing for the termination of the insurance contract before the date of enforcement of the changes, the Policyholder shall be deemed to have accepted the above referred changes.

12.5. The Policyholder and/or the Insured person undertakes to:

12.5.1. when concluding, amending the insurance contract, provide the Insurer with detailed and correct information about the Policyholder and insured person by filling in the form established by the Insurer and survey questionnaires required for the assessment of the insurance risk;

12.5.2. immediately notify about changes in the data specified in the application for conclusion of an insurance contract and the survey questionnaires occurring between the date of completion of the application and the conclusion of the insurance contract;

12.5.3. report an increase in the insurance risk (this provision shall not apply to a person whose sum insured of the life insurance is EUR 1 and this is the only insurance cover chosen), when:

12.5.3.1. the occupation / type of work or field of activity of the Policyholder or insured person changes;
12.5.3.2. the insured person begins to engage / changes the type of extreme and/or professional sports when this cover is provided under the terms and conditions of the concluded insurance contract, and due to the change in the risk it is necessary to change the insurance contract.

12.5.4. report the changes in contact details, forename and surname of the Policyholder and the insured person not later than within 30 calendar days of the change;

12.5.5. properly fulfil other duties established in the insurance contract and legal acts.

12.6. The Policyholder and/or the Insured person shall have the right to:

12.6.1. before occurrence of the insured event, the Policyholder shall have the right to change the beneficiary by informing the Insurer in writing. The Policyholder and the Insurer may additionally determine the cases in the insurance contract when the beneficiary also can be changed by the insured person by submitting a request of the form established by the Insurer and in accordance with Article 119 of the Law on Insurance;

12.6.2. request an amendment to the terms and conditions of the insurance contract upon reduction of the insurance risk if, during the period of validity of the contract, the circumstances specified in the insurance contract essentially change and due to that the insurance risk reduces or can reduce.

12.7. The beneficiary, insured person and Policyholder undertake to:

12.7.1. report the insured event to the Insurer by filling in the notice of the form established by the Insurer, within 30 days from the event and immediately, as soon as it becomes aware of it;

12.7.2. provide the Insurer with detailed and correct information about the event and cooperate in receiving information from third parties necessary for the investigation of the insured event.

12.8. The beneficiary shall have the right to:

12.8.1. receive information about the progress of investigation of the insured event;

12.8.2. request payment of the insurance benefit according to the procedure prescribed by the insurance contract.

12.9. The Policyholder, beneficiary and insured person shall also have other rights and obligations established by legal acts.

12.10. The parties must comply with the terms and conditions of the concluded insurance contract. The parties shall be liable for the failure to comply with the terms and conditions of the insurance contract according to the procedure prescribed by this insurance contract and the legal acts of the Republic of Lithuania.

13. Provision of notices, applications and information

13.1. The Policyholder shall send all notices, statements, claims and/or requests related to the Insurance contract and obligations arising from them to the Insurer's address or by electronic means using the Insurer's Customer self-service portal accessible on the Insurer's website www.ergo.lt, or by e-mail indicated by the Insurer.

13.2. An application for the conclusion of the contract, its amendment or payment of the benefit filed by the Policyholder, insured person or beneficiary shall be deemed to have been received when it is submitted in the form prescribed by the Insurer and all the information requested is completed in detail. Otherwise, the date of submission of the application shall be the day when the applicant provides the information requested by the Insurer in the right form. If the application is filed on a non-working day, the day of its receipt shall be considered to be the first working day following the submission of the application.

13.3. The Policyholder or the insured person shall submit to the Insurer all notices, applications, claims and requests relating to the insurance contract and obligations arising from it in the form and manner that allows the Insurer to clearly identify that the person submitting the document is the Policyholder or the insured person.

13.4. The Insurer may send notices, information and notifications of claims to the email address of the Policyholder and/or the insured person specified in the insurance contract. The Insurer shall have the right to send the required information to the Policyholder and/or to the insured person to the specified e-mail address if the Policyholder and/or the insured person have agreed to receive the insurance contract related information to that e-mail address.

13.5. The Insurer may inform the Policyholder of changes in the Insurer's contact details, Insurance Rules and requirements applicable to the insurance contract through the Insurer's website www.ergo.lt and/or by sending the information on the above referred changes to the last available Policyholder's address or by e-mail or by notifying through the Insurer's self-service.

13.6. Where according to laws of the Republic of Lithuania and/or the Insurance Rules the written information should be provided, this requirement shall be deemed to have been fulfilled, if by agreement of the parties to the insurance contract, the information to the Policyholder (insured person) is provided by post, e-mail or other telecommunications terminal equipment with a possibility to demonstrate the fact of the submission of the information.

14. Amendment to the insurance contract

14.1. The Policyholder shall notify the Insurer in writing of the requested amendments to the insurance contract, and the Insurer, not later than within 30 calendar days (except for changes in the accumulated capital structure or investment programme described in paragraph 14.3.) of the Policyholder's request and the date of receipt of the documents provided for in subparagraph 12.4.4, if such documents are required, shall examine the Policyholder's request to amend the insurance contract and shall notify the Policyholder of the decision. The Insurer, having assessed the insurance risk and other circumstances relevant to the Insurer may refuse to amend the terms and conditions of the contract. The amendment to the insurance contract shall enter into force after the Insurer has submitted an insurance policy or confirmation of the amendment. The process of amendments shall be regulated by the procedure for the administration of investment insurance contracts (posted on the Insurer's website at www.ergo.lt).

14.2. During the validity of the insurance contract, the Policyholder, having notified the Insurer in writing or in other manner agreed with the Insurer (e.g., via self-service) and, with the consent of the Insurer, shall have the right to change the structure of already accumulated capital without prejudice to the investment direction restrictions established by the Insurer. When changing the structure of accumulated capital, the available investment units shall be converted into investment units of newly selected investment directions at the price of the calculation day. Upon approval of the Insurer, the conversion shall be performed without undue delay, however, not later than within 5 business days. If there is no possibility to comply with these time limits for reasons that do not depend on the Insurer, the accumulated capital structure shall be changed later, but as soon as becomes possible.

14.3. The Policyholder shall have the right to change the investment programme, having informed the Insurer in writing or in other manner agreed with the Insurer (e.g., via self-service) and upon consent of the Insurer. The changed

investment programme shall only apply to insurance premiums paid from the date of change of the investment programme. The Insurer may impose restrictions on changes of investing programmes and apply the fees set out in the pricelist of the insurance contract administration services.

14.4. The Policyholder may change the beneficiary at any time before the insured event, except for the cases provided for by laws. If the beneficiary has been named with the consent of the insured person, the beneficiary may only be replaced with the consent of the insured person.

14.5. The Policyholder and the Insurer may agree in writing on amendment to the terms and conditions of the insurance contract.

14.6. For amendments to the terms and conditions of the insurance contract, the Insurer may charge fees specified in the Pricelist and in the Additional insurance contract administration services pricelist.

15. Early termination of the insurance contract

15.1. The Policyholder shall have the right to terminate the insurance contract by filing an application in the form established by the Insurer, and the Insurer, having received the application, shall terminate it without undue delay and not later than within 30 calendar days. If the Policyholder terminating the insurance contract requested a later termination date, such termination shall be considered to be the agreement of the parties.

15.2. If the Policyholder – a natural person – terminates the insurance contract by notifying the Insurer in writing within 30 days of the time when he was informed of the concluded insurance contract, the Insurer shall repay the amount of paid insurance premiums retaining the right to recalculate the latter in accordance with the investment result obtained during the insurance contract validity period.

15.3. The Insurer may unilaterally terminate the insurance contract in the cases provided for in subparagraph 9.3.3, paragraph 11.7 and subparagraph 12.2.1 of the Insurance Rules and/or in cases provided for by laws of the Republic of Lithuania.

15.4. Where the insurance contract is terminated at the initiative of the Insurer due to the Policyholder's breach of the terms and conditions of the insurance contract, the surrender value shall be refunded to the Policyholder.

15.5. Where the insurance contract is terminated on the initiative of the Policyholder, except in the case of paragraph 15.6, the surrender value shall be refunded to the Policyholder and the termination fee shall be applied as provided in the Pricelist. The amount paid shall be taxed with the personal income tax in accordance with the procedure established by laws.

15.6. Where the insurance contract is terminated on the initiative of the Policyholder due to the Insurer's breach of the terms and conditions of the insurance contract, the Policyholder shall be refunded the value of capital accumulated under the insurance contract and the compensation in the amount of 1% of the accumulated capital value shall be paid additionally.

15.7. If the Policyholder has not named any other authorized person, after his death a notice of insurance contract shall be submitted to the beneficiary. If there is no beneficiary or it is impossible to determine the place of stay of the beneficiary, the notice may be served on the Policyholder's heirs or successors.

15.8. The Insurer and the Policyholder may, by separate written agreement, agree on other terms and conditions and procedure for termination of the insurance contract.

16. Confidentiality of information and processing of personal data, disclosure of information to the participants of the contract

16.1. The Insurer shall ensure the confidentiality of the information of the Policyholder, the insured person, family members, the beneficiary, the contribution payer in accordance with the insurance contract and the requirements of applicable regulatory enactments unless the Insurer has an obligation to disclose this information to third parties under applicable legal acts.

16.2. For the purposes of assessment of the insurance risk, the conclusion, administration and performance of the insurance contract, the investigation of insured events, as well as for reinsurance purposes, the Insurer may provide, request and obtain personal data relating to health of the insured persons from all doctors, hospitals and other treatment, health care and nursing institutions, the State Patient Fund under the Ministry of Health, the Territorial Patient Fund, the State Social Insurance Fund Board (Sodra), the Agency for Protection of the Rights of Persons with Disabilities under the Ministry of Social Security and Labour (Anta).

16.3. Personal data may be disclosed to third parties (law enforcement bodies and other institutions, reinsurers, companies providing to us customer servicing and other services, other natural or legal persons, if this is required for the conclusion or performance of the insurance contract, or other legitimate grounds.

16.4. The Policyholder or other person whose personal data are processed shall have the right to contact the Insurer's Data Protection Officer (by e-mail: asmensduomenys@ergo.lt or by phone 1887) on all matters relating to the processing of personal data and the use of their rights.

16.5. The Policyholder or other person whose personal data are processed shall have the right to request the Insurer to access and rectify or delete their personal data or restrict the processing of the data, and the right to disagree to process the data, as well as the right to data transfer. Where personal data are processed on the basis of consent, the Policyholder or other person whose data are processed shall have the right to withdraw the consent at any time. If a participant in the insurance contract does not agree with the processing of his personal data, the Insurer shall have the right not to conclude and/or to terminate the insurance contract in accordance with paragraph 15.3 or not to insure the person who did not give such consent / has refuse the processing of personal data.

16.6. The Policyholder or other person whose data are processed, considering that his rights regarding the processing and protection of personal data have been violated, shall have the right to lodge a complaint with the State Data Protection Inspectorate.

16.7. More detailed information on the processing of personal data performed by the Insurer is available in the Privacy Policy of ERGO posted on the Insurer's website at www.ergo.lt.

16.8. The disclosure of information of the insurance contract shall be subject to a written consent or request of the Policyholder and/or the insured person and/or the beneficiary (the submission form must allow the identification of the giver of this consent), except in the below specified cases when the Insurer may disclose the information related to the insurance contract:

16.8.1. directly to the insured person (a legal representative of the minor insured person who submitted a document proving the right of representation) to the extent related to the rights and obligations of the insured person established in the insurance contract and providing information only about the insurance cover applicable to him, including sensitive personal data;

16.8.2. to the beneficiary to the extent related to his rights and obligations established in the insurance contract;

16.8.3. to the courts, law enforcement bodies and other institutions in cases prescribed by laws.

17. Dispute resolution procedure

17.1. All disagreements regarding the conclusion, performance or termination of the insurance contract shall be settled by mutual negotiations and, in the event of failure to agree, the dispute may be settled according to the extra-judicial or judicial procedure in accordance with the procedure established by the laws of the Republic of Lithuania.

17.2. The person, considering that the Insurer has breached his rights or interests related to the insurance contract, may apply to the Insurer in writing. The procedure regulating the lodging of complaints and submission of answers to applicants shall be posted on the Insurer's website: www.ergo.lt https://ergo.lt/teisine-information/pasiulymai-ir-skundai.

17.3. For the examination of a dispute according to the out-of-court procedure, the Policyholder shall have the right to apply to the supervisory authority of the financial market participants – the Bank of Lithuania. Information on the procedure for examination disputes between consumers and financial market participants can be found here: http://www.lb.lt/gincu_nagrinejimas.

18. Procedure of transfer of the Insurer's rights and obligations

18.1. The Insurer shall have the right to transfer its rights and obligations under the insurance contract to another Insurer in accordance with the procedure established by the legal acts of the Republic of Lithuania.

18.2. The Insurer must inform the Policyholder of its intention to transfer rights and obligations two months before the intended transfer.

18.3. The Policyholder, disagreeing with the transfer of rights and obligations under the insurance contract, shall have the right to terminate the insurance contract having notified the Insurer in writing within 1 month of the transfer of the rights and obligations. The insurance contract shall be terminated from the date of receipt of the notice of termination of the insurance contract and the Policyholder shall be paid the surrender value.

19. Final provisions

19.1. Legal acts of the Republic of Lithuania apply to the insurance contract.

19.2. Claims arising from the insurance contract shall be subject to the limitation periods established by the Civil Code of the Republic of Lithuania.

19.3. When concluding or amending the insurance contract, the parties may amend and/or supplement these Insurance Rules and the Special Conditions of Insurance by written agreement.

19.4. The Insurance Rules may be translated into English. In the event of any discrepancies between the Lithuanian and English texts, the text in Lithuanian shall prevail.

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ERGO Life Insurance SE

Special Cancer Insurance Conditions No 027-01

(these conditions shall apply along with the Universal Life Insurance Rules No 027)

1. Object of insurance

1.1. The object of insurance shall be property interests if the Insured develops cancer (a critical illness).

2. Insured persons

2.1. The person specified in the Insurance Certificate who is between 18 and 64 years old at the time of concluding the Insurance Agreement and who is subject to Insurance Coverage for the period of time specified in the Insurance Agreement, but no longer than till the age of 70.

2.2. Co-insured minor children and/or adopted children of the person referred to in clause 2.1 hereof, who have not been included in the Insurance Agreement and who are subject to Insurance Coverage for as long as the Insurance Coverage for cancer applies to one of their parents during the period of time specified in the Insurance Agreement, but no longer than till they turn 18.

3. Insured Events

3.1. The Insured shall be considered to have developed cancer when the diagnosis was confirmed by medical documents, i.e. when a malignancy was diagnosed in a histological test, and the diagnosis was confirmed by an oncologist, hematologist or pathologist, and complies with the description of the illness presented in the Insurance Agreement and clauses 3.2–3.3 of these Conditions, except for the cases provided for in clause 4 hereof.

3.2. Non-invasive/early stage cancer. This shall be cancer diagnosed and confirmed histologically and characterized by malignant cell growth in the primary tumor site without damaging the base membrane and spreading to other tissues. Such cancer may be:

- All primary carcinomas in situ according to the applicable AJCC classification adopted by the American Joint Cancer Committee;
- Melanoma in situ, except for other forms of skin cancer;
- Primary stage T1aN0M0, T1bN0M0 or T2aN0M0 prostate cancer – only when treating by radical prostatectomy;
- Papillary or follicular stage T1 thyroid cancer (including T1aN0M0 and T1bN0M0).

The following shall not be considered non-invasive/early stage cancer:

- Benign tumor, dysplasia or a precancerous illness;
- Any skin cancer, except for preinvasive melanoma in situ.

3.3. Invasive cancer

3.3.1. Invasive skin (except melanoma in situ) cancer – basal cell carcinoma, squamous cell carcinoma and dermatofibrosarcoma (10% of the Sum Insured shall be paid in this case).

3.3.2. Invasive cancer, which is characterized by uncontrolled growth and spread of malignant cells into tissues, blood, blood-forming organs and the lymphatic system, including malignant lymphoma, malignant bone marrow diseases, leukemia, malignant widespread melanoma, Hodgkin's disease and myelodysplastic syndrome.

The following shall not be considered invasive cancer:

- Benign tumor, dysplasia or precancerous disease;
- Skin basal cell and squamous cell carcinoma and dermatofibrosarcoma;
- Carcinoma in situ;
- Non-invasive malignancy;
- Prostate cancer of a stage lower than T2bN0M0;
- Papillary or follicular thyroid cancer of a stage lower than T2N0M0;
- True polycythemia and primary thrombocythaemia, monoclonal gamapathy of unknown origin.

4. Non-Insured Events

4.1. Non-Insured Events when an Insurance Benefit shall not be paid having diagnosed the illness:

4.1.1. within the first 6 months (if the Policyholder is a legal person insuring its employees under a group agreement – within the first 3 months, unless agreed otherwise) from the date of entry into force of the Insurance Coverage in respect of the Insured, also when Insurance Coverage was suspended;

4.1.2. does not meet the definition of the illness specified in clause 3 hereof and the established diagnostic criteria, diagnosed based on finding tumor cells and/or signs of cancer in blood, saliva, faeces, urine or other body fluids in the absence of other conclusive and clinically confirmed evidence of the oncological process;

4.1.3. suffered by the Insured due to the exposure to alcohol, drugs or toxic, psychotropic and other psychoactive substances used for the purpose of intoxication, also use of potent drugs that have not been prescribed by a doctor;

4.1.4. related to acts of war (regardless of whether a war was declared or not), exposure to nuclear energy, radiation;

4.1.5. to a person who is infected with HIV or AIDS;

4.1.6. to the Insured, who already was diagnosed with any type of tumor, leukemia, lymphoma, had bleeding, painful, discolored moles, skin lesions, colon polyposis, inflammatory bowel disease (Crohn's disease or ulcerative colitis), polycystic kidney disease, benign breast tumours, asbestosis, hepatitis in any form (except hepatitis A) or cirrhosis before concluding the Insurance Agreement, also if the Insured already referred for diagnosing the above illnesses before concluding the Insurance Agreement. If the Insured reached for a consultation, and illness was been diagnosed or the remission period has passed, and the Insured has recovered, and, before concluding the Insurance Agreement, the Insured provided the Insurer with written information (a medical statement and medical check-up data), and the Insurer, knowing all the detailed information, still concluded the Insurance Agreement, this clause shall not apply to cancer diagnosed after the conclusion of the Insurance Agreement.

5. Sum Insured and Insurance Benefits

5.1. The Insured's Sum Insured for cancer shall be indicated in the Insurance Certificate.

5.2. Having declared an illness diagnosed to the Insured an Insured Event, the Sum Insured or a part thereof shall be paid depending on the diagnosed illness:

10% of the Sum Insured	20% of the Sum Insured	100% of the Sum Insured
Invasive skin cancer (referred to in clause 3.3.1 hereof)	**Non-invasive/early stage cancer** (3.2) Melanoma in situ Primary carcinoma in situ Primary prostate cancer Papillary or follicular thyroid cancer	**Invasive cancer** (referred to in clause 3.3.2) Widespread melanoma

The Sum Insured for a minor child shall be equal to ½ of the Sum Insured for cancer for an insured adult, without exceeding EUR 25 000.
If 2 parents have been covered under a single Insurance Agreement, the Sum Insured for a minor child shall consist of ½ (without exceeding EUR 25 000) of the Sum Insured for each insured adult.

5.3. If both parents have been covered under different insurance agreements, the Sum Insured for a co-insured minor child shall be equal to ½ of the Sum Insured for cancer for each parent, but not more than EUR 25 000 under each insurance agreement.

5.4. Insurance Benefits for non-invasive/early stage cancer and invasive skin cancer shall be paid once to each Insured.

5.5. Having paid an Insurance Benefit for invasive cancer, Insurance Coverage in respect of this Insured and of co-insured minors shall terminate.

5.6. If the Sum Insured was increased, and the Insured developed a critical illness within the first 6 months after the increase of the Sum Insured, the Sum Insured to be paid shall be equal to the Sum Insured of the Insured which applied 6 months ago. When the Policyholder is a legal person insuring its employees under a group agreement, and the Insured develops a critical illness within the first 3 months after the increase of the Sum Insured, the Sum Insured to be paid shall be equal to the Sum Insured of the Insured person valid 3 months ago, unless the Insurance Agreement establishes otherwise.

5.7. If the Insured, for whom Insurance Benefits were being paid, was diagnosed with cancer within the first 6 months (when the Policyholder is a legal person insuring its employees under a group agreement – within the first 3 months, unless the Insurance Agreement establishes otherwise) from the date of entry into force of the Insurance Coverage in his respect, when Insurance Coverage can no longer continue in respect of the Insured, the Insurer shall refund the amount of the Insurance Premium paid for this Insured, and Insurance Coverage shall terminate in respect of the Insured.

5.8. In case of death of the Insured, the Insurance Coverage applicable to that person under the Insurance Agreement shall terminate in full.

6. Procedure of reporting Insured Events

6.1. In case of a critical illness of the Insured, the Insurer shall be provided with the following:

6.1.1. a critical illness statement in the form prescribed by the Insurer;

6.1.2. documents from health care institutions with confirmed illness diagnosis, description of anamnesis, performed tests and prescribed treatment;

6.1.3. other documents requested by the Insurer significant in determining circumstances of the Insured Event.

6.2. Expenses related to obtaining documents confirming the Insured Event listed in clause 6.1 hereof shall be covered by the person to claim the Insurance Benefit.

6.3. The Beneficiary/the Insured or the Policyholder shall notify the Insurer about the critical illness in writing, within 30 days from the day the critical illness was diagnosed.

7. Procedure of paying Insurance Benefits

7.1. In case of cancer insurance, the Insurer shall pay an Insurance Benefit to the Insured, unless the Insurance Agreement establishes otherwise.

8. Procedure of amending the insurance conditions

8.1. Given developments in medical science, changes in morbidity levels and legal regulation, the Insurer shall have the right to change the definitions of cancer (critical illnesses) and/or criteria used to diagnose cancer. The Insurer may make unilateral amendments, provided that they do not violate rights or interests of the customer, and by notifying the Policyholder thereof in writing not later than 30 days before the planned date of amendment of the insurance conditions.

8.2. The Policyholder shall have the right to terminate the Insurance Agreement or to refuse the selected Insurance Coverage before the entry into force of amendments to the rules, if the amendments are unacceptable.

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Special Life Insurance Conditions No 027-02

(these conditions shall apply along with the Universal Life Insurance Rules No 027)

1. Object of insurance

1.1. The object of insurance shall be the property interest related to the insured person's life expectancy (life) and capital accumulation.

2. Insured person

2.1. The person named in the insurance policy and covered by the insurance during the period specified in the insurance contract.

3. Insured event

3.1. The insured person's death occurring during the period of insurance cover, except as provided for in Clause 4 of these Conditions.

3.2. If the insured person is declared dead by a court, it shall be considered to be an insured event provided that the date of the insured person's death declared by a final court decision falls within the period of validity of the insurance cover. If the insured person is declared missing by a court it shall not be considered to be an insured event.

4. Non-insured events

4.1. Non-insured events when the insurance benefit shall not be paid:

4.1.1. suicide of the insured person during the first 3 years of validity of the insurance cover;

4.1.2. death of the insured person as a result of military acts, imposition of a state of war or state of emergency, local unrest, exposure to nuclear energy;

4.1.3. death of the insured person during the suspension of the insurance cover.

5. Sum insured and insurance benefit

5.1. The sums insured requested by the policyholder may be specified in the application. The sums insured for each insured risk shall be determined separately by agreement between the parties to the insurance contract.

5.2. The sum insured of the insured person shall be specified in the insurance policy. The insurer may determine different minimum sums insured for the principal insured person and the additional insured person.

5.3. **The principal insured person** may choose the sum insured of the life insurance from the below listed options when in the event of death due to an insured event the following is paid:

5.3.1. **Option A** – the greater of these sums: the sum insured of life insurance or the value of capital accumulated up to the date of death notification.

5.3.2. **Option B** – the sum insured of the life insurance and the value of capital accumulated up to the date of death notification.

5.4. **The additional insured person** may opt for a fixed sum insured, when upon declaration of the event to be the insured event, the benefit in the amount of the sum insured which was in force at the date of death notification is paid out. Upon expiry of the insurance contract or in the case of a non-insured event the insurance benefit shall not be paid.

5.5. Where the insured person's sum insured of the life insurance is EUR 1, life insurance risk deductions shall not apply and data on the insured person's health and occupation shall not be collected for the purpose of assessing the insurance risk (unless additional covers are selected).

5.6. If the sum insured has been increased and the insured person commits suicide within the first 3 years after the increase of the sum insured, except in the case provided for in subparagraph 4.1.1, the insurance benefit paid out shall be equal to the smallest sums insured of the insured person applied over the last 3 years.

5.7. In the event of death of the principal insured person, the capital accumulated by the policyholder shall, not later than within 5 working days of the date of receipt of insured person's death notification, be converted into cash and shall not be invested. If it is not possible to meet these deadlines for reasons beyond the insurer's control, the capital accumulated by the policyholder shall be converted into cash at a later date; however, as soon as it becomes possible.

5.8. If the principal insured person dies during a non-insured event, the value of capital accumulated up to the date of death notification shall be paid out.

6. Procedure of reporting an insured event

6.1. If the insured person dies, the following must be submitted to the insurer:

6.1.1. an official document in the form prescribed by legal acts confirming the fact of death of the insured person;

6.1.2. a medical certificate of the cause of death;

6.1.3. a document confirming the right to the insurance benefit (inheritance document, court decision), if there is no beneficiary named in the insurance contract;

6.1.4. the insured person's death notification in the form prescribed by the insurer;

6.1.5. other documents requested by the insurer which are relevant for establishing the fact and circumstances of the insured event.

6.2. At the end of the insurance period – an application in the form prescribed by the insurer.

6.3. The person applying for the insurance benefit should inform the insurer in writing as soon as possible, but not later than within 30 days of the insured person's death or within 30 days of the enforcement of the court decision declaring the insured person dead.

6.4. The costs of obtaining the documents referred to in paragraph 6.1 supporting the insured event shall be borne by the person applying for the insurance benefit.

7. Procedure for payment of insurance benefits

7.1. Insurance benefits shall be paid to the beneficiaries named in the insurance contract. In the event of the death of a minor or if no beneficiary is named in the insurance contract, insurance benefits upon death of the insured person shall be paid to the insured person's heirs.

7.2. In the case of death due to a non-insured event:

7.2.1. the principal insured person – the beneficiaries – shall be paid the surrender value;

7.2.2. the insurance cover of an additional insured person shall be terminated and no insurance benefits shall be paid;

7.3. At the end of the insurance period, the insurance benefit shall be paid out to the beneficiary named in the contract.

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Special Accident Insurance Conditions No 027-03

(these conditions shall apply along with the Universal Life Insurance Rules No 027)

1. Object of insurance

1.1. The object of insurance shall be property interests related to accidents or health impairment listed in the Additional Assistance Benefit Table No 3.

1.2. An event, when the body of the Insured was suddenly, beyond his will, affected by an external impact (chemical, thermal, toxic gases or other physical effects), also an accidental acute moderate or severe poisoning with food, medicine, chemicals, gases or vapours, poisonous plants or fungi beyond the Insured's will, which had an adverse impact on health or life of the Insured, and the time and date of which can be determined, shall be considered an accident.

1.3. The Insurer shall provide insurance coverage for those accidents which the Insured may suffer during the period of validity of Insurance Coverage around the clock and worldwide.

1.4. Insurance risks (risk of death, disability, traumas, ordinary medical assistance, additional assistance, daily allowances, sickness benefits, additional expenses) against which the Insured shall be covered have been specified in the Insurance Certificate.

1.5. Injuries and health impairments that can be declared insured events have been listed in the Benefit Tables No 1, No 2 and No 3 of these Insurance Conditions.

2. The Insured

2.1. The person specified in the Insurance Certificate who is subject to Insurance Coverage for the period of time specified in the Insurance Agreement.

2.2. Insurance Coverage in respect of the Insured shall terminate having received a report on the death of the Insured.

3. General non-insured events

3.1. In addition to the non-insured events listed under the description of each Insurance Risk, the following shall always be considered non-insured events:

3.1.1. events related to hostilities, military mission, introduction of the state of emergency, active participation in riots;

3.1.2. events related to exposure to nuclear energy and any rays (radioactive, electromagnetic, thermal, light, etc.), also the use of chemical or biological substances for non-peaceful purposes;

3.1.3. accidents suffered during the suspension or non-validity of Insurance Coverage;

3.1.4. events that have not been confirmed by medical documents, diagnostic tests, conclusions of medical commissions, also if the presented documents do not allow determining the date, severity and circumstances of the Insured Event;

3.1.5. health problems caused by treatment, surgery or other medical procedures. If a surgery or treatment was necessary due to an accident, it shall be considered an Insured Event.

3.1.6. Accidents suffered due to the following:

- intentional injury or attempted suicide of the Insured;
- development disorders and/or illnesses causing seizures;
- impact of alcohol when the Insured is in a state of moderate and severe insobriety, and this condition affected the Insured Event; poisoning with alcohol, surrogates, narcotic or other psychotropic substances, or potent agents that were not prescribed by a doctor.

3.1.7. Accidents suffered when the Insured engaged in Professional and/or Extreme Sports or leisure, unless the Insurance Agreement establishes otherwise (this condition shall not apply to insured persons under the age of 18).

4. Insurance risks

4.1. Death due to an accident

4.1.1. **Insured Events:**

4.1.1.1. death of the Insured due to an accident, when the Insured dies as a result of suffered injuries within one year from the accident date;

4.1.1.2. after the court declares the Insured dead, when the court decision states that the Insured went missing under such circumstances that allow assuming that the Insured died as a result of an Insured Event, and the Insured went missing and presumably died during the Insurance Coverage period. The declaring of the Insured missing shall not be an Insured Event.

4.1.2. **Non-insured Events** shall be accidents that resulted in death of the Insured due to the Insured's:

4.1.2.1. suicide;

4.1.2.2. acts subjecting to criminal or administrative liability;

4.1.2.3. participation in and/or starting fights, unless these actions were socially valuable (necessary defence, performance of official duties, etc.);

4.1.2.4. death from an illness.

4.1.3. **The Sum Insured and Insurance Benefits in case of death caused by an accident:**

4.1.3.1. The Sum Insured for death of the Insured due to an accident has been indicated in the Insurance Certificate;

4.1.3.2. Having recognized death of the Insured to be an Insured Event, the Sum Insured for death of the person due to an accident shall be paid;

4.1.3.3. If the Insured covered under accident insurance in case of death dies as a result of the same accident within one year from the accident date, the right of claim to Insurance Benefits for disability and traumas shall be lost, i.e. the part of the Benefit that has already been paid to the Policyholder due to disability and traumas shall be deducted from the Insurance Benefit provided for in clause 4.1 hereof in case of death.

4.1.3.4. An Insurance Benefit shall be paid to:

4.1.3.4.1. the last beneficiaries known to the Insurer and specified in the Insurance Agreement, or, if they have not been appointed and/or if the deceased is a minor and/or an incapacitated person – to legal heirs of the Insured;

4.1.3.4.2. legal heirs of the Insured, if the sole Beneficiary specified in the Insurance Agreement died at the same time or before the Insured Event;

4.1.3.4.3. if a court declares one of the appointed beneficiaries guilty of intentional misconduct against the Insured, an Insurance Benefit shall not be paid to him, while an Insurance Benefit to the remaining beneficiaries shall be increased respectively, and if a person found guilty of intentional misconduct against the Insured was appointed the sole Beneficiary, an Insurance Benefit shall be paid to legal heirs of the Insured;

4.1.3.4.4. legal heirs of the Beneficiary, if the Beneficiary died before receiving an Insurance Benefit.

4.2. Disability due to an accident

4.2.1. **Insured Events:**

4.2.1.1. injuries suffered in an accident which occurred during the Insurance Coverage period, or consequences remaining after tick-borne encephalitis or Lyme disease, which led to a person's long-term and/or permanent loss of a part of his functions, physical or mental capacity, inability to fully or partially take care of his personal or social life, exercise his rights and discharge his duties. Cases of disability have been listed in the Benefits Table No 1;

4.2.1.2. The Insurer may assess and determine long-term and permanent loss of physical or mental capacity (disability) of the Insured and its degree after 9 months after the accident at the least, provided that the disability has been confirmed by a respective medical statement issued no later than within 18 months (in case of Lyme disease or tick-borne encephalitis – within 24 months) from the accident date. If the incurable loss of physical or mental capacity (disability) is unquestionable, the Insurer shall have the right to pay an Insurance Benefit without complying with the terms set forth in this clause.

4.2.2. **Non-insured Events** shall be an accident or a health impairment:

4.2.2.1. if the Insured injured himself intentionally or attempted to commit a suicide;

4.2.2.2. due to the Insured's acts subjecting to criminal or administrative liability;

4.2.2.3. disability due to illnesses listed in Additional Assistance Benefit Table No 3.

4.2.3. **The Sum Insured and Insurance Benefits in case of disability:**

4.2.3.1. The Sum Insured of the Insured in case of disability caused by an accident has been indicated in the Insurance Certificate;

4.2.3.2. Having recognized an event to be an Insured Event, the part of the Sum Insured for disability indicated in Table No 1 shall be paid;

4.2.3.3. Experts of the Insurer or medical experts shall determine the amount of the Insurance Benefit in accordance with the Insurance Benefit Tables presented in these Insurance Conditions, taking into account conclusions of doctors who treated the suffered person, the treatment applied, counseling, recommendations and the effectiveness of the rehabilitation of the suffered person;

4.2.3.4. An Insurance Benefit shall be paid to the Insured.

4.3. Traumas due to an accident

4.3.1. **Insured Events:**

4.3.1.1. an injury and health impairment suffered in an accident that occurred during the Insurance Coverage period: a bone fracture, dislocation or deformity, soft tissue injury, accidental acute and moderate poisoning with food, poisonous plants or fungi, medicines, chemicals, gas or vapour. Benefit Table No 2 lists the trauma cases.

4.3.2. **Non-insured Events** shall be an accident or a health impairment:

4.3.2.1. if the Insured attempted to commit a suicide or injured himself;

4.3.2.2. due to the Insured's acts subjecting to criminal or administrative liability and the Insured serving a sentence in prison;

4.3.2.3. due to the Insured's participation in and/or starting fights, unless these actions were socially valuable (necessary defence, performance of official duties, etc.);

4.3.2.4. procedure for removal of osteosynthesis structures, their breakage and/or dislocation as well as breakage and/or dislocation of joint prostheses;

4.3.2.5. pathologocial bone fractures, intervertebral disk impairments, intervertebral hernia, abdominal or abdominal cavity hernia;

4.3.2.6. joint dislocations/deformities, when the first dislocation/deformity was suffered before the Insurance Coverage took effect;

4.3.2.7. teeth damage by biting (chewing);

4.3.2.8. infections, except for those, the pathogens of which get into the body during the Insured Event provided for in these Insurance Conditions.

4.3.3. **The Sum Insured and Insurance Benefits in case of traumas:**

4.3.3.1. The Sum Insured of the Insured for traumas due to an accident has been indicated in the Insurance Certificate.

4.3.3.2. Having recognized an event to be an Insured Event, the part of the Sum Insured for traumas indicated in Table No 2 shall be paid.

4.3.3.3. Insurer's experts or medical experts shall determine the amount of the Insurance Benefit in accordance with the Insurance Benefit Tables in these Insurance Conditions, taking into account conclusions of doctors who treated the suffered person, the treatment applied, counseling, proposals and the effectiveness of the rehabilitation of the suffered person.

4.3.3.4. An Insurance Benefit shall be paid to the Insured.

4.4. Ordinary medical assistance

4.4.1. **Insured Events:**

4.4.1.1. If the Insured is covered against the risks of death, disability and traumas under the Insurance Agreement, the Insured shall be reimbursed for the following costs incurred:

4.4.1.1.1. up to EUR 1 500 – for cosmetic plastic surgeries for fixing cosmetic defects or deformities within 5 years from the accident date, if the surgery was necessary to fix consequences of the injuries sustained during the accident;

4.4.1.1.2. up to EUR 1 000 – for rehabilitation in a personal health care institution, for posterizing limbs, joints or organs, or acquiring prosthetics and orthopaedic aids, if these costs were incurred as a result of disability of at least 15% diagnosed according to clause 4.2 hereof, and they have not been covered from compulsory health insurance fund budget or voluntary health insurance funds, or have been reimbursed only in part. Rehabilitation costs shall comprise the sums of money paid by the Insured for the following medical services: physiotherapy procedures, kinesiotherapy sessions and 10 massages;

4.4.1.1.3. up to EUR 1 000 – for reimbursing psychological assistance (consultations of a psychologist, psychiatrist or psychotherapist), if the said assistance was provided to the Insured due to a disability of at least 15% diagnosed according to clause 4.2 hereof.

4.4.1.2. The Insured shall notify the Insurer in writing and obtain a confirmation from the Insurer regarding the amount and payment of expenses before receiving ordinary medical assistance services.

4.4.2. **Non-insured Events:**

4.4.2.1. costs that have not been substantiated with invoices/purchase documents.

4.4.3. **The Sum Insured and Insurance Benefits in case of ordinary medical assistance:**

4.4.3.1. Insurance Coverage shall apply if the Insured is covered against the risks of death, disability and traumas under the Insurance Agreement;

4.4.3.2. experts of the Insurer or medical experts shall determine the amount of the Insurance Benefit in accordance with the Insurance Benefit Tables presented in these Insurance Conditions, taking into account conclusions of doctors who treated the suffered person, the treatment applied counseling, recommendations and the effectiveness of the rehabilitation of the suffered person;

4.4.3.3. an Insurance Benefit shall be paid to the Insured.

4.5. Additional assistance

4.5.1. **Insured Events:**

4.5.1.1. expenses listed in the Additional Assistance Table No 3 incurred by the Insured due to an injury and health impairment suffered during an accident, which were received within 5 years after the accident date;

4.5.1.2. acute illness of the Insured provided for in the Additional Assistance Table No 3, if it has not been diagnosed before the start of additional assistance insurance coverage, and the Insured was hospitalized for it, and/or the illness was confirmed by a doctor's statement and medical tests.

4.5.2. **Non-insured Events:**

4.5.2.1. an acute illness indicated in clauses 2.8 – 2.16 of Additional Assistance Table No 3, if it occurred within the first 30 days from the inception of the additional assistance insurance coverage.

4.5.3. **The Sum Insured and Insurance Benefits in case of additional assistance:**

4.5.3.1. the Sum Insured of the Insured in case of additional assistance has been specified in the Insurance Certificate;
4.5.3.2. having recognized an event to be an Insured Event, expenses incurred by the Insured shall be reimbursed according to the presented invoices, without exceeding the sum set in the Additional Assistance Table No 3;
4.5.3.3. experts of the Insurer or medical experts shall determine the amount of the Insurance Benefit in accordance with the Insurance Benefit Tables presented in these Insurance Conditions, taking into account conclusions of doctors who treated the suffered person, the treatment applied counseling, recommendations and the effectiveness of the rehabilitation of the suffered person;
4.5.3.4. the sum of all Benefits paid for one Insured Event may not exceed the Sum Insured for additional assistance specified in the Insurance Certificate;
4.5.3.5. the sum of a compensation for incurred expenses paid to the Insured, who has several valid insurance agreements with additional assistance insurance may not exceed the sum of expenses actually incurred by the Insured;
4.5.3.6. an Insurance Benefit shall be paid to the Insured.

4.6. Daily allowance

4.6.1. **Insured Events:**

4.6.1.1. temporary incapacity for work of the Insured, when the Insured is temporarily out of work due to an accident recognized to be an Insured Event in accordance with Disability Benefit Table No 1 and Trauma Benefit Table No 2;
4.6.1.2. when the insured minor person suffered an Insured Event referred to in Disability Benefit Table No 1 and Trauma Benefit Table No 2 due to an accident, and one of the parents covered against daily allowance Insurance Risk under the same Insurance Agreement gets a certificate of incapacity for work for looking after the suffered person;
4.6.1.3. a medically justified objective duration of incapacity for work and a certificate of incapacity for work issued in accordance with the procedure established by legal acts shall be the basis for paying daily allowance.

4.6.2. **Non-insured Events:**

4.6.2.1. the incapacity for work of the Insured, which has not been confirmed by a certificate of incapacity for work issued in accordance with the established procedure.

4.6.3. **The Sum Insured and Insurance Benefits in case of daily allowance:**

4.6.3.1. the Insurance Benefit amount for each day of incapacity for work has been indicated in the Insurance Certificate;
4.6.3.2. having recognized an event to be an Insured Event, the payment of daily allowance shall start on the first day of incapacity for work;
4.6.3.3. It shall be paid for no more than 30 days of incapacity for work for one Insured Event;
4.6.3.4. daily allowance for all Insured Events that occurred during one year of insurance validity shall be paid to one Insured for not more than 100 days of incapacity for work;
4.6.3.5. daily allowance for injuries that have not been provided for in Trauma Benefit Table No 2 shall be paid for a maximum of 14 calendar days;
4.6.3.6. An Insurance Benefit shall be paid to the Insured.

4.7. Sickness benefits

4.7.1. **Insured Events:**

4.7.1.1. inpatient treatment of the Insured for consequences of an event recognized as an Insured Event according to Benefit Tables No 1, No 2 and No 3;

4.7.1.2. when an insured minor person suffered in an accident due to an Insured Event according to the Tables No 1, No 2 and No 3, and one of the parents co-insured under the same Insurance Agreement for sickness benefit Insurance Risk looks after him, and the doctor of the injured minor confirms the Insured's stay in the hospital due to the child's state of health or provides a document proving that the carer has paid for his accommodation at the hospital at his own expense.

4.7.2. **Non-insured Events:**

4.7.2.1. inpatient treatment of the Insured for a reason other than provided for in Benefit Tables No 1, No 2 and No 3.

4.7.3. **The Sum Insured and Insurance Benefits in case of sickness benefits:**

4.7.3.1. the sickness Insurance Benefit amount for each day has been specified in the Insurance Certificate;
4.7.3.2. having recognized an event to be an Insured Event, the payment of sickness benefits shall start on the first day of the hospital stay, having presented a medical statement/epicrisis on the cause and duration of treatment;
4.7.3.3. no more than 30 days of hospital treatment shall be paid for one Insured Event;
4.7.3.4. sickness benefit for all Insured Events that occurred during one year of validity of Insurance Coverage shall be paid for a maximum of 100 days of hospital treatment for one Insured;
4.7.3.5. an Insurance Benefit shall be paid to the Insured.

4.8. Additional expenses

4.8.1. **Insured Events:**

4.8.1.1. expenses incurred by the Insured, which the Insurer shall compensate within the limits of the agreed amount, if provided for in the Insurance Agreement.

4.8.2. **Non-insured Events:**

4.8.2.1. expenses of the Insured unsubstantiated by any documents or which are not covered according to conditions of the Insurance Agreement.

4.8.3. **The Sum Insured and Insurance Benefits in case of additional expenses:**

4.8.3.1. the Sum Insured and Insurance Benefits have been specified in the Insurance Certificate;
4.8.3.2. the Insured shall be reimbursed additional expenses on the basis of the submitted documents substantiating the expenses and the fact of the Insured Event;
4.8.3.3. an Insurance Benefit shall be paid to the Insured;
4.8.3.4. the amount of compensation of the incurred expenses for the Insured who has several valid Insurance Agreements with additional expense coverage may not exceed the amount of the expenses actually incurred by the Insured.

5. Procedure of reporting Insured Events

5.1. The person claiming an Insurance Benefit shall notify the Insurer in writing about the Insured Event without any undue delay, but not later than within 30 days after suffering a trauma, illness, death of the Insured or the entry into force of the court decision declaring the Insured dead. Insured Events can be reported using the self-service portal https://mano.ergo.lt and by other means specified on the Insurer's website.

5.2. A legal person claiming an Insurance Benefit shall present a document confirming the right to the Insurance Benefit, if it has been signed separately before the Insured Event.

5.3. In case of death of the Insured, the Insurer shall be provided with the following:

5.3.1. a notice on the death of the Insured in the form established by the Insurer (the form is available online at www.ergo.lt);

5.3.2. an official document in the form prescribed by legal acts confirming the fact of death;

5.3.3. a medical statement on the cause of death;

5.3.4. documents certifying inheritance, if the Benefit under the Insurance Agreement is to be paid to legal heirs.

5.4. In case of disability, trauma or acute illnesses of the Insured, the Insurer shall be provided with the following:

5.4.1. a report on the accident in the form established by the Insurer (the form is available online at www.ergo.lt);

5.4.2. medical documents substantiating the fact of the Insured Event (trauma, disability, acute illness);

5.4.3. invoices substantiating expenses – for covering costs of ordinary medical assistance and additional assistance;

5.4.4. a document issued by the search and rescue service substantiating the fact of the works and costs – for covering search and rescue;

5.4.5. payment documents – for covering costs of consultations of a psychologist or a psychiatrist;

5.4.6. a doctor's statement on the necessity to be transported to a place of permanent residence for further treatment – for covering costs of transportation of the suffered Insured to his permanent place of residence;

5.4.7. documents substantiating expenses – for covering funeral expenses;

5.4.8. for daily allowance – a certificate from a medical institution confirming the fact of the accident and a certificate of incapacity for work issued in accordance with the procedure established by legal acts;

5.4.9. for sickness benefits – a medical statement/epicrisis from the medical institution about the cause and duration of treatment;

5.4.10. other documents requested by the Insurer necessary for determining the fact and circumstances of the Insured Event.

6. Cases of amendments to the Insurance Agreement due to an increase in risk

6.1. When the Policyholder and/or the Insured notifies of the changed Insurance Risk (cases listed in clause 4.5.3 of the Universal Life Insurance Conditions), the Insurer shall have the right to amend conditions of the Insurance Agreement or increase the Insurance Premium amount. The Policyholder shall have the right to refuse Insurance Coverage if amendments are unacceptable thereto.

6.2. If the Policyholder/the Insured fails to notify of the increase in Insurance Risk (cases specified in clause 4.5.3 of the Universal Life Insurance Conditions), in case of an Insured Event, the Insurer shall have the right to refuse to pay an Insurance Benefit, if knowing about these circumstances, the Insurer would not have assumed this risk, or to reduce the premium payable in proportion to the extent that the actually received premium amount corresponds to the payable premium calculated with the increase in risk.

7. Procedure of amending Insurance Conditions

7.1. During the validity period of the Insurance Agreement, the Insurer shall have the right to amend Special Accident Insurance Conditions once per calendar year, if they do not violate rights or interests of the customer, by notifying the Policyholder thereof in writing no later than 30 days before the planned date of amendment of the Insurance Conditions.

7.2. The Policyholder shall have the right to terminate the Insurance Agreement or to refuse the selected Insurance Coverage before the effective date of amendments to the Conditions, if the amendments are unacceptable.

Accident Insurance Benefit Tables

Table No 1 for benefits for disability due to an accident

1. General provisions

1.1. Having declared disability of the Insured an Insured Event, the percentage share of the Sum Insured for disability of the person shall be paid based on consequences of the suffered injuries to the body (traumas).

1.2. The total sum of Insurance Benefits for consequences of one event may not exceed 100% of the Sum Insured for disability during the insurance year.

1.3. Having suffered several injuries to one part of the body during the same accident, a single Benefit shall be paid for the most serious injury of that body part.

1.4. Having suffered several injuries of the same organ in one accident, the percentage sum of Benefits may not exceed the amount of the Benefit paid for the loss of that organ.

1.5. If a bodily injury (trauma) which led to a complete or partial loss of functions of the organ has not been included in the Benefit Table To. 1, the Insurer's claims expert or a medical expert shall decide on the payment of the Insurance Benefit and the severity of consequences of the bodily injury (trauma).

2. Grounds for reducing an Insurance Benefit

2.1. An Insurance Benefit shall be reduced:

2.1.1. if an organ/an organ function, a part of which/a part of the function of which the Insured had already lost before the Insured Event, was lost in the Insured Event. The Insurance Benefit to be paid shall be reduced taking into consideration the loss of a part of the organ/the organ function before the trauma.

3. Grounds for increasing an Insurance Benefit

3.1. An Insurance Benefit shall be increased by 15%:

3.1.1. if the right hand of a right-handed person or the left hand – of a left-handed person was injured.

Item No	Injury	Insurance Benefit (% of the Sum Insured)
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 per 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 suffered 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 hereof 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 is 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.	
4.1.	Peripheral nerve injury in forearm, wrist, shin and tarsus areas;	5
4.2.	Peripheral nerve injury in upper arm, elbow, thigh and knee areas.	10

Item No	Injury	Insurance Benefit (% of the Sum Insured)
III. Eyes		
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 eye injuries: eye ball dislocation, tear duct injury, strabismus, retinal detachment (as a result of direct eye injury).	
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 hereof shall not be paid.	5
12.	Complete loss of vision in one or both eyes.	100
13.	Complete loss of vision in one eye.	45
14.	Decreased visual acuity due to eye injury. Note: Visual acuity shall be determined according to the Table in the text below, separately for each eye.	

Visual acuity		Insurance Benefit (%)	Visual acuity		Insurance Benefit (%)
Before trauma	**After trauma**		**Before trauma**	**After trauma**	
1.0	0.7	1	0.6	0.4	1
	0.6	3		0.3	3
	0.5	5		0.2	10
	0.4	7		0.1	15
	0.3	10		<0.1	20
	0.2	15		0.0	30
	0.1	20			
	<0.1	30			
	0.0	45			
0.9	0.7–0.6	1	0.5	0.4–0.3	1
	0.5	3		0.2	5
	0.4	5		0.1	10
	0.3	10		<0.1	15
	0.2	15		0.0	25
	0.1	20			
	<0.1	30			
	0.0	45			
0.8	0.6–0.5	2	0.4	0.3–0.2	2
	0.4–0.3	7		0.1	7
	0.2	15		<0.1	10
	0.1	20		0.0	20
	<0.1	30	0.3	0.1	5
	0.0	45		<0.1	10
				0.0	20
0.7	0.5–0.4	2	0.2	0.1	5
	0.3	7		<0.1	10
	0.2	15		0.0	20
	0.1	20	0.1	<0.1	10
	<0.1	25		0.0	20
	0.0	40			
			<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 (% of the Sum Insured)
IV. Ears		
15.	Severe disorders of the vestibular function: multiple, unremitting bouts of dizziness with vegetative reactions and balance impairment.	30
16.	Loss of the entire auricle.	5
17.	Hearing impairment in one ear: Note: Audiogram and impedancemetry data and the ability to hear a person speak 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
V. Respiratory 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

Item No	Injury	Insurance Benefit (% of the Sum Insured)
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 a 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 strenuous exercise;	15
30.2.	functional class III – when heart failure symptoms are observed during moderate exercise;	40
30.3	functional class IV – when heart failure symptoms are observed at rest and sometimes persist.	70
31.	Blood flow disorder because of an 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: in case of a cardiovascular injury, 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 due to a facial bones fracture or lower jaw trauma:	
32.1.	significant bite and chewing impairment;	7
32.2.	severe bite and mouth opening impairment, jaw deformation.	25
33.	Loss of the 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 (% of the Sum Insured)
36.	Oesophageal or pharyngeal narrowing as a result of burns or trauma: Note: The narrowing shall 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 a 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 clause 13.1 of Table No 2 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 the injuries provided for in Item 38 of this Table and at least one of the 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 clause 13.1 of Table No 2 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 clause 40.1, an Insurance Benefit for the 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

Item No	Injury	Insurance Benefit (% of the Sum Insured)
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;	20
41.2.	part of penis 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 clause 4.4.1.1.1 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 area;	1
43.2.	scars take up 1–2% of area;	2
43.3.	scars take up 3–4% of area;	4
43.4.	scars take up 5–10% of area;	5
43.5.	scars take up more than 10% of area;	8
43.6.	scars take up more than 15% of area.	10

Note: A palm of the person corresponds to 1% of the body's surface area. Scars shall be assessed after at least one year from the accident date. If the Insurer has paid at least one Insurance Benefit indicated in Item 43 of this Table, the Insured shall lose the right of claim to indemnification 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 3 of this Table.	
Shoulder girdle; shoulder joint		
45.	Complete shoulder joint immobility after resection of humerus head.	40
46.	Complete shoulder joint immobility.	30

Item No	Injury	Insurance Benefit (% of the Sum Insured)
47.	Limited mobility of the shoulder joint.	10
Arm		
48.	Loss of an arm and scapula (or a part thereof).	75
49.	Loss of an arm after disarticulation at the shoulder joint or a stump in the middle part of the arm.	70
50.	Loss of an arm – a stump at the lower third of the arm.	65
51.	Loss of a forearm after disarticulation at the elbow joint.	65
52.	Loss of a forearm under the elbow joint.	60
Elbow joint		
53.	Complete immobility of the elbow joint.	20
54.	Limited mobility of the elbow joint.	7
Wrist joint; hand		
55.	Loss of a 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 part II 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 part II of this Table shall not be paid.	10
Fingers		
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 a finger;	20
59.5.	loss of a finger and metacarpus or a part thereof.	25
60.	Immobility of a thumb joint.	5
61.	Immobility of a thumb palm joint.	10
62.	Second (index) finger:	
62.1.	partially amputated distal phalange;	3
62.2.	completely amputated distal phalange;	4

Item No	Injury	Insurance Benefit (% of the Sum Insured)
62.3.	completely amputated intermediate phalange;	8
62.4.	partially amputated proximal phalange;	10
62.5.	loss of a finger;	12
62.6.	loss of a finger and a 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
63.	Third (middle), fourth (ring) or fifth (pinky) fingers:	
63.1.	partially amputated distal phalange;	2
63.2.	partially amputated stump of intermediate or proximal phalange;	5
63.3.	loss of a 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 the function of individual fingers.		
67.	Loss of all fingers of the same hand.	45

Item No	Injury	Insurance Benefit (% of the Sum Insured)
Leg		
68.	Loss of a leg or a stump at the upper third:	
68.1.	Loss of a leg after disarticulation at hip joint or stump at the upper third;	70
68.2.	Loss of a 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 a shin or a stump at the upper third;	
71.1.	Loss of a shin after disarticulation at the knee joint or a stump at the upper third;	50
71.2.	Loss of a shin of the only leg;	80
72.	Stump at the middle or the 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
Tarsal joint; foot		
78.	Complete immobility of the 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 the 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

Item No	Injury	Insurance Benefit (% of the Sum Insured)
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 individual toes.

XI. Other functional disorders

88.	Loss of speech.	50

Trauma Benefit Table No 2

1. General provisions

1.1. An Insurance Benefit is a percentage share of the Sum Insured against the risk of bodily injuries (traumas) specified for bodily injuries (traumas) listed in this Table or their consequences incurred during an Insured Event.

1.2. A fracture of one bone in several places due to the same Insured Event shall be treated as a single fracture.

1.3. If several injuries were suffered in an Insured Event, Insurance Benefits shall be summed up, however the amount of Insurance Benefits for one event may not exceed 100% of the Sum Insured for traumas.

1.4. If the Insured has suffered a dislocation, tears in soft tissues, muscles, tendons or ligaments in the same limb due to an external impact on his body, an Insurance Benefit shall be paid in accordance with the Item providing for the highest Insurance Benefit.

1.5. The fact of an injury or trauma shall be confirmed by medical documents/objective medical tests:

1.5.1. bone fractures – confirmed by radiological examinations (X-ray, computed tomography or magnetic resonance imaging);
1.5.2. dislocation (deformity) of joints (bones) – confirmed by radiological examinations (X-ray, computed tomography or magnetic resonance imaging) or ultrasound tests, or fixed at a healthcare facility;
1.5.3. ruptures (tears) of menisci, muscles, ligaments, tendons – confirmed by magnetic resonance imaging, ultrasound tests or an arthroscopic surgery;
1.5.4. concussion (commotion) or concussion of the brain or spinal cord – diagnosed by a neurologist or neurosurgeon.

2. Grounds for reducing Insurance Benefits

2.1. An Insurance Benefit shall be reduced by 50%:

2.1.1. in the event of a recurrent bone fracture at the bone rhumb or at the place of reinforcement of the metal structure, in case of a rupture of the same meniscus, ligament, tendon and/or muscle for the second time. An Insurance Benefit shall not be paid for subsequent injuries of this type.
2.1.2. In case of a joint (bone) deformity or second recurrent joint dislocation. An Insurance Benefit shall not be paid for subsequent dislocations of the same joint.
2.1.3. When the diagnosed injuries occurred in limbs with degenerative changes.
2.1.4. Due to a traumatic injury of a tooth affected for periodontitis, caries or another dental pathology.

3. Grounds for increasing Insurance Benefits

3.1. An Insurance Benefit shall be increased by 50%:

3.1.1. if an osteosynthetic surgery was performed in case of open bone fractures or for joining the ends of a broken bone (using a metal plate, nails, wire or a fixation device externally), but not more than once for the same Insured Event;
3.1.2. in case of wounds on the face.

3.2. An Insurance Benefit shall be increased by 100%:

3.2.1. if an artificial joint had to be implanted due to a fracture of a joint during an acute trauma period;
3.2.2. if an injury was suffered by the Insured who was pregnant at the time of the event (with the exception of a Benefit under Item 17 “Loss of pregnancy”).

Item No	Injury	Insurance Benefit (% of the Sum Insured)
1.	**Skull bone fractures:**	
1.1.	Bones of the top of the skull.	10
1.2.	Bones of the base of the skull.	15
1.3.	Bones of the top and the base of the skull.	20
2.	**Facial bone fractures:**	
2.1.	Cheekbone and the upper jaw.	7
2.2.	Lower jaw.	6
2.3.	Orbit of the eye (any of the rims).	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 injury of teeth having lost the entire tooth crown and/or the root:**	
3.1.	Loss of a milk tooth before the age of 5. Note: an Insurance Benefit for one insured 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 teeth.	14
3.6.	Other traumatic injury of permanent teeth (tooth dislocation, punching it into the alveolus, breakage of at least ¼ of the teeth). Note: an Insurance Benefit shall be paid for each injured tooth, however it may not exceed 4%.	2
3.7.	Other traumatic injury of milk teeth (tooth dislocation, punching it into the alveolus, breakage of at least ¼ of the teeth) before the Insured turns 5. Note: an Insurance Benefit shall be paid for each injured tooth, however it may not exceed 2%.	1
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.		
4.	**Vertebrae fractures:**	
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 in a hospital for less than 6 days or outpatiently. Note: in case of a fracture of three or more vertebrae, an Insurance Benefit shall not exceed 16%.	10

Item No	Injury	Insurance Benefit (% of the Sum Insured)
4.2.	Transverse or spinous processes of a vertebra. Note: in case of a fracture of three or more vertebrae, an Insurance Benefit shall not exceed 10%.	5
4.3.	Sacrum.	5
4.4.	Coccyx.	4
5.	**Sternum and rib fractures:**	
5.1.	Sternum.	5
5.2.	Rib (1).	3
5.3.	Ribs (2 and more). Note: an Insurance Benefit shall be paid for each fractured rib, however it may not exceed 8%.	2
6.	**Arm fractures:**	
6.1.	Scapula, clavicle.	5
6.2.	Compression fracture of the humeral head during join dislocation.	3
6.3.	Fracture of the tubercle of the humerus.	5
6.4.	Fracture of the humerus (except for the tubercle).	9
6.5.	Fracture of one bone of the forearm.	5
6.6.	Fracture of the distal end of one bone of the forearm and styloid process of another bone.	7
6.7.	Fractures of two bones of the forearm.	10
6.8.	Styloid processes of the ulna or the radius.	3
6.9.	Wrist bones (except for scaphoid bone).	3
6.10.	Scaphoid bone.	5
6.11.	Metacarpal bones. Note: an Insurance Benefit shall be paid for each bone fracture, but shall not exceed 8%	3
6.12.	Thumb.	3
6.13.	Fingers II-V. Note: an Insurance Benefit shall be calculated for a phalange fracture of each finger, but shall not exceed 6%.	2
Note: a fracture of several phalanges of a single finger shall be treated as a single fracture. An Insurance Benefit shall be paid according to the clause providing for the highest Insurance Benefit amount.		
7.	**Pelvic bone (ilium, ischium, hip bone, pubis) fractures:**	
7.1.	Fracture of acetabulum.	12
7.2.	Tear of symphyses and bone fractures.	13
7.3.	Fracture of two or more bones.	10

Item No	Injury	Insurance Benefit (% of the Sum Insured)
7.4.	Tear of one symphysis.	8
7.5.	Fracture of one bone.	7
8.	**Leg fractures:**	
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.	Intracranial fractures of the femur or tibia (in the knee joint).	10
8.5.	Patella.	8
8.6.	Tibia (except for posterior edge and medial malleolus).	8
8.7.	Posterior edge and medial malleolus of tibia.	5
8.8.	Fibula, external malleolus.	5
8.9.	Tibia and fibula.	10
8.10.	Tibia and fibula with a tear of syndesmosis.	12
8.11.	Calcaneus, talus.	7
8.12.	Other ankle bones and phalanges (metatarsus bones). Note: an Insurance Benefit shall be paid for a fracture of each bone, but it may not exceed 10%.	4
8.13.	Big toe.	3
8.14.	Toes II-V.	2
8.15.	Sesamoid bones.	1
Note: a fracture of several phalanges of a single toe shall be treated as a single fracture.		
9.	**Other traumas:**	
9.1.	Bone infractures (splinters), bone impactions (impression), stress fractures. Avulsion fractures, bone splits/splinters which were treated by immobilisation for more than 21 days shall be treated as a complete fracture of that bone.	1
10.	**Brain and spinal cord traumas:**	
10.1.	Cerebrovascular haemorrhage (hematoma).	10
10.2.	Cerebrovascular haemorrhage with opening of the cranial cavity.	18
10.3.	Brain concussion treated for at least 3 days in a hospital and then outpatiently.	6
10.4.	Brain concussion treated outpatiently for at least 14 days or in a hospital for 1–2 days and then outpatiently.	4

Item No	Injury	Insurance Benefit (% of the Sum Insured)
10.5.	Cerebral contusion.	8
10.6.	Spinal cord commotion treated for at least 3 days in a hospital and then outpatiently.	5
10.7.	Spinal cord commotion treated outpatiently for at least 14 days or in a hospital for 1–2 days and then outpatiently.	4
10.8.	Spinal cord contusion.	7
10.9.	Cerebral and spinal cord compression.	15
Note: if the Insured suffered several cerebral and/or spinal cord injuries due to an external impact to his body, an Insurance Benefit shall be paid according to the Item providing for the highest insurance benefit amount.		
11.	**Dislocation of joints (bones):**	
11.1.	Dislocation of joints – shoulder, elbow, hip, knee.	5
11.2.	Dislocation of joints – shoulder, elbow, hip, knee, if a surgery had to be performed thereon.	7
11.3.	Dislocation of wrist, ankle joints.	3
11.4.	Dislocation of wrist, ankle joints, if it required a surgery.	5
11.5.	Lower jaw.	3
11.6.	Lower jaw, if it required a surgery.	5
11.7.	Dislocation of phalanges.	1
11.8.	Dislocation of phalanges with impaired integrity of tendons/ligaments or capsule, if it required a surgery.	3
Note: dislocation of several phalanges of one finger shall be treated as one dislocation.		
11.9.	Dislocation of the patella.	4
11.10.	Dislocation of a vertebra of the cervical spine.	5
11.11.	Dislocation of two and more vertebrae of the cervical spine.	7
12.	**Tear of tendons, ligaments, muscles, menisci:**	
12.1.	Tear of menisci. Note: In case of a tear of both menisci of one knee joint due to a trauma, an Insurance Benefit shall be paid for a tear of one meniscus only.	4
12.2.	Tear of menisci and ligaments of the knee joint in a single event.	7
12.3.	Tear of tendons, ligaments, muscles of the lower jaw, neck, hand, wrist, ankle, foot, fingers, if no surgery was required.	2
12.4.	Tear of tendons, ligaments, muscles of the lower jaw, neck, hand, wrist, ankle, foot, fingers, if a surgery was required.	4
12.5	Tear of tendons, ligaments, muscles of the shoulder, elbow, hip, knee or intervertebral ligaments, if no surgery was required.	3

Item No	Injury	Insurance Benefit (% of the Sum Insured)
12.6.	Tear of tendons, ligaments, muscles of the shoulder, elbow, hip, knee or intervertebral ligaments, if a surgery was required.	6
12.7.	Achilles tendon rupture.	5
12.8.	Achilles tendon rupture, if a surgery was performed thereon.	7
12.9.	Sprain of tendons, ligaments, muscles. Note: 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
13.	**Traumatic injury of internal organs, soft tissues:**	
13.1.	Traumatic impairment of internal organs, when a surgery had to be performed on the impaired organ.	6
13.2.	Chest injury having led to pneumothorax, hemothorax, exudative pleuritis, hypodermic emphysema.	2
13.3.	Chest injury having led to pneumothorax, hemothorax, exudative pleuritis (when a surgical intervention was needed to treat these conditions).	4
13.4.	Perforating injury of the eyeball.	8
13.5.	Perforating injury of cornea, displacement of a lens.	2
13.6.	Erosion of tunica conjuctive, cornea of the eye with foreign objects, rupture of the iris, when the insured was treated outpatiently for 6 days at the least.	1
13.7.	Traumatic rupture of the drum of one ear, when hearing was not impaired.	3
13.8.	Soft tissue damage greater than 10 cm, which required stitching the tissues.	5
13.9.	3–10 cm soft tissue damages, which required stitching the tissues.	2
13.10.	Injuries of soft tissues having led to impaired integrity of tissues less than 3 cm, which required stitching the tissues.	1
13.11.	Finger wound with torn nail, when the nail was torn by direct impact of external force at the time of an accident.	2
13.12.	Stab wounds, when one stab has led to damaged skin, hypoderma and muscular layers.	1
13.13.	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.	4
13.14.	Soft tissue injuries having led to multiple hematomas; posttraumatic osteomyelitis, phlegmon, abscess (that were treated surgically); crush 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 3 of them at the least.	3
13.15.	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, when their total area covers at least 2% of the surface of the body, and a person was incapacitated for work for more than 6 days.	3
13.16.	Haemarthrosis (if the joint had to be punctured).	3

Item No	Injury	Insurance Benefit (% of the Sum Insured)
14.	**Accidental acute poisoning of the Insured of moderate or severe degree with drugs, chemicals, gas, vapor, poisonous plants or fungi, bites of poisonous animals, insect bites, exposure to natural or technical electricity or other injuries not provided for in this Table (when the Insured was treated in a hospital):**	
14.1.	Up to 2 days.	1
14.2.	3 to 6 days.	2
14.3.	7 to 15 days.	4
14.4.	More than 15 days.	7
14.5.	Traumatic, post-hemorrhagic, anaphylactic shock, fat embolism.	10
15.	**Burns, frostbites:**	
15.1.	Second degree burns covering at least 1% of the surface of the body.	3
15.2.	Second degree burns covering at least 4% of the surface of the body.	5
15.3.	Second degree burns covering at least 10% of the surface of the body.	12
15.4.	Third degree burns covering up to 2% of the surface of the body.	4
15.5.	Third degree burns covering at least 2% of the surface of the body.	6
15.6.	Second – third degree eye burns.	4
15.7.	Extensive first degree burn causing an inflammatory illness.	6
15.8	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.		
16.	**Tick-borne diseases:**	
16.1.	Falling sick with tick-borne encephalitis or Lyme disease. Note: the disease shall be confirmed by serological tests and the manifestation of the first signs of the disease, at least 30 days after the date of application of the additional insurance coverage. After-effects can be assessed according to the disorders specified in Table No 1 (according to clause 4.2 of the insurance conditions).	1
17.	**Miscarriage:**	
17.1.	An Insurance Benefit shall be paid when pregnancy of more than 22 weeks ends or must be induced due to an external impact (trauma).	20
17.2.	An Insurance Benefit shall be paid when pregnancy of more than 14 weeks ends or must be induced for other reasons (an Insurance Benefit under this Item shall be paid once during the entire period of validity of the Insurance Agreement).	10

Additional Assistance Benefit Table No 3

Item No	Injury, condition	Insurance benefit
1.	**Additional assistance, if the Insured suffered due to an accident, which has been declared an Insured Event. The Insurer shall reimburse the necessary expenses:**	
1.1.	a) search and rescue of the suffered Insured carried out by public or private services; b) if the Insured dies as a result of an Insured Event abroad, transportation of the body of the Insured to his permanent place of residence or the necessary funeral expenses abroad, without exceeding cost of transport:	No more than EUR 10 000
	c) transportation of the suffered Insured by special transport to the nearest medical facility (once for one Insured Event), if the necessity was confirmed by a doctor:	Up to EUR 200 in one insurance year for all events
	d) transportation of the suffered Insured to his permanent place of residence after receiving first aid (once for one Insured Event), if the necessity was confirmed by a doctor.	Up to EUR 200 in one insurance year for all events
1.2.	Costs of acquisition or rent of medical aids and orthopedic equipment (splints, sticks, crutches, rehabilitation equipment, wheelchair). The maximum Benefit paid for one event shall be EUR 200.	Up to EUR 200 in one insurance year for all events
1.3.	Diagnostic/radiological examinations necessary to confirm or treat injuries. Note: a doctor's consultation shall not be paid. The maximum Benefit paid for one event shall be EUR 200.	Up to EUR 200 in one insurance year for all events
1.4.	Wound sutures, bandaging, injections, infusions.	Up to EUR 100 in one insurance year for all events
1.5.	In case of a disability/loss of working capacity of the Insured – costs of adapting the place of residence for the Insured.	Up to EUR 600 for one event
1.6	In case of the death, a disability/loss of working capacity of the Insured – costs of psychological assistance to the suffered person or closely related Insured persons (parents/legal guardians, children, brothers, sisters or spouse). The maximum Benefit paid for one event shall be EUR 300.	Up to EUR 300 in one insurance year for all events
1.7.	In case of death of the Insured – costs of funeral/cremation.	Up to EUR 600 for one event

General comment to Item 1 of Table No 3: if costs were incurred in a currency other than the currency of the Insurance Agreement, they shall be reimbursed by converting the costs to the currency of the Insurance Agreement at the exchange rate valid on the day the costs were incurred. Costs shall be substantiated by an invoice itemizing the purchased goods/services.

Item No	Injury, condition	Insurance benefit
2.	**Additional assistance in case of acute illnesses:**	
2.1.	Ebola virus, malaria, diphtheria, pertussis, tetanus, botulism.	EUR 500 for one event, without exceeding EUR 1 000 in one insurance year
2.2.	Acute appendicitis.	
2.3.	Meningococcal infection in case of meningitis, encephalitis, meningoencephalitis, meningococcal sepsis or meningococcal disease.	
2.4.	Gas gangrene.	
2.5.	Pneumococcal infection.	
2.6.	Nosocomial infection, sepsis.	
2.7.	Surgery for an ectopic pregnancy.	
2.8.	Fragile bone syndrome (in children) diagnosed for the first time during the validity period of the Insurance Agreement.	
2.9.	Tick-borne encephalitis, tick-borne myelitis, tick-borne encephalomyelitis.	
2.10.	Trichinellosis, legionellosis.	
2.11.	Perforated stomach or duodenal ulcer.	
2.12.	Systemic lupus erythematosus diagnosed for the first time during the validity period of the Insurance Agreement.	
2.13.	Gallstones, if this has resulted in a surgery for removing gallbladder.	
2.14.	Nephrolithiasis, if it has resulted in the removal of kidney stones by lithotripsy or a surgery operating no more than twice during the validity period of the Insurance Agreement.	
2.15.	Tuberculosis in persons under 18 years of age diagnosed for the first time during the validity period of the Insurance Agreement.	
2.16	Type I diabetes diagnosed for the first time during the validity period of the Insurance Agreement.	

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Special Conditions of Cancer and Other Critical Illness Insurance of Adults No 027-04

(these conditions shall apply along with the Universal Life Insurance Rules No 027)

1. Object of insurance

1.1. The object of insurance shall be property interests if the Insured develops cancer or another critical illness insured under the Insurance Agreement conditions and corresponding to the list of insured critical illnesses and the criteria for recognizing it as an Insured Event (Annex 1 to these conditions).

2. Insured persons

2.1. The person specified in the Insurance Certificate who is 18 to 64 years old at the time of conclusion of the Insurance Agreement and who shall be subject to insurance coverage for the period of time specified in the Insurance Agreement, but no longer than until he turns 70.

2.2. Minor children and/or adopted children of the person referred to in clause 2.1 that have not been indicated in the Insurance Agreement shall be co-insured under cancer insurance. They shall be covered for as long as one of their parents has cancer insurance coverage for the period specified in the Agreement, but no longer than until they turn 18.

3. Insured events

3.1. When the Insured is diagnosed with an illness referred to in the list of insured critical illnesses for the first time during the validity period of insurance coverage or undergoes a surgery, where the diagnosis has been confirmed by medical documents and meets the description of the illness and the criteria for recognition as an insured event as set out in the Insurance Agreement and Annex 1 to these conditions, except as provided for in Article 4 hereof.

3.2. An event shall only be recognised an insured event if all the statements made by the Insured (or by the Policyholder on his behalf) in the health questionnaire provided by the Insurer were true before the moment of entry into force of the Insurance Agreement, or if the circumstances referred to in the statements were already manifested after the entry into force of insurance coverage.

4. Non-insured events

4.1. Non-insured events when no Insurance Benefit shall be paid include cases when an illness has been diagnosed:

4.1.1. within the first 3 months from the date of entry into force of insurance coverage in respect of the Insured, also before the commencement of insurance coverage or when the insurance coverage is suspended, as well as 3 months following the resumption of insurance coverage, when coverage has been suspended. **Exception:** the 3-month timeframe shall not apply if:

- agreed in writing in the Insurance Agreement;
- the Insured has previously been insured against the illness (to the same extent) with the same insurance company, and the insurance coverage has continued uninterruptedly;

- blindness, paralysis and/or loss of limbs, deafness, coma, severe head injury has been diagnosed as a consequence of an accident and occurred during the insurance coverage period;

4.1.2. cases that do not meet the definition of critical illness and the criteria for recognition as an insured event provided in Annex 1 hereto;

4.1.3. cases related to hostilities (whether or not a war has been declared) and participation in a peacekeeping mission, exposure to nuclear energy and radioactive radiation (excluding the effects of radiotherapy);

4.1.4. events caused by the Insured as a result of being under the influence of alcohol, drugs or toxic, psychotropic or other psychoactive substances used for the purpose of intoxication, or of potent medicinal products that were not prescribed by a doctor;

4.1.5. events suffered while the Insured was committing or preparing to commit a criminal offence, or from any other act contrary to the law;

4.1.6. events caused by deliberate self-harm or attempted suicide;

4.1.7. events related to engagement of the Insured in professional and/or extreme sports/leisure-time. If the Insured has notified of engagement in such a sport at the time of conclusion or during the validity period of the Insurance Agreement, and the Insurer has assessed and assumed this risk, the specific agreement between the Insurer and the policyholder regarding the risk assumed shall be indicated in the Insurance Agreement;

4.1.8. in respect of a person who is infected with HIV or AIDS;

4.1.9. a critical illness was the cause of the death of the Insured occurring within 30 days of the diagnosis of a critical illness (not applicable in case of cancer).

5. Insurance options

5.1. The Policyholder may choose one of the following insurance options:

- Option A – 1 critical illness;
- Option B – a list of 4 critical illnesses;
- Option C – a list of 39 critical illnesses.

6. Sum insured and insurance benefits

6.1. The Insured's Sum Insured for cancer and critical illness insurance shall be indicated in the Insurance Certificate and can be variable.

6.2. Having recognized the Insured person's critical illness to be an insured event, the Sum Insured of the critical illness insurance of that person shall be paid, and, in case of cancer, the Sum Insured or a part of the Sum Insured may be paid as provided for in clause 5.2 of the Special Conditions of Cancer Insurance.

6.3. If a person has already been paid a part of the Sum Insured as provided for in clause 5.2 of the Special Conditions of Cancer Insurance, it shall not be deducted from the 100% of the Sum Insured payable for critical illnesses.

6.4. Having paid a benefit of 100% of the Sum Insured for a critical illness, the cancer and other critical illness insurance in respect of that Insured shall terminate.

6.5. If the Sum Insured has been increased, and the Insured contracts a critical illness within the first 3 months from the date of increase of the Sum Insured, the Sum Insured equal to the Sum Insured of the Insured applicable 3 months ago shall be paid. This clause shall not apply if the Insured is diagnosed with blindness, paralysis and/or loss of limbs, deafness, coma, or a severe head injury as a result of an accident suffered during the validity period of the Insurance Agreement.

6.6. Upon death of the Insured, insurance coverage under the Insurance Agreement for that person shall cease in full.

7. Procedure of reporting insured events

7.1. In case of a critical illness of the Insured, the following shall be submitted to the Insurer:

7.1.1. a report on contracting a critical illness in the form prescribed by the Insurer;

7.1.2. documents from health care institutions confirming the diagnosis of the illness, the medical history, a description of the examinations performed and the treatment prescribed, as well as the surgeries performed;

7.1.3. any other documents requested by the Insurer which are relevant for determining circumstances of the Insured Event.

7.2. Costs related to obtaining the documents listed in clause 7.1 above in support of the Insured Event shall be borne by the person claiming an Insurance Benefit.

7.3. The beneficiary/the Insured or the policyholder shall notify the Insurer in writing of the critical illness within 30 days from the date when the critical illness was diagnosed.

8. Procedure of payment of insurance benefits

8.1. The Insurer shall pay an Insurance Benefit in the event of a critical illness to the Insured, unless the Insurance Agreement establishes otherwise.

8.2. If the Insured is deceased on the date the event is recognized as an insured event, an Insurance Benefit shall be paid to the beneficiaries designated by the Insured and indicated in the Insurance Agreement as beneficiaries in the event of his death or, in the absence of such designation, – to the heirs of the estate of the Insured.

9. Procedure of amending the insurance conditions

9.1. In light of developments in medical science or changes in incidence rates, as well as changes in legal regulation, the Insurer shall have the right to change definitions of critical illnesses and/or the criteria for diagnosing them. The Insurer may make unilateral amendments provided that they do not violate rights or interests of the customer, and by warning the Policyholder thereof in writing at least 30 days before the scheduled date of amendment of the insurance conditions.

9.2. The Policyholder shall have the right to terminate the Insurance Agreement or to cancel the selected insurance coverage before the date of entry into force of amendments to the rules, if he finds amendments unacceptable.

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Annex No 1 to Special Conditions of Cancer and Other Critical Illness Insurance of Adults No 027-04

List of Critical Illnesses Insured and Criteria for Recognizing Insured Events

Option A – 1 critical illness (covering the illness referred to in clause 1)

1. Cancer – invasive cancer, invasive skin cancer, non-invasive/early-stage cancer.
The Special Cancer Insurance Conditions No 027-01 and the illness criteria set out herein shall be followed.

Option B – 4 critical illnesses (covering the illnesses listed in clauses 1 to 4)

2. Myocardial infarction – an irreversible damage to cardiac muscle tissue (necrosis) due to prolonged circulatory problems. The diagnosis shall be confirmed by a change in the levels of laboratory myocardial infarction indicators (troponin or CK-MB) to levels typical of myocardial infarction and have the illness-specific symptoms:
- ischemic symptoms (e.g. chest pain);
- new changes in electrocardiogram (ECG) showing myocardial infarction ischemia (new ST-T changes or a new block of the left bundle of His);
- appearance of pathological Q waves on the electrocardiogram (ECG).

3. Cerebral infarction/stroke – an acute cerebral blood flow disorder where a sudden blockage of a blood vessel supplying the brain results in impaired blood flow to brain tissue and symptoms of brain damage.
It shall be confirmed by a neurologist, with diagnosed acute onset of neurological symptoms, and a new objective neurological deficit confirmed during a clinical examination and imaging tests. The neurological deficit shall be permanent and persist for more than 3 months after the onset of the illness.

4. Multiple sclerosis – a diagnosis shall be confirmed by a neurologist, diagnosing it based on permanent illness symptoms and on all the below criteria:
- the existing clinically diagnosed sensory or motor dysfunctions lasting longer than 6 months;
- at least two cases of demyelination typical of multiple sclerosis found in the brain or spinal cord during a Magnetic Resonance Imaging (MRI) test.

Option C – 39 critical illnesses (covering the illnesses listed in clauses 1 to 39)

5. Coronary artery bypass surgery – an open-heart surgery for correcting stenosis or occlusion of two or more coronary arteries by using arterial grafts.
The need for surgery shall be confirmed by a cardiologist or a cardio surgeon and proven by data of coronary angiography.
An Insurance Benefit shall not be paid in the following cases:
- a bypass surgery was performed for treating one coronary artery;
- coronary artery angioplasty or stent implantation was performed.

6. Chronic renal failure – an irreversible terminal insufficiency of the function of both kidneys requiring a regular dialysis.
The need for dialyses shall be confirmed by a nephrologist and renal function tests.
An Insurance Benefit shall not be paid in case of an acute reversible insufficiency of renal function treated by temporary kidney dialyses.

7. Transplantation of internal organs, tissues and bone marrow – a transplantation surgery of one or more organs performed on the Insured, when the Insured is the recipient of the following:
- a heart;
- a kidney (kidneys);
- liver (including a part of liver or transplantation of liver of a living donor);
- lungs (including transplantation of a lobe of a living donor or transplantation of one lung);
- bone marrow (transplantation of allogeneic hematopoietic stem cells performed after complete removal of bone marrow);
- small intestine;
- pancreas;
- a part or the entire face, arm, hand or leg (composite tissue allotransplantation).

A transplantation shall be vital and confirmed by a specialist of a respective field.

An Insurance Benefit shall not be paid in the following cases:
- transplantation of organs, body parts or tissues other than those listed above;
- transplantation of stem cells other than those listed above.

8. Heart valve surgery – performed in order to replace or repair one or more affected heart valves. The need for surgery shall be confirmed by a cardiologist or cardiac surgeon and an echocardiogram or heart catheterisation data.
A Benefit shall be paid in the following cases:
- open heart valve replacement or repair surgery;
- Ross procedure;
- transcatheteral valve plastics;
- transcatheteral aortic valve implantation (TAVI).

An Insurance Benefit shall not be paid in the following cases:
- transcatheter mitral valve stenosis.

9. Aortic surgery – surgery performed in order to treat aortic stenosis, occlusion, aneurysm or flattening.
The need for surgery shall be confirmed by a cardiologist and imaging tests.
It shall cover minimally invasive procedures such as endovascular repair.

An Insurance Benefit shall not be paid in the following cases:
- chest and abdominal aortic surgery (including shunting of the aorta and femoral/hip artery);
- aortic surgery related to congenital connective tissue diseases (e.g. Marfan syndrome, Ehlers-Danlos syndrome;
- surgeries after traumatic injury of the aorta.

10. Paralysis of the extremities – a complete and irreversible loss of muscle function of any 2 extremities due to a trauma or an illness. Persistent nature of the illness shall be confirmed by a neurologist, clinical data and diagnostic tests, and shall persist for more than 3 months.

An Insurance Benefit shall not be paid in the following cases:
- paralysis of the extremities caused by self-harm or psychological disorders;
- Guillain-Barre syndrome.

11. Blindness – an irreversible loss of vision of both eyes due to an illness or trauma. An irreversible condition confirmed by an ophthalmologist that cannot be treated with refractive correction, medication or surgery.
Loss of vision shall be proven when visual acuity of the better seeing eye is 3/60 or less (0,05 or less on a decimal scale) as measured after correction, or when the field of vision of the better seeing eye is less than 10° in diameter after correction.

12. Deafness – irreversible deafness in both ears due to an illness or trauma. Deafness shall be confirmed by an otorhinolaryngologist with a hearing threshold of at least 90 db in the better-hearing ear after tonal threshold audiometry in all frequency ranges.

13. Loss of speech – complete and irreversible loss of the ability to speak as a result of physical injury or illness.
A permanent condition confirmed by an otorhinolaryngologist persisting for more than 6 months from the onset of the illness.

An Insurance Benefit shall not be paid in the following cases:
- loss of speech due to a mental disorder or mental illness.

14. Alzheimer's disease – shall be diagnosed before the age of 65, confirmed by a neurologist, meet diagnostic criteria and be confirmed by imaging tests of the nervous system, when the Insured requires permanent care due to the disease.

An Insurance Benefit shall not be paid:
– having diagnosed other forms of dementia due to cerebral, systemic or psychiatric diseases.

15. Idiopathic Parkinson's disease – shall be diagnosed for individuals up to 65 years of age; confirmed by a neurologist based on at least at least two of the following clinical symptoms:
– muscular rigidity;
– tremor;
– bradykinesia (abnormally slow movement, sluggish physical and mental response).
The impairment shall have persisted for at least 3 months from the date of diagnosis, with the person being unable to perform independently at least 3 out of 6 (washing, dressing/undressing, eating, personal hygiene, moving around indoors, getting in and out of bed) activities of daily living and there is no sign of improvement despite ongoing treatment.
The implantation of a neurostimulator for symptom control by deep brain stimulation shall also be considered a critical illness, when the necessity of the procedure has been confirmed by a neurologist or neurosurgeon. In this case, the degree of impairment in the functions of daily living shall not be assessed.

An Insurance Benefit shall not be paid in the following cases:
– secondary parkinsonism (including the one caused by drugs or toxins);
– essential (spontaneous) tremor;
– Parkinsonism associated with other neurodegenerative disorders.

16. Transient vegetative state – absence of responsiveness and awareness due to hemispheric dysfunction in the brain, when the brainstem, which controls respiratory and cardiac functions, is intact. The clinical condition of the Insured shall be confirmed by the treating neurologist as not having improved for at least one month and shall meet the diagnostic criteria for the illness.

17. Primary cardiomyopathy – one of the below-listed:
– dilated cardiomyopathy;
– hypertrophic cardiomyopathy (obstructive or non-obstructive);
– restrictive cardiomyopathy;
– arrhythmogenic right ventricular cardiomyopathy.
The diagnosis shall be confirmed on the basis of one of the following criteria:
– a left ventricular ejection fraction (LVEF) of less than 40%, measured twice at least 3 months apart;
– at least 6 months of noticeably restricted physical activity, with less than normal activity leading to fatigue, cardiac palpitations, shortness of breath or chest pain (NYHA class III or IV);
– implantation of an implantable cardioverter/defibrillator (ICD) to prevent sudden death due to cardiac problems.
– Medical necessity of implantable cardioverter/defibrillator (ICD) implantation, diagnosis to be confirmed by a cardiologist and supported by an echocardiogram or cardiac MRI results.

An Insurance Benefit shall not be paid in the following cases:
– secondary (ischaemic, valvular, metabolic, toxic or hypertensive) cardiomyopathy;
– transient ventricular dysfunction due to myocarditis;
– cardiomyopathy due to systemic diseases;
– implantable cardioverter/defibrillator (ICD) implantation due to primary arrhythmias (e.g. Brugada or prolonged QT syndrome).

18. Sporadic Creutzfeldt-Jakob Disease (sCJD) – is a diagnosis confirmed by a neurologist based on all of the following criteria:
– progressive dementia;
– at least two of the following four clinical features: muscle convulsions, visual or balance impairment, pyramidal/extrapyramidal signs, akinetic mutism;
– an electroencephalogram (EEG) showing sharp wave complexes and/or detection of protein 14-3-3 in cerebrospinal fluid;
– the results of routine investigations do not suggest another diagnosis.

An Insurance Benefit shall not be paid in the following cases:
– iatrogenic or familial Creutzfeldt-Jakob disease;
– other variants of Creutzfeldt-Jakob disease (vCJD).

19. Aplastic anaemia – resulting in severe bone marrow failure with anaemia, neutropenia and thrombocytopenia. The condition requires treatment with blood transfusions and at least one additional one of the following treatment methods:
- bone marrow stimulants;
- immunosuppressants;
- a bone marrow transplant.

The diagnosis shall be confirmed by a haematologist and substantiated by the results of a bone marrow histological examination.

20. A benign brain tumour – a non-malignant tumour located in the cerebral part of the skull, meninges or the cranial nerves. The tumour shall be treated with at least one of the following therapies:
- complete or partial surgical removal;
- stereotactic radiosurgery;
- external beam radiotherapy.

If none of the treatments can be used for medical reasons, the tumour shall cause a permanent neurological deficit which persist for at least 3 months after the diagnosis. It shall be diagnosed by a neurologist or neurosurgeon and confirmed by imaging tests.

An Insurance Benefit shall not be paid having diagnosed:
- any cyst, granuloma, hamartoma or malformation of the cerebral arteries or veins;
- pituitary tumours.

21. A coma – a loss of consciousness without responding to external stimuli or internal demands, when:
- the condition lasts for at least 96 hours and is scored 8 or less on the Glasgow Coma Scale,
- requires the use of a life support system, and
- a permanent neurological deficit[1] that persists for at least 30 days from the onset of coma.

The diagnosis shall be confirmed by a neurologist.

An Insurance Benefit shall not be paid in the following cases:
- coma has been artificially induced by medical means or medication (for medically justified reasons);
- coma has been caused by deliberate self-harm, alcohol or drug use.

22. Severe lever disease – a chronic condition based on at least 7 Child-Pugh points (Child-Pugh class B or C).
Diagnosis shall be confirmed by a gastroenterologist, based on imaging findings, calculating the score on the basis of all these criteria:
- total serum bilirubin;
- serum albumin level;
- severity of ascites;
- International Normalised Ratio (INR);
- hepatic encephalopathy.

An Insurance Benefit shall not be paid having diagnosed:
- severe liver disease due to alcohol or drug use (including hepatitis B or C infections contracted by the patient using intravenous drugs).

23. Chronic lung disease – manifests in chronic respiratory failure.
Diagnosis shall be confirmed by a pulmonologist, substantiated with results of instrumental investigations and confirmed according to all the following criteria:
- FEV1 (forced expiratory volume in 1 second) less than 40% of default, determined by two measurements with at least one month apart;
- treatment with oxygen therapy for at least 16 hours per day for 3 months at the least;
- a persistent decrease in partial pressure of oxygen (PaO2) below 55 mmHg (7,3 kPa) in arterial blood (without supplementary oxygen therapy), confirmed by an arterial blood gas test.

24. Acute viral encephalitis – a diagnosis causing a permanent neurological deficit[1] that persists for at least 3 months from the diagnosis.
The diagnosis shall be confirmed by a neurologist and substantiated with typical clinical symptoms and cerebrospinal fluid tests or the results of a brain biopsy.

An Insurance Benefit shall not be paid in the following cases:
- encephalitis where the Insured has been diagnosed with HIV infection;
- encephalitis caused by bacterial or protozoal infections;
- myalgic or paraneoplastic encephalomyelitis.

25. Fulminant viral hepatitis – a diagnosis shall be confirmed by a gastroenterologist or infectologist based on laboratory test results and all of the following criteria:
- serological tests characteristic of acute viral hepatitis;
- development of hepatic encephalopathy;
- reduction in liver size;
- an increase in bilirubin levels;
- a blood clotting disorder (coagulopathy) with a TNS value greater than 1.5;
- development of hepatic failure within 7 days of onset of symptoms;
- no history of liver disease.

An Insurance Benefit shall not be paid in the following cases:
- acute liver failure caused by all other non-viral causes (including drug poisoning, paracetamol or aflatoxin);
- fulminant viral hepatitis associated with intravenous drug use.

26. Severe head injury – an injury that causes severe and permanent damage to the brain.
The suffered person is unable to perform at least 3 out of 6 daily tasks on his own (washing, dressing/undressing, eating, personal hygiene, moving around indoors, getting in and out of bed) for at least 3 months continuously, and there is no sign of improvement. The diagnosis shall be confirmed by a neurologist or neurosurgeon, substantiated with the results of functional independence and imaging tests (CT scan, MRI).

27. Loss of limbs – the loss of two or more limbs above the wrist or ankle joint as a result of an accident or medically necessary amputation. The diagnosis shall be confirmed by a surgeon or orthopaedic traumatologist.

28. HIV infection due to transfusion of blood products – infection following transfusion of blood products confirmed by all of the following criteria:
- the infection developed as a result of a medically necessary transfusion of blood products carried out after the entry into force of the Insurance Agreement;
- the establishment which carried out the transfusion is an officially registered and licensed healthcare establishment;
- the establishment that supplied the blood products and the establishment that carried out the transfusion has assumed liability for the fact of infection;
- HIV seroconversion occurred within 12 months from the transfusion date;
- transfusion of infected blood product has been carried out in a European Union or European Economic Area state, the United Kingdom or Switzerland.

An Insurance Benefit shall not be paid in the following cases:
- HIV infection resulting from any other means of transmission, including sexual intercourse or drug use;
- HIV infection resulting from transfusion of blood products intended for the treatment of haemophilia or thalassaemia.

29. HIV infection contracted at work in the course of legal employment – when the Insured contracted infection due to an accident in the course of his normal job duties, i.e. while working:
as a medical doctor or dentist, nurse or midwife, physician's assistant or dental assistant, laboratory worker or laboratory technician, member of an ambulance team, hospital housekeeper or hospital maintenance worker, member of a fire service, police or prison officer.
HIV infection shall be confirmed according to all of the following criteria:
- the incident must have occurred after the Insurance Agreement came into force;
- the incident must have been reported, investigated and documented in accordance with the current recommendations of the relevant authorities (e.g. the authority investigating the workplace incident);
- the HIV test taken within 5 days of the incident was negative;
- HIV seroconversion must have occurred within 12 months of the incident;
- the incident must have occurred in the course of official duties in the European Union or Switzerland.

An Insurance Benefit shall not be paid in the following cases:
- HIV infection contracted by other means of transmission, including sexual intercourse or drug use.

30. Muscular dystrophy – one of the following diagnoses confirmed by a neurologist and supported by electromyography (EMG) and muscle biopsy test results:
- 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);
- Oculo-ocular muscular dystrophy (OPMD).

The Insured is unable to perform at least 3 out of 6 daily tasks independently (washing, dressing/undressing, eating, personal hygiene, moving around indoors, getting in and out of bed) and there are no signs of improvement.

An Insurance Benefit shall not be paid in the following cases:
- Myotonic dystrophy type 2 (PROMM) and all forms of myotonia.

31. Motor neurone disease – one of the following diagnoses, confirmed by a neurologist and supported by nerve conduction studies and electromyography:
- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease);
- primary lateral sclerosis (PLS);
- progressive muscular atrophy (PMA);
- progressive bulbar palsy (PBP).

The impairment must have lasted for at least 3 months from the date of diagnosis, with the person being unable to perform independently at least 3 out of 6 daily tasks (washing, dressing/undressing, eating, personal hygiene, moving around indoors, getting in and out of bed) and there are no signs of improvement.

An Insurance Benefit shall not be paid in the following cases:
- multifocal motor neuropathy (MMN) and inclusion body myositis;
- post-polio syndrome;
- spinal muscular atrophy;
- polymyositis and dermatomyositis.

32. Systemic scleroderma – a diagnosis confirmed by a rheumatologist based on all of the following criteria:
- typical laboratory test results (e.g. scleroderma anti-Scl-70 antibodies);
- typical clinical features (e.g. Raynaud's syndrome, skin sclerosis, erosions);
- continuous treatment with corticosteroids or other immunosuppressants.
- The presence of damage to one of the following organs shall also be established:
- pulmonary fibrosis with less than 70% than normal gas diffusion capacity (DCO);
- pulmonary hypertension with a mean pulmonary artery pressure greater than 25 mmHg at rest, as measured by right heart catheterisation procedure;
- chronic kidney disease with a glomerular filtration rate of less than 60 ml/min (MDRD-formula);
- echocardiographic features characteristic of severe left ventricular diastolic dysfunction.

An Insurance Benefit shall not be paid in the following cases:
- localised scleroderma not affecting organs;
- eosinophilic fasciitis;
- CREST syndrome.

33. Systemic lupus erythematosus – a diagnosis confirmed by a rheumatologist on the basis of all of the following criteria:
- laboratory test results, e.g. detection of antibodies against nuclear antigens (ANA) or double-stranded DNA (dsDNA);
- symptoms characteristic of systemic lupus erythematosus (bow-tie-shaped rash, photosensitivity, serositis);
- continuous treatment with corticosteroids or other immunosuppressants.
- In addition, damage to one of the following organs shall be diagnosed:
- lupus-related 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 lasting more than 3 months, confirmed by appropriate cerebrospinal fluid studies or EEG results. Headache, cognitive and psychiatric symptoms shall not be considered a typical neurological deficit in this context.

An Insurance Benefit shall not be paid in the following cases:
- discoid lupus erythematosus or subacute cutaneous lupus erythematosus;
- drug-induced lupus erythematosus.

34. Severe rheumatoid arthritis – a diagnosis confirmed by a rheumatologist based on all of the following criteria:
- typical symptoms of inflammation (arthralgia, swelling, tenderness) lasting more than 6 weeks from the date of the diagnosis, a significant increase in CRB levels;
- a positive rheumatoid factor test result (at least twice the upper limit) and/or the presence of antibodies to cyclic citrullinated peptide;
- continuous treatment with corticosteroids;
- treatment with disease-modifying anti-rheumatic drugs (e.g. methotrexate and sulfasalazine/leflunomide) or a TNF inhibitor for at least 6 months.

An Insurance Benefit shall not be paid in the following cases:
- reactive arthritis;
- psoriatic arthritis;
- osteoarthritis.

35. Necrotizing fasciitis – a diagnosis confirmed by a surgeon, substantiated with microbiological or histological tests and based on all of the following criteria:
- progressive, rapidly spreading bacterial infection of the deep muscle fascia accompanied by secondary subcutaneous lesions of the extremities or trunk secondary necrosis of the tissues of the trunk and lower limbs;
- fever and rapidly increasing C-reactive protein (CRB) levels;
- surgical removal of all dead (necrotic) tissue as part of the treatment.
- Fournier's gangrene shall also be considered a critical illness.

An Insurance Benefit shall not be paid in the following cases:
- gaseous gangrene;
- gangrene caused by diabetes, neuropathy or vascular disease.

36. Chronic pancreatitis – a diagnosis confirmed by a gastroenterologist, substantiated with imaging studies and laboratory tests (e.g. faecal elastase), lasting at least 3 months from the date of diagnosis and confirmed on the basis of all the following criteria:
- exocrine pancreatic insufficiency in presence of weight loss and steatorrhea;
- endocrine pancreatic insufficiency in presence of pancreatic diabetes;
- pancreatic enzyme replacement therapy is required.

An Insurance Benefit shall not be paid in the following cases:
- chronic pancreatitis due to alcohol or drug use;
- acute pancreatitis.

37. Third-degree burns – affect the skin throughout its entire depth to the subcutaneous tissue and cover at least 20% of the surface area of the body of the Insured as determined by the Rule of Nines, the Lund-Browder diagram or the rule of the palm (1% of the surface area of the body is equal to the surface area of the palm of the hand (palm and fingers together) of the insured hand). The diagnosis shall be confirmed by a surgeon.

38. Primary pulmonary hypertension – a diagnosis shall be confirmed by a cardiologist or pulmonologist based on all of the following criteria:
- marked limitation of physical activity for at least 6 months, where less than ordinary activity leads to fatigue, cardiac palpitations, shortness of breath or chest pain (NYHA (New York Heart Association) class III or IV);
- a mean pulmonary artery pressure greater than 25 mmHg at rest as measured by right heart catheterisation.

An Insurance Benefit shall not be paid in the following cases:
- secondary hypertension due to pulmonary/cardiac or systemic diseases;
- chronic thromboembolic pulmonary hypertension (CTEPH).

39. Bacterial meningitis – the diagnosis that causes:
- a permanent neurological deficit[1] that persists for at least 3 months after diagnosing it; or
- in children under the age of 6 years, complete loss or cessation of motor, cognitive and speech skills for 12 months development.
- The diagnosis shall be confirmed by a neurologist or an infectologist and be based on the results of a bacteriological examination when growth of pathogenic bacteria is detected in a cerebrospinal fluid sample.

The diagnosis shall be confirmed by a neurologist or an infectologist and be based on the results of a bacteriological examination when growth of pathogenic bacteria is detected in a cerebrospinal fluid sample.

An Insurance Benefit shall not be paid in the following cases:
- aseptic, viral, parasitic or non-infectious meningitis.

[1] Neurological deficit
Symptoms of neurological impairment as determined by clinical examination. Symptoms include numbness, hyperaesthesia (hypersensitivity), paralysis, local weakness, dysarthria (impaired speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficult walking, incoordination, tremor, convulsions, lethargy, dementia, delirium and coma.

An Insurance Benefit shall not be paid in the following cases:
- abnormalities visible on CT or MRI scans or other neuro-visual examinations which are not obviously related to clinical symptoms;
- neurological signs occurring without pathological symptoms, e.g. sudden reflexes without other symptoms;
- symptoms of psychological or psychiatric origin.

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Special Conditions of Cancer and Other Critical Illness Insurance of Children No 027-05

(these conditions shall apply along with the Universal Life Insurance Rules No 027)

1. Object of insurance

1.1. The object of insurance shall be property interests if the Insured develops cancer or another critical illness insured under the Insurance Agreement conditions and corresponding to the list of insured critical illnesses and the criteria for recognizing it as an Insured Event (Annex 1 to these conditions).

2. Insured persons

2.1. The person specified in the Insurance Certificate who is 2 to 17 years old at the time of conclusion of the Insurance Agreement and who shall be subject to insurance coverage for the period of time specified in the Insurance Agreement, but no longer than until he turns 18.

3. Insured events

3.1. When the Insured is diagnosed with an illness referred to in the list of insured critical illnesses for the first time during the validity period of insurance coverage or undergoes a surgery, where the diagnosis has been confirmed by medical documents and meets the description of the illness and the criteria for recognition as an insured event as set out in the Insurance Agreement and Annex 1 to these conditions, except as provided for in Article 4 hereof.

3.2. An event shall only be recognised an insured event if all the statements made by the Insured (or by the Policyholder on his behalf) in the health questionnaire provided by the Insurer were true before the moment of entry into force of the Insurance Agreement, or if the circumstances referred to in the statements were already manifested after the entry into force of insurance coverage.

4. Non-insured events

4.1. Non-insured events when no Insurance Benefit shall be paid include cases when an illness has been diagnosed:

4.1.1. within the first 3 months from the date of entry into force of insurance coverage in respect of the Insured, also before the commencement of insurance coverage or when the insurance coverage is suspended, as well as 3 months following the resumption of insurance coverage, when coverage has been suspended.
Exception: the 3-month timeframe shall not apply if:

- agreed in writing in the Insurance Agreement;
- the Insured has previously been insured against the illness (to the same extent) with the same insurance company, and the insurance coverage has continued uninterruptedly;
- blindness, paralysis and/or loss of limbs, deafness, coma, severe head injury has been diagnosed as a consequence of an accident and occurred during the insurance coverage period.

4.1.2. cases that do not meet the definition of critical illness and the criteria for recognition as an insured event provided in Annex 1 hereto;

4.1.3. cases related to hostilities (whether or not a war has been declared), exposure to nuclear energy and radioactive radiation (excluding the effects of radiotherapy);

4.1.4. events caused by the Insured as a result of being under the influence of alcohol, drugs or toxic, psychotropic or other psychoactive substances used for the purpose of intoxication, or of potent medicinal products that were not prescribed by a doctor, if this has a causal link to the diagnosed illness;

4.1.5. events suffered while the Insured was committing or preparing to commit a criminal offence, or from any other act contrary to the law;

4.1.6. events caused by deliberate self-harm or attempted suicide;

4.1.7. events related to engagement of the Insured in professional and/or extreme sports/leisure-time. If the Insured has notified of engagement in such a sport at the time of conclusion or during the validity period of the Insurance Agreement, and the Insurer has assessed and assumed this risk, the specific agreement between the Insurer and the policyholder regarding the risk assumed shall be indicated in the Insurance Agreement;

4.1.8. in respect of a person who is infected with HIV or AIDS;

4.1.9. in respect of a person who has a congenital defect;

4.1.10. cases when the Insured has already been diagnosed with a tumour of any kind, leukaemia, lymphoma, bleeding, painful, discoloured or disfigured moles or skin lesions, colorectal polyposis, inflammatory bowel disease (Crohn's disease or ulcerative colitis), polycystic kidney disease, benign breast tumours, asbestosis, hepatitis in any form (except hepatitis A), cirrhosis of the liver before the conclusion of the Insurance Agreement, also if the Insured has already been consulted for the diagnosis of the above-mentioned disorders before the date of conclusion of the Insurance Agreement. If the Insured has been consulted, and an illness has not been diagnosed, or if the Insured has gone into remission and has recovered, and has provided written information (medical report and test data) to the Insurer thereon before the date of conclusion of the Insurance Agreement, and the Insurer has concluded an Insurance Agreement knowing all the detailed information thereon, then this clause shall not apply to cancers diagnosed after the conclusion of the Insurance Agreement;

4.1.11. a critical illness was the cause of the death of the Insured occurring within 30 days of the diagnosis of a critical illness (not applicable in case of cancer).

5. Insurance options

5.1. The Insured shall be insured against 14 critical illness listed in Annex 1 hereto.

6. Sum insured and insurance benefits

6.1. The Insured's Sum Insured for cancer and critical illness insurance shall be indicated in the Insurance Certificate and can be variable.

6.2. Having recognized the Insured person's critical illness to be an insured event, the Sum Insured of the critical illness insurance of that person shall be paid, and, in case of cancer, a part of the Sum Insured depending on the diagnosed illness the criteria of which is listed in Annex 1 hereto may also be paid:

10% of the Sum Insured	20% of the Sum Insured	100% of the Sum Insured
Invasive skin cancer	**Non-invasive/early-stage cancer** Melanoma in situ Primary carcinoma in situ Primary prostate cancer Papillary or follicular thyroid cancer	**Invasive cancer** Advanced melanoma

6.3. If a person has already been paid a part of the Sum Insured in accordance with conditions of clause 6.2 hereof, it shall not be deducted from the 100% of the Sum Insured payable for critical illnesses.

6.4. Having paid a benefit of 100% of the Sum Insured for a critical illness, the cancer and other critical illness insurance in respect of the Insured shall terminate.

6.5. If the Sum Insured has been increased, and the Insured contracts a critical illness within the first 3 months from the date of increase of the Sum Insured, the Sum Insured equal to the Sum Insured of the Insured applicable 3 months ago shall be paid. This clause shall not apply if the Insured is diagnosed with blindness, paralysis and/or loss of limbs, deafness, coma, or a severe head injury as a result of an accident suffered during the validity period of the Insurance Agreement.

6.6. Upon the death of the Insured, insurance coverage under the Insurance Agreement for that person shall cease in full.

7. Procedure of reporting insured events

7.1. In case of a critical illness of the Insured, the following shall be submitted to the Insurer:

7.1.1. a report on contracting a critical illness in the form prescribed by the Insurer;

7.1.2. documents from health care institutions confirming the diagnosis of the illness, the medical history, a description of the examinations performed and the treatment prescribed, as well as the surgeries performed;

7.1.3. any other documents requested by the Insurer which are relevant for determining circumstances of the Insured Event.

7.2. Costs related to obtaining the documents listed in clause 7.1 above in support of the Insured Event shall be borne by the person claiming an Insurance Benefit.

7.3. The beneficiary/the Insured or the policyholder shall notify the Insurer in writing of the critical illness within 30 days from the date when the critical illness was diagnosed.

8. Procedure of payment of insurance benefits

8.1. The Insurer shall pay an Insurance Benefit in the event of a critical illness to the Insured, unless the Insurance Agreement establishes otherwise.

8.2. If the Insured is deceased on the date the event is recognized as an insured event, an Insurance Benefit shall be paid to heirs of the Insured.

9. Procedure of amending insurance conditions

9.1. In light of developments in medical science or changes in incidence rates, as well as changes in legal regulation, the Insurer shall have the right to change definitions of critical illnesses and/or the criteria for diagnosing them. The Insurer may make unilateral amendments provided that they do not violate rights or interests of the customer, and by warning the Policyholder thereof in writing at least 30 days before the scheduled date of amendment of the insurance conditions.

9.2. The Policyholder shall have the right to terminate the Insurance Agreement or to cancel the selected insurance coverage before the date of entry into force of amendments to the rules, if it finds amendments unacceptable.

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Annex No 1 to Special Conditions of Cancer and Other Critical Illness Insurance of Children No 027-05

List of Critical Illnesses Insured and Criteria for Recognizing Insured Events

1. Cancer – invasive cancer, invasive skin cancer, non-invasive/early-stage cancer.
It shall be confirmed by a medical oncologist, haematologist or pathologist and supported by medical documentation, i.e. a histological examination shall be performed diagnosing malignant process, and meet the criteria set out in clauses 1.1 and 1.2 hereof.

1.1. Non-invasive/early-stage cancer
It is a cancer with a histologically confirmed diagnosis, characterised by malignant cell growth at the original tumour site, which does not affect the base membrane and has not spread to other tissues. In this case, 20% of the Sum Insured shall be paid.
Such cancer includes:
- all primary carcinomas in situ according to the current AJCC classification adopted by the American Joint Committee on Cancer;
- melanoma in situ, excluding other forms of skin cancer;
- primary prostate cancer stage T1aN0M0, T1bN0M0 or T2aN0M0 – only when treated with radical prostatectomy;
- papillary or follicular thyroid cancer stage T1 (including T1aN0M0 and T1bN0M0).

The following shall not be considered non-invasive/early-stage cancer:
- benign tumour, dysplasia or precancerous disease;
- any skin cancer other than pre-invasive melanoma in situ.

1.2. Invasive cancer
Invasive skin cancer (except melanoma in situ) means basal cell carcinoma of the skin, squamous cell carcinoma and dermatofibrosarcoma. In this case, 10% of the Sum Insured shall be paid.
Invasive cancer is cancer characterised by uncontrolled growth and spread of malignant cells into tissues, blood organs and the lymphatic system, including malignant lymphoma, malignant bone marrow disorders, leukaemia, malignant advanced melanoma, Hodgkin's disease and myelodysplastic syndrome. In this case, 100% of the Sum Insured shall be paid.

The following shall not be considered invasive cancer:
- Benign tumour, dysplasia or precancerous disease;
- Basal cell and squamous cell carcinoma of the skin and dermatofibrosarcoma;
- Carcinoma in situ;
- Non-invasive malignant cancer;
- Prostate cancer – in stage lower than T2bN0M0;
- Papillary or follicular thyroid cancer – in stage lower than T2N0M0;
- True polycythemia and primary thrombocythemia, monoclonal gammopathy of undetermined origin.

2. A benign brain tumour – a non-malignant tumour located in the cerebral part of the skull, meninges or the cranial nerves. The tumour shall be treated with at least one of the following therapies:
- complete or partial surgical removal;
- stereotactic radiosurgery;
- external beam radiotherapy.

If none of the treatments can be used for medical reasons, the tumour shall cause a permanent neurological deficit which persist for at least 3 months after the diagnosis. It shall be diagnosed by a neurologist or neurosurgeon and confirmed by imaging tests.

An Insurance Benefit shall not be paid having diagnosed:
- any cyst, granuloma, hamartoma or malformation of the cerebral arteries or veins;
- pituitary tumours;
- congenital tumours.

3. Transplantation of internal organs, tissues and bone marrow – a transplantation surgery of one or more organs performed on the Insured, when the Insured is the recipient of the following:
- a heart;
- a kidney (kidneys);
- liver (including a part of liver or transplantation of liver of a living donor);
- lungs (including transplantation of a lobe of a living donor or transplantation of one lung);
- bone marrow (transplantation of allogeneic hematopoietic stem cells performed after complete removal of bone marrow);
- small intestine;
- pancreas;
- a part or the entire face, arm, hand or leg (composite tissue allotransplantation).

A transplantation shall be vital and confirmed by a specialist of a respective field.

An Insurance Benefit shall not be paid in the following cases:
- transplantation of organs, body parts or tissues other than those listed above;
- transplantation of stem cells other than those listed above;
- transplantation for congenital defects or abnormalities.

4. Chronic renal failure – an irreversible terminal insufficiency of the function of both kidneys requiring a regular dialysis. The need for dialyses shall be confirmed by a nephrologist and renal function tests.

An Insurance Benefit shall not be paid for:
- acute reversible renal failure treated by temporary renal dialysis;
- renal failure due to congenital kidney and/or congenital urinary tract anomalies;
- renal failure due to impaired renal perfusion in the perinatal phase.

5. Paralysis of the extremities – a complete and irreversible loss of muscle function of any 2 extremities due to a trauma or an illness.
Persistent nature of the illness shall be confirmed by a neurologist, clinical data and diagnostic tests, and shall persist for more than 3 months.

An Insurance Benefit shall not be paid in the following cases:
- paralysis of the extremities caused by self-harm or psychological disorders;
- Guillain-Barre syndrome;
- paralysis due to congenital defects or abnormalities.

6. Blindness – an irreversible loss of vision of both eyes due to an illness or trauma. An irreversible condition confirmed by an ophthalmologist that cannot be treated with refractive correction, medication or surgery.
Loss of vision shall be proven when visual acuity of the better seeing eye is 3/60 or less (0,05 or less on a decimal scale) as measured after correction, or when the field of vision of the better seeing eye is less than 10° in diameter after correction.

An Insurance Benefit shall not be paid:
- for a congenital or inherited loss of vision, including due to infection during pregnancy.

7. Deafness – irreversible deafness in both ears due to an illness or trauma.
Deafness shall be confirmed by an otorhinolaryngologist with a hearing threshold of at least 90 db in the better-hearing ear after tonal threshold audiometry in all frequency ranges.

An Insurance Benefit shall not be paid:
– for a congenital or inherited deafness, including due to infection during pregnancy.

8. Coma – a loss of consciousness without responding to external stimuli or internal demands, when:
– the condition lasts for at least 96 hours and is scored 8 or less on the Glasgow Coma Scale,
– requires the use of a life support system, and
– a permanent neurological deficit[1] that persists for at least 30 days from the onset of coma.
The diagnosis shall be confirmed by a neurologist.

An Insurance Benefit shall not be paid in the following cases:
– coma has been artificially induced by medical means or medication (for medically justified reasons);
– coma has been caused by the use of alcohol or drugs, psychotropic or other psychoactive substances without a doctor's prescription;
– injury resulting from exploitation or abuse of a child by a parent, legal guardian or their spouse/cohabitant;
– coma due to complications of childbirth or congenital defects.

9. Acute viral encephalitis – a diagnosis causing a permanent neurological deficit[1] that persists for at least 3 months from the diagnosis, or complete loss or cessation of motor, cognitive and language development for 12 months in children under 6 years of age.
The diagnosis shall be confirmed by a neurologist and substantiated with typical clinical symptoms and cerebrospinal fluid tests or the results of a brain biopsy.

An Insurance Benefit shall not be paid in the following cases:
– encephalitis caused by bacterial or protozoal infections;
– myalgic or paraneoplastic encephalomyelitis.

10. Severe head injury – an injury that causes severe and permanent damage to the brain.
The suffered person is unable to perform at least 3 out of 6 daily tasks on his own (washing, dressing/undressing, eating, personal hygiene, moving around indoors, getting in and out of bed) for at least 3 months continuously, and there is no sign of improvement.
The diagnosis shall be confirmed by a neurologist or neurosurgeon, substantiated with the results of functional independence and imaging tests (CT scan, MRI).

An Insurance Benefit shall not be paid in the following cases:
– use of alcohol or drugs, psychotropic or other psychoactive substances without a doctor's prescription;
– injury resulting from child abuse or exploitation by a parent, legal guardian or their spouse/ cohabitant.

11. Loss of limbs – the loss of two or more limbs above the wrist or ankle joint as a result of an accident or medically necessary amputation. The diagnosis shall be confirmed by a surgeon or orthopaedic traumatologist.

12. Bacterial meningitis – the diagnosis that causes:
– a permanent neurological deficit[1] that persists for at least 3 months after diagnosing it; or
– in children under the age of 6 years, complete loss or cessation of motor, cognitive and speech skills for 12 months development.
The diagnosis shall be confirmed by a neurologist or an infectologist and be based on the results of a bacteriological examination when growth of pathogenic bacteria is detected in a cerebrospinal fluid sample.

An Insurance Benefit shall not be paid in the following cases:
– aseptic, viral, parasitic or non-infectious meningitis.

13. Severe asthma exacerbation – the diagnosis for which the Insured has been treated in a hospital at least twice in the last 12 months. The condition shall be confirmed by a pulmonary index score of at least 12 or an equivalent value of alternative scores.
The diagnosis shall be confirmed by a pulmonologist and be based on typical clinical signs and laboratory test results.

An Insurance Benefit shall not be paid in the following cases:
- asthma due to gastroesophageal reflux disease (GERD);
- drug-induced asthma;
- asthma as a result of a respiratory infection.

14. Insulin-dependent diabetes mellitus (type I) – a diagnosis characterised by the inability of the pancreas to produce enough insulin, with the need for lifelong use of exogenous insulin.
The diagnosis shall be confirmed by an endocrinologist and supported by typical clinical features and laboratory test results.
The conducted laboratory tests shall demonstrate at least one of the following results:
- pancreatic autoantibodies;
- insulin and C-peptide levels consistent with a diagnosis of type 1 diabetes mellitus.

An Insurance Benefit shall not be paid in the following cases:
- when the Insured suffers from diseases of the exocrine system (e.g. cystic fibrosis, hereditary haemochromatosis or chronic pancreatitis);
- endocrine disorders of glucose regulation (e.g. Cushing's syndrome);
- drug-induced diabetes;
- type II diabetes mellitus.

[1] Neurological deficit
Symptoms of neurological impairment as determined by clinical examination. Symptoms include numbness, hyperaesthesia (hypersensitivity), paralysis, local weakness, dysarthria (impaired speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficult walking, incoordination, tremor, convulsions, lethargy, dementia, delirium and coma.

An Insurance Benefit shall not be paid in the following cases:
- Abnormalities visible on CT or MRI scans or other neuro-visual examinations which are not obviously related to clinical symptoms;
- neurological signs occurring without pathological symptoms, e.g. sudden reflexes without other symptoms;
- symptoms of psychological or psychiatric origin.

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Special Conditions of Insurance against Partial or Total Disability (Loss of Participation) No 027-06

(these conditions shall apply along with the Universal Life Insurance Rules No 027)

1. Insurance object

1.1. The insurance object shall be the financial interests relating to partial or total disability (loss of participation) of the Insured Person due to illness or accident during the period of validity of the insurance cover.

2. Insured person

2.1. The person named in the insurance certificate who, at the time of concluding an insurance contract, is between 18 and 64 years of age and is covered by insurance for the term specified in the insurance contract, but no longer than until age 65 (the particular end date of this insurance cover shall be specified in the insurance certificate).

3. Insured event

3.1. An insured event shall be the disability (loss of participation) of the insured person resulting from pronounced disorders of various bodily functions occurring during the period of validity of the insurance cover. A health condition due to which reduced disability (loss of participation) had already been assessed for the insured person before entry into effect of this cover shall not qualify as an insured event.

3.2. For the purposes of these terms and conditions, the terms “disability” and “loss of participation” shall be used as synonyms.

3.3. **Total disability (loss of participation)** – a health condition due to which an insured person is assessed to have a participation level of up to 30% (inclusive) for a continuous period of at least 12 months.

3.4. **Partial disability (loss of participation)** – a health condition due to which participation level of 31% to 40% (inclusive) has been assessed for the insured person for a continuous period of at least 12 months.

3.5. A decision on declaring the disability (loss of participation) an insured event shall be made by the insurer in accordance with the Criteria and Procedure for Determining the Participation Level in force in the Republic of Lithuania (unless otherwise agreed in the contract) and a certificate issued by a competent authority authorized to determine the level of participation in Lithuania.

4. Non-insured Events

4.1. The following shall be declared non-insured events and an insurance benefit shall not be paid when total or partial disability (loss of participation):

4.1.1. is assessed within the first 6 months (or, where the policyholder is a legal entity providing insurance cover for its employees under a group contract – within the first 3 months) of the effective date of insurance cover in respect of the insured person, as well as when the insurance cover is suspended; **exception:** the restriction in point 4.1.1 shall not apply if:

- this was agreed upon in writing in the insurance contract;
- the risk of disability had been previously insured with the same insurance company (to the same extent of the risk), and the insured person's cover continues without interruption;
- it is established that disability (loss of participation) was caused by an accident which occurred during the insurance cover validity period and was beyond the insured person's control.

4.1.2. it is related to acts of war (whether war has been declared or not) and taking part in a peacekeeping mission, while performing combat tasks during military service, or exposure to nuclear energy or radioactive radiation (other than radiotherapy effects);

4.1.3. resulted from the effects on the insured person of alcohol, drugs or toxic, psychotropic or other psychoactive substances used for the purpose of intoxication, or of potent medications not prescribed by a physician;

4.1.4. occurred when the insured person committed or was preparing to commit a criminal offence, or as a result of another unlawful act;

4.1.5. was caused by the insured person's intentional self-harm or attempted suicide;

4.1.6. resulted from the insured person's involvement in professional sports and/or extreme sports / recreational activities. If the insured person reported such sports at the time of conclusion, or during validity, of the contract and the insurer assessed and accepted this risk, then a special agreement between the insurer and the policyholder regarding the accepted risk shall be noted in the insurance contract;

4.1.7. if the person is HIV-positive or has AIDS (except for reduced participation resulting from events related to the consequences of accidents).

5. Sum insured and insurance benefit

5.1. The sum insured for the insured person shall be specified in the insurance certificate.

5.2. Having declared the insured person's disability an insured event, the following shall be paid:

5.2.1. upon **total disability (loss of participation)** – the sum insured effective on the date of the insured event (the participation level assessment date) and the insurance cover shall cease in respect of such insured person;

5.2.2. upon **partial disability (loss of participation)** – 25% of the sum insured effective on the date of the insured event (the participation level assessment date) and the insurance cover shall continue to apply to such insured person;

5.2.3. upon total disability related to mental disorders, mental or consciousness disorders, as well as nervous system diseases and functional disorders resulting from them, as defined by ICD codes F00–F99 and G00–G99 – a benefit in the amount of 5% of the sum insured shall be paid if a reduction in functional capacity is assessed for a period of 12 months, and, where the same or lower level of functional capacity is assessed repeatedly – the remaining 20% of the sum insured shall be paid.

5.3. If the sum insured has been increased and the insured person's disability (loss of participation) reduces within the first 6 months following the increase in the sum insured, the insurance benefit to be paid shall be equal to the insured person's sum insured effective 6 months before. When the policyholder is a legal person providing insurance for its employees under a group contract and the insured person's disability (loss of participation) reduces within the first 3 months following the increase in the sum insured, the insurance benefit to be paid shall be equal to the insured person's sum insured effective 3 months before, unless otherwise specified in the insurance contract. This clause shall not apply if the reduction in disability (loss of participation) is assessed to have resulted from an accident occurring during the period of validity of the insurance cover and beyond the insured person's control.

6. Procedure for reporting an insured event

6.1. Upon disability (loss of participation) of the insured person, the following must be submitted to the insurer:

6.1.1. a report in the form prescribed by the insurer;

6.1.2. a certificate issued by a competent authority authorized to assess the level of participation in Lithuania;

6.1.3. documents from a healthcare facility regarding the causes, onset and prolonged nature of the disability;

6.1.4. other documents requested by the insurer that are relevant to determining the circumstances of the insured event.

6.2. The insured person or the policyholder must notify the insurer in writing of the disability within 30 days of its assessment.

7. Payment arrangements for insurance benefits

7.1. The insurer shall pay the insured person an insurance benefit upon disability (loss of participation), unless provided otherwise in the insurance contract.

8. Procedure for amending terms and conditions of insurance

8.1. Taking account of amendments to the methodology for assessing the disability (loss of participation) level and to the relevant legal regulations, the insurer shall have the right to amend the definitions and adjust the rates accordingly if amendments regulated by the Government extend the criteria for disability (loss of participation) leading to a change in the risk accepted by the insurer. The insurer may amend unilaterally the terms and conditions of insurance provided that such amendments do not infringe the customer's rights or interests and provided that the insurer notifies the policyholder in writing no later than 30 days in advance of the scheduled date of the amendment to the terms and conditions of insurance.

8.2. If the amendments are unacceptable, the policyholder shall have the right to terminate the insurance contract or withdraw from the selected insurance cover before the date of enactment of the amendments to the terms and conditions.

8.3. The insurer shall have the right to amend the Special Conditions of Insurance against Partial or Total Disability for contracts concluded for 1 (one) year by giving the policyholder written notice no later than 30 days before the date of automatic extension of the insurance contract.

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Pricelist

Applies to insurance agreements concluded from 01 03 2026 according to ERGO Universal Life Insurance Rules No. 027.

Deductibles from capital

Insurance agreement deductibles calculated from the accumulated capital value each month	
Agreement conclusion deductible	24% of periodic insurance premiums set at the time of conclusion of the insurance agreement. Applied in the first, second and third year of insurance.
Administration deductible	EUR 2.80 and 0.025% of the accumulated capital value.
Insurance risk deductibles	Deductible amounts depend on the selected insurance coverages, personal data of the insured persons and valid insurance tariffs.

If the term of the insurance agreement is less than 10 years, the agreement conclusion deductible amount shall be proportionately reduced. If the term of the insurance agreement is less than 3 years, the agreement conclusion deductible shall be deducted monthly during the entire insurance period.

Deductible from single insurance premiums

Premium amount	**Deductible amount**
up to EUR 10 000.00	3%
EUR 10 000.01 to EUR 20 000.00	2%
EUR 20 000.01 to EUR 50 000.00	1%
EUR 50 000.01 and more	0.5%

Deductibles from additional insurance premiums

Not applicable.

Termination fee

The insurance agreement termination fee shall be 2% of the value of the accumulated capital, but not more than EUR 50.00. The termination fee shall be deducted from the accumulated capital value.

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Pricelist of Additional Insurance Agreement Administration Services

Applies to insurance agreements concluded according to Endowment Insurance Rules No 002, Term life Insurance Rules No 003, Studies Insurance Rules No 004, Pension Insurance Rules No 005, Immediate Pension Insurance (Annuity) Rules No 006, Unit-linked Insurance Rules No 013, Unit-linked Insurance Rules No 016, Pension Annuity Agreement Insurance Rules No 017, Unit-linked Insurance Rules No 018, ERGO Universal Life Insurance Rules No 027, Universal Life Insurance Rules No 028.

Amendments to the insurance agreement	EUR 0.00
Change of investment programme/or the structure of accumulated capital	EUR 0.00
Withdrawal of a part of capital*	EUR 30.00

* In case of ERGO Universal Life Insurance (Rules No 027), the minimum sum of accumulated capital, which shall remain after the withdrawal of a part of capital, shall be at least EUR 500. Conditions for the withdrawal of a part of capital in case of other types of insurance, if such a possibility has been provided for, are established in the insurance rules.

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Procedure for the Administration of Investment Life Insurance Contracts

1. General provisions

1.1. The procedure for administration of investment insurance contracts (hereinafter – the Procedure) shall apply applies to all investment insurance contracts.

1.2. The terms used in communication messages, letters and annual reports listed below in alphabetical order are defined in the insurance rules on the basis of which the insurance contract is concluded:

1.2.1. **Administrative deductions** – amounts specified the pricelist and the insurance policy for covering the costs of conclusion and administration of the insurance contract.

1.2.2. **Investment direction** – one of the directions of investment in the policyholder's funds offered by the insurer. The funds indicated in the insurance contract (definitions are provided in the contract rules) are also considered to be the investment direction.

1.2.3. **Investment programme** – investment directions chosen by the policyholder and the distribution of insurance premiums invested in them in respective proportions. For the purposes of the rules, the investment programme may be referred to as an investment plan.

1.2.4. **Investment portfolio** – units of investment directions allocated to the insurance contract

1.2.5. **Investment unit** – nominal unit of accounting for an investment direction that denotes part of the investment direction.

1.2.6. **Investment unit price** – investment fund unit value at a certain time usually announced by the fund manager. The fund manager's website address is provided in the description of each investment direction distributed by ERGO on the website of ERGO at www.ergo.lt (in the "Investment Funds" section).

1.2.7. **Operation** – actions of the insurer necessary for the administration of an investment insurance contract.

1.2.8. **Last available price** – investment unit price of the operation day, and if the price for that day is not determined, the last known investment unit price.

1.2.9. **Risk deduction** – amount payable for the insurance cover specified in the insurance policy which depends on the sum insured and is calculated according to the Table of risk deduction tariffs. The Table of risk deduction tariffs applicable to the insurance contract is provided in the insurance policy.

1.2.10. **Price of the calculation day** – investment unit price used to perform the operation according to the table below. If the price of the day necessary for the calculation is not specified, the last available price of the investment unit is used.

1.2.11. **Accumulated capital value** – sum of values of investment units for the insurance contract calculated as the product of the number of investment units and of their price.

1.2.12. **Amount payable for restoration of the contract** – the amount of an additional premium in order for the contract value to be sufficient for deductions before the insurance cover suspension month and the contract deduction due for 3 months.

2. Operation performance procedure:

Abbreviations T^d – working day, T^k – calendar day

Operation	Operation date	Investment unit price	Administration actions
2.1. **Investment of premium received**			
2.1.1. Investment of received periodic / one-off premium	Day of crediting premium to the insurer's account T^k	T^d+2	T^d +2 Sum of investment units shown in the contract.
2.1.2. Investment of received additional premium			
2.2. **Change of investment structure:**			
2.2.1. New programme of investment of insurance premiums (investment plan)	Day of receipt of application of established form self-service: T^k other channels: T^d	T^d+2	Change made within 7 working days of T^d. Contract is not sent to the customer (carried out on the basis of request).
2.2.2. New structure of accumulated capital			
2.3. **Amendment to the contract:**			
2.3.1. Increase or decrease of cover, change in insurance risk Change of a policyholder or beneficiary Change of payment frequency, premium, insurance period	Day of receipt of application of established form self-service: T^k other channels: T^d	-	Approval submitted to the customer not later than within 30 calendar days after receipt of the request.
2.3.2. Change to insurance without premiums (suspension of premiums)	Day of receipt of application of established form self-service: T^k other channels: T^d	-	Change is made from the nearest due date of outstanding periodic payment. Additional insurances remain valid if the accumulated value is sufficient for administration and risk deductions or upon payment of the established premium. On request of the policyholder, all additional insurances may be terminated, leaving for the principal insured person life insurance sum insured of EUR 1 (minimum). Confirmation to the customer is provided not later than within 30 calendar days of receipt of the request.
2.3.3. restoring payment of premiums (for contracts concluded from 01 09 2025)	Day of receipt of application of established form self-service: T^k other channels: T^d	T^d+2	Change is introduced from the periodic payment day requested by the customer. Confirmation to the customer is provided not later than within 30 calendar days of receipt of the request.

Operation	Operation date	Investment unit price	Administration actions
2.4. **Restoration of cover**			
2.4.1. Payment of premium under the contract with suspended cover due to the non-payment of the contribution (applicable to contracts the concluded before 01 09 2025)	Day T^k of crediting premium to the insurer's account – when premium paid covers all overdue premiums on due date	T^d+2	Cover is restored on the next day after payment of premium, 00 hr
	Day T^k of crediting premium to the insurer's account – when premium paid does not cover all overdue premiums on due date	T^d+2	Cover is not restored (notice of additional debt and suspension is not sent)
2.4.2. Payment of premium under the contract with suspended cover due to accumulated capital value insufficient for covering administration deductions and risk deductions (applicable to contracts the concluded before 01 09 2025)	Day T^k of crediting premium to the insurer's account – when premium paid is sufficient for deductions (see 1.2.12)	T^d+2	Cover is restored on the next day after payment of premium, 00 hr
	Day T^k of crediting premium to the insurer's account – when contract value after payment is insufficient for deductions (see 1.2.12)	T^d+2	Cover is not restored (notice of additional debt and suspension is not sent)
2.5. **Payment**			
2.5.1. Contract amendment due to payment of part of the capital	Day of receipt of application of established form: self-service: T^k other channels: T^d	T^d+2	Change is made on T^d+2, but not later than within 8 business days. The amount to be paid out is reduced by the fee for withdrawal of a part of capital (according to Additional services pricelist).
2.5.2. Contract expiry upon death of the principal insured person	Day of receipt of death notification: self-service: T^k other channels: T^d	T^d	Accumulated capital value before death notification date is registered (but not later than within 5 business days of the day of receipt of death notification date).
2.5.3. žContract expiry	Last day of insurance period T^k / T^d	Insurance period expiry day T^k or T^d	Not later than within 7 working days of / and not later than within 7 working days after submission of the beneficiary's written request for payment of benefit. Letter confirming the benefit is issued to the beneficiary.
2.5.4. žContract termination within 30 calendar days' period from conclusion (applicable when a policyholder is a natural person)	Day of receipt of application of established form: self-service: T^k other channels: T^d	T^d+2	Termination is carried out not later than within 8 working days. The insurer shall refund: 1. Insurance premium paid during insurance contract period recalculated according to investment result – when contract is concluded according to Universal Life Insurance Rules No 027 (wording of 01 09 2025) 2. Insurance premium paid during insurance contract period – according to conditions of rules applicable to investment contract.

Operation	Operation date	Investment unit price	Administration actions
2.5.5. Contract termination by policyholder's request	Day of receipt of application of established form: self-service: T^k other channels: T^d	T^d+2	Cover is terminated on the day the application is received. Termination is carried out not later than within 8 working days. The amount due is reduced by the PIT (if tax relief was used) and termination fee. Letter confirming termination is provided to the policyholder.
2.6. **Deduction of fees**			
Administration deductions: – contract conclusion deduction – administration deduction (if covers were chosen)	Last day of the month / T^d or the first day of each month T^k / T^d (according to conditions of applicable rules)	T^d+2	T^d+1 sale of investment units (proportionally according to insurance directions chosen) for the amount required for deductions of the current month (or next month if so provided in conditions of the rules applicable to the contract).

2.7. If the operation is related to several investment directions, it actually may only be performed after the price of investment units of all investment directions is known, but, in any case, prices of investment units shall be determined according to the procedure specified in the contract.

2.8. If the policyholder submits several requests, the application submitted later shall be carried out only after having finished the operations of the previous request, in which case the contract reflects the data of the insurer. If the operations may be carried out at a time, all changes made shall be reflected in the contract.

2.9. Upon payment of the premium by the policyholder / payer when the insurance contract number is not indicated in the payment order, the contract, for which the payment has been made cannot be objectively determined, the premium investment term shall be calculated from the day when the policyholder provides the explanatory information.

2.10. The insurer shall apply "T+2" model for calculating and announcing the units of investment directions, i.e. the price of the investment unit shall be calculated every working day and announced until the end of the next working day. Please note that the non-working days affect the announcement of prices and, also, the circumstances that do not dependent upon the insurer, due to which the unit prices of the investment direction will be calculated and announced later, may occur.

2.11. After the operation date, the policyholder may not change or cancel the operation.

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VAT registration number LT107071314
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Key information document

Purpose

This document provides you with key information about this investment product. It is not marketing material. The information is required by law to help you understand the nature, risks, costs, potential gains and losses of this product and to help you compare it with other products.

Product

Product	ERGO Universal Life Insurance
Manufacturer	ERGO Life Insurance SE (hereinafter ERGO), which is part of the international ERGO Group.
Additional information	www.ergo.lt. For more information, please call 1887 (or +370 5 2683222).
Supervisory authority	The Bank of Lithuania is responsible for supervising ERGO in relation to this Key Information Document.
Publication date	01 06 2026

You are about to purchase a product that is not simple and may be difficult to understand.

What is this product?

Type: Unit-linked life insurance.

Term: You have the flexibility to choose the duration of the insurance contract, with a minimum term of one year. You can terminate the insurance contract at any time, by notifying us 30 days in advance. ERGO has the right to unilaterally terminate the insurance contract in the cases stipulated by the law or terms and conditions, by notifying you in advance.

Objectives: This product can be used for capital accumulation and insurance of life and/or other insurance risks. It provides you with the flexibility to choose from a range of investment options. The growth of your capital is tied to the performance of investment fund units within the selected investment directions or investment program. You are bearing investment risk which means that the accumulated capital may increase or decrease. The product promotes environmental or social characteristics, without having as its objective a sustainable investment.

You have the flexibility to determine both the investment amount and desired insurance coverage. You can invest through regular payments at your preferred frequency or make a one-time payment. Additional payments can be made at any time. You can either choose from our pre-defined investment programs or create a custom program by selecting one or more investment directions from the offer list. You can modify your choice later. The underlying investment objects (investment funds) of the investment directions are managed by external professional fund managers. For clarity, ERGO is responsible for choosing underlying funds that align with the investment direction objectives and adhere to established fund selection criteria. Further details about management of investment directions are available on our website.

Intended retail investor: This product is designed for various types of investors, catering to individual needs, goals and risk tolerances. It requires at least basic knowledge about insurance products and financial markets. Whether you're an experienced or novice investor, seeking long-term capital growth and the flexibility to choose from diverse investment options, this product provides the balance between life insurance coverage and the opportunity to enhance savings over time. Investors should be able to bear the investment risk associated with the underlying assets. **Insurance benefits and costs: the size of the insurance benefit** in the event of the death of the insured person depends on the chosen insurance option: either the larger of the two amounts (life insurance amount or accumulated capital value) or both can be paid. If the insured person is alive at the end of the insurance policy term, the accumulated capital value at that time is paid out. You can select any life insurance amount according to your preference and can optionally include in the contract additional protections of life insurance, disability insurance, accident insurance, or cancer and critical illness insurance (details of the corresponding benefits are outlined in the insurance rules).

The cost of the insurance protection is deducted from the accumulated capital value and is detailed in the offer and policy. An illustrative example for a retail investor aged 35 with a 20-year holding period, who selected the life insurance protection in the amount of 10 000 euros, is provided in the “What are the costs?” section. In this example, the cost of the insurance protections is included in the total costs. The calculations are performed for the insurance option, according to which in the event of the insured person's death, the larger of the two amounts (life insurance amount or the accumulated capital value) is paid out. In the provided example, the impact of the insured’s death risk costs on the investment return at the end of the recommended holding period amounts to between 0,09% and 0,10% per year (with regular contributions) and 0,00% per year (with a single contribution).

What are the risks and what could I get in return?

Risk Indicator



The risk indicator assumes you keep the product for 20 years. The actual risk can vary significantly if you cash in at an early stage and you may get back less. You may have to pay significant extra costs to cash in early.

The summary risk indicator is a guide to the level of risk of this product compared to other products. It shows how likely it is that the product will lose money because of movements in the markets or because we are not able to pay you.

We have classified this product into risk classes 3 to 4, where 1 = the lowest, 2 = a low, 3 = a medium-low, 4 = a medium, 5 = a medium-high, 6 = the second-highest, 7 = the highest risk class. The risk depends on the chosen investment program and investment directions.

This product does not include any protection from future market performance so you could lose some or all of your investment.

Performance scenarios

In this product, you have the opportunity to choose between various investment options. Investments are allocated to the investment directions you choose, and therefore, performance scenarios cannot be provided in this general key information document. Instead, you can find them in the separate key information document for each respective investment direction or investment program. The contract's performance depends on the returns of the chosen investment directions, and the fluctuations in their unit prices will impact the value of your contract. Information on past performance is available at www.ergo.lt. In the event of death, the designated person will receive a payout of 100% of the accumulated reserve value, in addition to the benefit for the death insurance coverage, if selected.

What happens if ERGO Life Insurance SE is unable to pay out?

ERGO has separated the assets of unit-linked life insurance contracts and manages them separately from other assets. There is no national investment compensation or guarantee scheme to cover potential losses. In the event that ERGO cannot make payments (for example, if the funds become insolvent), you may partially or completely lose the capital invested in the product.

What are the costs?

Costs over time

The tables show the amounts that are taken from your investment to cover different types of costs. These amounts depend on how much you invest, how long you hold the product. The amounts shown here are illustrations based on an example investment amount and different possible investment periods.

We have assumed:

In the first year you would get back the amount that you invested (0% annual return). For the other holding periods we have assumed the product performs as shown in the moderate scenario

	Regular premium 1 000 EUR per year			Single premium 10 000 EUR		
	If you exit after 1 year	If you exit after 10 years	If you exit after 20 years	If you exit after 1 year	If you exit after 10 years	If you exit after 20 years
Total costs	310–320 EUR	1450–1920 EUR	2530–4780 EUR	420–520 EUR	1200–2450 EUR	2210–6230 EUR
Annual cost impact*	31,15–32,17%	2,97–4,03%	1,27–2,31%	4,20–5,22%	1,01–2,04%	0,75–1,78%

* This illustrates how costs reduce your return each year over the holding period. For example, it shows that if you exit at the recommended holding period your average return per year is projected to be:

	Regular premium	Single premium
% before costs and	1,79–11,64%	1,79–11,70%
% after costs	0,72–9,24%	1,04–9,92%

Composition of costs

		Regular premium	Single premium
One-off costs upon entry or exit		Annual cost impact if you exit after 20 years	Annual cost impact if you exit after 20 years
Entry costs	It includes a deduction for the conclusion of the contract, which is 24% off the regular insurance premiums in the first, second, and third years of insurance. A one-time payment is subject to a 3% deduction.	0,39–0,58%	0,16–0,18%
Exit costs	Exit costs are stated as 'Not applicable' in the next column as they do not apply if you keep the product until the recommended holding period.	Not applicable	Not applicable

		Regular premium	Single premium
Ongoing costs taken each year			
Management fees and other administrative or operating costs	This is an estimate based on actual costs over the last year. Includes administration deduction, insurance risk deduction and fund ongoing fees.	1,27–2,31%	0,75–1,78%
Transaction costs	This is an estimate of the costs incurred when we buy and sell the underlying investments for the product.	0,00%	0,00%
Incidental costs taken under specific conditions			
Performance fees	There is no performance fee for this product	0,00%	0,00%

How long should I hold it and can I take money out early?

Recommended holding period: 20 years

The product does not have the minimum required holding period, but it is designed primarily for long-term investment emphasizing the capital accumulation, particularly during the working age, such as for pension or children's needs. The recommended holding period for the product is 20 years. However, the actual investment duration can vary for each client, influenced by factors like age, savings goals and risk tolerance. You have the flexibility to terminate the contract or make partial withdrawals at any time, subject to service charges outlined in the price list. Nevertheless, it is advisable to maintain the insurance contract until the conclusion of the term, when the value of the accumulated capital is paid out. Early termination may lead to additional losses due to fluctuations in unit values.

How can I complain?

If you have complaints about the quality of services or the behavior of the employee who served you, first contact 1887 (or +370 5 2683222). If this step did not help in solving your problem, please submit a written complaint. Send it to the registered office address or by e-mail info@ergo.lt. You can find the detailed procedure for examining claims on our website at www.ergo.lt. If the above-mentioned actions did not help resolve your issue, you may submit a complaint to the Bank of Lithuania. More information is available at www.lb.lt.

Other relevant information

You can find more information about the product and relevant documents, such as insurance terms and conditions, the price list, sustainability-related disclosures, as well as information about the product's historical performance and further details about the investment programs, investment directions and underlying investment objects (funds) offered within this product, on our website at www.ergo.lt.

List of investment options available in this product:

Investment Option	The Key Information Document is available here:
Investment Programs	
Moderate 25	https://ergo.lt/PID-Programa-Nuosaiki-25
Balanced 50	https://ergo.lt/PID-Programa-Subalansuota-50
Growth 75	https://ergo.lt/PID-Programa-Augimo-75
Active 100	https://ergo.lt/PID-Programa-Aktyvi-100
Investment Directions	
Short-term Bonds	https://ergo.lt/PID-Trumpalaikes-investicijos
Bonds	https://ergo.lt/PID-Obligacijos
Global Equity Index	https://ergo.lt/PID-Pasaulio-akciju-indeksas
US Equity Index	https://ergo.lt/PID-JAV-akciju-indeksas
Europe Equity Index	https://ergo.lt/PID-Europos-akciju-indeksas
Japan Equity Index	https://ergo.lt/PID-Japonijos-akciju-indeksas
Global ESG Equity Index	https://ergo.lt/PID-Pasaulio-ASV-akciju-indeksas
Global Emerging Markets Equity	https://ergo.lt/PID-Pasaulio-besivystanciu-rinku-akcijos
Europe Emerging Markets Equity	https://ergo.lt/PID-Europos-besivystanciu-rinku-akcijos
Global Equity	https://ergo.lt/PID-Pasaulio-akcijos
Europe Equity	https://ergo.lt/PID-Europos-akcijos
US Equity	https://ergo.lt/PID-JAV-akcijos
Asia Equity	https://ergo.lt/PID-Azijos-akcijos
Gold	https://ergo.lt/PID-Auksas

What should I do in case of an insured event?

Report the event (not later than within 30 days):

- by logging in to the authorized ERGO self-service portal **mano.ergo.lt** or
- by calling ERGO insurance phone number **1887** (or +370 5 2683222 when calling from abroad).

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