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ERGO Life Insurance SE

Universal Life Insurance Rules No 028



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Pre-contractual information for a policyholder entering into an insurance agreement in accordance with ERGO's Universal Life Insurance Rules No 028

Purpose of insurance

This insurance is designated for individuals or families seeking for financial protection in the event of an accident, who want to insure their own life and life of their loved ones, and/or to receive benefits in case of death, illness or accidents. It is an insurance product the premiums of which are not intended for investment or accumulation.

Having concluded an insurance agreement, the insurance company undertakes to pay an insurance benefit upon occurrence of an insured event to the persons specified in the agreement, and the policyholder undertakes to pay insurance premiums on time.

Insurer

ERGO Life Insurance SE, Lvivo str. 37, LT-09307 Vilnius, Lithuania. Registration number 110707135.

Policyholder and the Insured

The policyholder may be an adult natural person or a legal entity who concludes an insurance agreement with the Insurer. One insurance agreement can also be used to insure several persons.

The age of the Insured persons at the beginning of the insurance:

- 0 to 74 years – for life insurance;
- 2 to 17 years – for children's cancer and other critical illness insurance;
- 18 to 64 years – for adult cancer and other critical illness insurance;
- 0 to 69 years – for accident insurance;
- 18 to 64 years – for partial or total disability (loss of participation) insurance.

Having insured a natural person of full age against cancer, his minor children and adopted children shall be co-insured until they reach 18.

Concluding an insurance agreement

In order to conclude an insurance agreement, you need to submit an application form to the Insurer and complete the requested health questionnaires. Your submitted application and health questionnaires, together with the applicable insurance rules, shall become an integral part of the insurance agreement.

Submission of an application and payment of a premium does not oblige the Insurer to conclude an insurance agreement. Having assessed the insurance risk, the Insurer may propose the conditions whereon an insurance agreement may be concluded or refuse to conclude an insurance agreement. The main factors that affect the insurance risk include: professional and occupational activities, leisure interests and health condition.

If the Insurer agrees to conclude an insurance agreement, the policyholder shall be issued an insurance certificate confirming the conclusion of the agreement. The date of issue of an insurance certificate shall be the date of conclusion of the insurance agreement.

Having concluded an insurance agreement, a commission shall be paid to the insurance service distributor as a component of the insurance premium, and an additional remuneration dependent on performance may be paid, without prejudice to the requirements laid down in the Law on Insurance.

The customer shall be provided with the necessary consultations, however, no recommendation shall be given as defined in the Law on Insurance of the Republic of Lithuania.

Sums insured

The minimum Sum Insured for life insurance shall be EUR 3000. The minimum Sum Insured for cancer, critical illness and partial or total disability (loss of participation) insurance shall be EUR 10 000. The Insurer may set other minimum and/or maximum amounts of the Sum Insured.

The amounts of the Sums Insured of accident insurance shall be chosen according to insurance coverages included by the policyholder. The Insurer may set the amounts of the minimum and/or maximum Sum Insured.

The policyholder shall specify the desired Sums Insured in the application form, while insurance coverages agreed upon between the parties shall be indicated in the insurance certificate.

Insured events

An insured event is an occurrence specified in the insurance agreement, upon the occurrence of which the Insurer shall pay an Insurance Benefit.

Descriptions of insured events and the conditions for paying Insurance Benefits are set out in the Special Insurance Conditions of ERGO Universal Life Insurance Regulations No 028.

A life insurance insured event is the death of the Insured during the insurance coverage validity period. A life insurance benefit shall not be paid in the following cases: suicide of the Insured during the first 3 years of insurance coverage; death of the Insured related to military actions or nuclear energy exposure, criminal acts of the Insured. Detailed information on insured and non-insured events is presented in the Special Life Insurance Conditions No 028-02.

An insured event for cancer insurance is the Insured contracting cancer:

- Non-invasive/early-stage cancer means a cancer the diagnosis of which was confirmed histologically and which is characterised by malignant cell growth at the primary site of the tumour, which does not impair the base membrane and does not spread to other tissues;
- Invasive skin cancer (other than melanoma in situ);
- Invasive cancer characterised by uncontrolled growth and spread of malignant cells into tissues, blood, blood-forming organs and the lymphatic system, including malignant lymphoma, malignant bone marrow disorders, leukaemia, malignant advanced melanoma, Hodgkin's disease and myelodysplastic syndrome.

The critical illness insurance insured event is a critical illness of the Insured, which corresponds to the list of critical illnesses and the criteria for diagnosing critical illnesses specified in the insurance conditions. The insured children shall be subject to the list of 14 critical illnesses, while adults may choose from the list of 1, 4 or 39 critical illnesses. An Insurance Benefit shall not be paid if the Insured has been diagnosed with a critical illness within the first 3 months of insurance or the Insured dies as a result of the critical illness within 30 days of its diagnosis. An Insurance Benefit shall not be paid if the Insured has been diagnosed with cancer within the first 6 (or, in case of group insurance for employees, – within the first 3) months of insurance. Detailed information on insured and non-insured events is provided in the Special Cancer Insurance Conditions No 028-01, the Special Conditions of Cancer and Other Critical Illness Insurance of Adults No 028-04 and the Special Conditions of Cancer and Other Critical Illness Insurance of Children No 028-05.

The optional insured events for accident insurance are accidental death of the Insured, disability, injuries, daily allowances, sickness allowances and additional assistance insurance risks. An Insurance Benefit shall not be paid if an accident is related to acts of war or exposure to nuclear energy, criminal activities of the Insured, the use of alcohol, drugs or other psychoactive substances, etc. Detailed information on insured and non-insured events is provided in the Special Accident Insurance Conditions No 028-03.

The insured event of partial or total disability (loss of participation) insurance is the disability (loss of participation) of the insured person resulting from pronounced disorders of various bodily functions occurring during the validity period of insurance coverage. Total disability means a condition whereby the insured person has been assigned a participation level of up to 30% (inclusive) for a continuous period of at least 12 months. Partial Disability means a condition whereby the insured person has been assigned a participation level of 31% to 40% (inclusive) for a continuous period of at least 12 months. An Insurance Benefit shall not be paid if the disability (loss of participation) is related to acts of war or exposure to nuclear energy, criminal acts of the Insured, use of alcohol, drugs or other psychoactive substances, etc. Detailed information on insured and non-insured events is provided in the Special Conditions of Insurance against Partial or Total Disability (Loss of Participation) No 028-06.

Possible terms of the insurance agreement

The minimum insurance term shall be 5 years (in case of group insurance – 1 year). The Insurer may set another minimum term. The duration of the insurance agreement is indicated in the Insurance Certificate.

Amending the insurance agreement

You may change the terms and conditions of the insurance agreement in accordance with the procedure set out in the Insurance Rules, including the amount of the Sum Insured, the beneficiary, the periodicity of the payment of premiums, etc. The Policyholder and/or the Insured shall notify an increase in the insured risk when the nature of the work has changed in the Insured's life or activity, or upon a change of any other circumstance indicated in the Policyholder's application or health declaration.

Upon the Insurer's consent, an insurance agreement may be supplemented with insurance coverages in accordance with the Special Insurance Conditions of the Insurance Rules No 028.

Withdrawal and early termination of the insurance agreement

The Policyholder, who is a natural person, shall have the right to withdraw from a life insurance agreement within 30 days from the moment of being notified of the conclusion of the insurance agreement. In such a case, the Insurer shall refund the premium paid in full (preferential termination under Article 124 of the Law on Insurance). In order to withdraw from the insurance agreement, the Policyholder shall provide the Insurer with a completed sample agreement withdrawal form or a clear statement of his decision to withdraw from the insurance agreement. A completed withdrawal form or a statement shall be submitted by e-mail to info@ergo.lt, on ERGO's self-service portal at https://mano.ergo.lt/lt/prisijungti or at Lvivo str. 37, LT-09307 Vilnius, Lithuania. The withdrawal from the insurance agreement shall be executed in accordance with applicable legislation of the Republic of Lithuania.

You shall have the right to terminate the insurance agreement by giving written notice to the Insurer in accordance with the procedure set out in the Insurance Rules and the applicable legislation of the Republic of Lithuania.

Once you terminate the insurance agreement (except on the grounds provided for in Article 124 of the Law on Insurance), the insurance premiums paid shall be refunded for the unused period of insurance coverage. If you violate material terms and conditions of the agreement, the Insurer shall have the right to terminate the insurance agreement by refunding a part of the insurance premium for the unused insurance coverage period.

Methods, procedure and duration of payment of insurance premiums

When concluding an insurance agreement, you choose the frequency of payment of premiums. The insurance premium amounts and method of payment (annual, semi-annual, quarterly or monthly) shall be specified in the insurance certificate.

The insurance agreement shall enter into force and insurance cover shall apply only after the insurer has received the first insurance premium and not earlier than on the insurance commencement date specified in the agreement. If the first premium is paid late, insurance cover shall become effective from the calendar day following the receipt of the premium.

If a periodic premium is not paid and the outstanding amount is not settled within 30 days from the date the insurer sends a notice, the insurance cover may be suspended. No insurance benefit shall be payable for insured events occurring during the suspension period (and, in the case of Critical Illness Insurance, also for events occurring during the 3-month period following the reinstatement of cover in the cases specified in the Rules).

If the suspension of insurance cover continues for more than 6 months, the insurance agreement may be terminated unilaterally.

The detailed procedure for the payment of insurance premiums and the consequences of late or missed payments are set out in the section "Entry into force of the Insurance Agreement and Procedure of Payment of Premiums" of ERGO Universal Life Insurance Rules No 028.

Procedure for setting the amount of insurance benefits and the procedure and methods of payment of insurance benefits

The Insurer shall pay insurance benefits within 30 days from the date of receipt of all information relevant for determining the fact, circumstances, consequences of the insured event and the benefit amount. In case of death of the Insured, benefits shall be paid to the heirs of the Insured in accordance with the Civil Code, unless the insurance agreement lists the beneficiaries. Other insurance benefits shall be paid to the suffered Insured.

In case of life insurance, if the Insured dies as a result of an insured event, an insurance benefit equal to the life insurance Sum Insured shall be paid. In case of cancer insurance, when the contraction of cancer of the Insured is confirmed to be an insured event, the cancer insurance Sum Insured or a part thereof, depending on the diagnosed illness, shall be paid.

In case of critical illness insurance, if the critical illness of the Insured is confirmed to be an insured event, the critical illness Sum Insured shall be paid.

In case of a trauma or other accidents, having confirmed an insured event, the Sum Insured of this insurance or a part thereof depending on the injury sustained shall be paid.

In the event of Total disability (loss of participation), if the insured person's loss of working capacity is confirmed to be an insured event, the Sum Insured under this insurance shall be paid, and in the event of Partial disability (loss of participation), the corresponding part of the Sum Insured shall be paid.

Detailed information on insurance benefit amounts and their payment procedure is available in the special insurance conditions of the Insurance Rules.

Taxing procedure

Benefits under this life insurance agreement shall be paid upon occurrence of an insured event (death, health impairment or illness) only, thus insurance premiums paid by a permanent resident of Lithuania are not deductible from income in accordance with the Law on Personal Income Tax. Insurance benefits paid in case of an insured event are tax-free.

A more detailed explanation of the taxing procedure applicable to life insurance agreements is available on the website of the State Tax Inspectorate www.vmi.lt.

Law applicable to the insurance agreement and dispute settlement

The insurance agreement is governed by the laws of the Republic of Lithuania.
All information related to the Insurance Agreement shall be provided in the official language (Lithuanian).

If you believe that your rights or legitimate interests have been infringed, please submit a written complaint to us no later than 3 (three) months from the date on which you became aware or ought to have become aware of the alleged infringement. The complaint form must be completed, signed and submitted by e-mail to kokybe@ergo.lt or via the customer self-service portal ERGO's self-service portal at https://mano.ergo.lt/lt/prisijungti.

The procedure for handling complaints by ERGO is available on the Company's website.

Disputes arising out of the insurance agreement shall be settled by court in accordance with laws of the Republic of Lithuania, or, in an out-of-court procedure, – by the Bank of Lithuania in accordance with the procedure laid down in the Law on the Bank of Lithuania of the Republic of Lithuania. Resolution No 03-23 of the Bank of Lithuania of 26 January 2012 available online at http://www.lb.lt/gincu_nagrinejimas lays down the out-of-court procedure for settling disputes between the Insurer and the consumer.

All the insurance provisions are available in the Insurance Rules. The Insurance Rules and the report on the Insurer's solvency and the financial condition is available online at www.ergo.lt.

The pricelist of additional services of administration of the insurance agreement applicable by the Insurer is available online at www.ergo.lt.

In case of an event, you can register a claim on ERGO's self-service portal at https://mano.ergo.lt/lt/prisijungti. For consultations regarding the Insurance Agreement or in the event of a claim, please contact ERGO Insurance by phone 1887.

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

Valid from 18 11 2019

Universal Life Insurance Rules No 028

1. General definitions

1.1. **Insurer** shall mean ERGO Life Insurance SE.

1.2. **Policyholder** shall mean an adult natural or legal person, who has either applied to the Insurer for concluding an insurance agreement, or whom the Insurer has offered to conclude an insurance agreement, or who concluded an insurance agreement with the Insurer.

1.3. **Insured** shall mean the natural or legal person indicated in the insurance agreement, who is a part of the group of persons referred to in the insurance agreement, upon an occurrence of an insured event in the life of whom the Insurer shall pay an insurance benefit.

1.4. **Beneficiary** shall mean the person indicated in the insurance agreement entitled to receive an insurance benefit.

1.5. **Insurance Agreement** shall mean an agreement concluded between the Insurer and the Policyholder. By an Insurance Agreement, the Insurer undertakes to pay to the Policyholder or a third party, for the benefit of whom the Insurance Agreement was concluded, an insurance benefit calculated in accordance with the procedure established in the Agreement upon the occurrence of an insured event specified in the Insurance Agreement for the insurance premium indicated in the Insurance Agreement. The Insurance Agreement shall comprise these insurance rules, special insurance conditions, insurance certificate and other documents, if presented or issued.

1.6. **Insurance Rules** shall mean these standard insurance agreement conditions prepared by the Insurer, which are an integral part thereof.

1.7. **Insurance Certificate** shall mean a printed or electronic document (at the Policyholder's choice) issued by the Insurer, which confirms the conclusion of the Insurance Agreement.

1.8. **Insurance Premium** shall mean the amount of money specified in the Insurance Agreement, which the Policyholder shall pay to the Insurer for insurance coverage in accordance with the conditions laid down in the Insurance Agreement.

1.9. **Insurance Coverage** shall mean the Insurer's obligation to pay an insurance benefit in case of an insured event.

1.10. **Insurance Agreement Period** shall mean the period specified in the Insurance Certificate. When the Policyholder duly discharges its obligation to pay an Insurance Premium, the Insurance Agreement Period shall be the same as the Insurance Coverage period, unless otherwise agreed in the Insurance Agreement.

1.11. **Insurance Year** shall mean an insurance period, which starts on the date of commencement of the Insurance Coverage and lasts 12 months, but not longer than the expiry of Insurance Coverage.

1.12. **Application for Concluding an Insurance Agreement** shall mean a document of the form established by the Insurer completed by the Policyholder or information provided by the Policyholder (who is a legal person) to the Insurer about the Insured in another form, also facts and circumstances necessary to assess the insurance risk of the Insured.

1.13. **Sum Insured** shall mean the amount of money specified in the Insurance Agreement or calculated in accordance with the procedure established in the Insurance Agreement, which an insurance benefit may not exceed, unless otherwise agreed in the Insurance Agreement.

1.14. **Insured Event** shall mean an event specified in the Insurance Agreement, upon the occurrence of which the Insurer shall pay an insurance benefit.

1.15. **Insurance Benefit** shall mean the amount of money which the Insurer shall pay to the Policyholder or another person in case of an Insured Event.

1.16. **Insurance Risk** shall mean a likely danger threatening the object of insurance.

1.17. **Non-Insured Event** shall mean an event provided for in the Insurance Agreement upon the presence or the occurrence of which the Insurer shall not pay an Insurance Benefit.

1.18. **Special Insurance Conditions** shall mean conditions of the Insurance Agreement specially applicable to each product of the Insurer.

1.19. **Pricelist of Additional Insurance Agreement Administration Services** shall mean agreement administration (amendment, issue of a duplicate and other services) fees set by the Insurer available on the website www.ergo.lt. The Insurer shall notify of any amendments to the Pricelist in accordance with the procedure established by laws.

1.20. **Sports Activities** shall mean 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.

1.21. **Professional Sports** shall mean the Insured'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.

1.22. **Extreme Sport/Leisure** shall mean 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:

a) 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. Exceptions shall include 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;

b) 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, waterboarding, windsurfing and surfing, jet skiing, power kiting. Exceptions shall include 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;

c) snow kite skiing, ski jumping or snowboard jumping, off-piste skiing, helicopter or paragliding skiing. Exceptions shall include leisure cross-country skiing, in specially adapted downhill and other designated trails;

d) 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. Exceptions shall include leisure jogging, except for trainings held in extreme conditions and areas;

e) martial arts and contact sports such as boxing, wrestling, karate, judo, fencing, etc. Exceptions shall include children under the age of 14, who practice these sports activities.

2. Concluding an Insurance Agreement

2.1. In order to conclude an Insurance Agreement, the Policyholder shall submit to the Insurer an Application for Concluding an Insurance Agreement. The persons insured shall complete questionnaires in the form set by the Insurer, if the Insurer so requests.

2.2. Submission of an Application for Concluding an Insurance Agreement and the payment of an Insurance Premium shall not oblige the Insurer to conclude an Insurance Agreement. An Application for Concluding an Insurance Agreement shall expire if the Insurer does not issue an Insurance Certificate certifying the conclusion of an Insurance Agreement within 3 months from its submission.

2.3. An Insurance Agreement may be concluded in a direct meeting or by means of distance communication.

2.4. An Insurance Certificate issued by the Insurer shall confirm the conclusion of an Insurance Agreement. The date indicated in the Insurance Certificate shall be considered to be the date of conclusion of the Insurance Agreement. The Insurance Certificate shall list conditions of the Insurance Agreement, including the insurance period, the object of insurance and insurance coverages, sums insured of the Insured and other important information.

2.5. The Insurance Agreement shall consist of the following documents:

2.5.1. an Application for Concluding an Insurance Agreement;

2.5.2. questionnaires of the Insured;

2.5.3. an Insurance Certificate and annexes thereto;

2.5.4. the Universal Life Insurance Rules and the Special Insurance Conditions;

2.5.5. other documents provided by the Policyholder that affect the conclusion, amendments and execution of the Insurance Agreement.

2.6. Automatic extension of the Insurance Agreement:

2.6.1. before concluding an Insurance Agreement for one year, the Insurer and the Policyholder may agree on an automatic extension of the Insurance Agreement for the following year, with the parties individually agreeing in writing on the terms of the extension, which shall become an integral part of the Agreement;

2.6.2. the Insurer and the Policyholder shall have the right to refuse automatic extension of the Insurance Agreement for the following insurance year by notifying the other party thereof in writing not later than one month before the expiry of the Insurance Agreement;

2.6.3. if the Policyholder does not accept the conditions of the automatically extended Insurance Agreement, the new automatically extended Insurance Agreement shall be subject to the conditions laid down in clause 3.2 hereof, if an Insurance Premium was not been and the Insurer was not informed about refusing to extend the Insurance Agreement for the following year.

3. Entry into force of the Insurance Agreement and procedure of payment of Insurance Premiums

3.1. Insurance Premium amounts and the method of payment (lump sum or periodic instalments) shall be indicated in the Insurance Certificate. The Policyholder shall pay Insurance Premiums in the agreed manner, at the time specified in the Insurance Agreement, by indicating in the payment order the number of the Insurance Certificate for which the payment is made. The date of crediting an Insurance Premium to the Insurer's bank account shall be considered the date of payment of the Insurance Premium. Other persons may also pay an Insurance Premium for the Policyholder, without acquiring any rights to the Insurance Agreement and the Premiums paid.

3.2. In all cases the entry into force of the Insurance Agreement shall be associated with the payment of the full or a partial Insurance Premium amount, i.e. the Insurance Agreement shall enter into force only after the full or the first Insurance Premium was paid, regardless of whether the Insurance Agreement stipulates that the full or the first Insurance Premium must be paid on the day of concluding the Insurance Agreement, or the Agreement provides for a later deadline for paying the full or the first Insurance Premium:

3.2.1. if the Insurance Agreement establishes that the full or the first Insurance Premium shall be paid on the day of concluding the Insurance Agreement, and the Policyholder pays it on time, the Insurance Agreement shall take effect on the day and time of the start of the Insurance Agreement Period specified in the Agreement, and the Insurance Coverage shall only apply to Insured Events having occurred after the entry into force of the Insurance Agreement;

3.2.2. if the Insurance Agreement establishes that the full or the first Insurance Premium shall be paid after the day of conclusion of the Insurance Agreement, and the Policyholder pays it on time, the Insurance Agreement shall take effect from the moment of payment of the Insurance Premium, while the Insurance Coverage shall also apply for Insured Events which the Parties to the Insurance Agreement were not aware of when concluding the Insurance Agreement, which occurred during the period of time from the day and time of the start of the Insurance Agreement Period specified in the Agreement till the moment of entry into force of the Agreement (i.e. the Insurance Coverage shall apply retroactively);

3.2.3. if the Policyholder pays the full or the first Insurance Premium having missed the deadline for paying the Premium provided for in the Insurance Agreement, the Insurance Agreement shall take effect on 00:00 of the day following the payment of the Insurance Premium, and the Insurance Coverage shall apply only to Insured Events that occurred after the entry into force of the Insurance Agreement regardless of whether the Insurance Premium had to be paid on the Agreement conclusion day, or the Agreement provided for a later deadline for its payment.

3.3. In all the cases provided for in clauses 3.2, 3.2.1 to 3.2.3 hereof, the application of Insurance Coverage shall commence not earlier than the start date of the Insurance Agreement Period specified in the Insurance Agreement.

3.4. If the Policyholder fails to pay a periodic Insurance Premium or its part at the time specified in the Insurance Agreement, the Insurer shall notify the Policyholder thereof in writing. Having failed to pay an Insurance Premium within 30 days from the day of sending a notice to the Policyholder, the Insurer shall have the right to suspend Insurance Coverage under the Insurance Agreement until the Policyholder covers the Insurance Premium arrears. If the suspension of Insurance Coverage lasts for more than 6 months, the Insurer shall have the right to terminate the Insurance Agreement unilaterally.

4. Rights and duties of the parties to the Insurance Agreement and their liability for non-compliance with Insurance Agreement conditions

4.1. The Insurer shall undertake:

4.1.1. to provide the Policyholder with the Insurance Rules, Special Insurance Conditions, Insurance Premium amounts and other Insurance Agreement-related information, which the Insurer is obliged to provide according to legal acts of the Republic of Lithuania;

4.1.2. having concluded an Insurance Agreement – to issue an Insurance Certificate, Insurance Rules, Special Insurance Conditions;

4.1.3. to pay all Insurance Benefits due according to the Insurance Agreement, if there is a basis for paying an Insurance Benefit;

4.1.4. to duly discharge other obligations specified in the Insurance Agreement and legal acts.

4.2. The Insurer shall have the right:

4.2.1. to terminate the Insurance Agreement, to reduce an Insurance Benefit or to refuse to pay it altogether, if after concluding the Insurance Agreement it determined that when concluding the Insurance Agreement or during its validity period, the Policyholder or the Insured defaulted on their duty to disclose information and intentionally or negligently provided the Insurer with incomplete, false information about the Policyholder, the Insured or about circumstances that may have a material impact on the assessment of the Insurance Risk, the likelihood of occurrence an Insured Event, the determining of the amounts of deductibles under the Insurance Agreement or other circumstances important for the Insurance Agreement, except in cases when the circumstances which the Policyholder and/or the Insured concealed disappeared before an Insured Event or did not affect the Insured Event;

4.2.2. to assess the Insurance Risk of the Policyholder and the Insured and, to this end:

4.2.2.1. to require the Policyholder or the Insured to have a medical check-up before concluding the Insurance Agreement. The Insurer shall bear medical check-up costs;

4.2.2.2. taking into account the information provided in the health questionnaire of the Policyholder or the Insured, to ask the Insured additional questions about his health condition and/or circumstances related to the assessment of the Insurance Risk;

4.2.2.3. to offer to conclude an Insurance Agreement on conditions other than those specified in the Application for Concluding an Insurance Agreement, if the conditions specified in the Application cannot be fulfilled due to the insured person's risk, but the offered Agreement must be concluded in the best interests of the Policyholder/the Insured and in pursuit of it meeting the actual interests and expectations of the customer;

4.2.2.4. to refuse to conclude an Insurance Agreement without indicating any reason for such a refusal;

4.2.2.5. to determine the minimum and maximum Sum Insured of the Insured, the minimum or maximum age of the Insured, and the minimum or maximum duration of the Insurance Agreement.

4.2.3. to amend the Pricelist of Additional Insurance Agreement Administration Services available online at www.ergo.lt, notifying of the amendments thereto in accordance with the procedure prescribed by laws;

4.2.4. other rights provided for in legislation of the Republic of Lithuania.

4.3. The Policyholder shall undertake:

4.3.1. to notify the Insured and/or the Beneficiary about the concluded Insurance Agreement and amendments thereto, to familiarize the Insured and/or the Beneficiary with their rights and obligations set out in the Insurance Agreement;

4.3.2. to pay Insurance Premiums in a timely manner. Other persons and/or the Insured may also pay Premiums for the Policyholder without acquiring any rights to the Insurance Agreement;

4.3.3. to notify of any changes in contact data or the list of the persons insured no later than within 30 days from the change (unless the Agreement establishes otherwise).

4.4. The Policyholder shall have the right:

4.4.1. to receive an Insurance Certificate, the Insurance Rules and the Special Insurance Conditions;

4.4.2. to receive a copy of the Insurance Agreement and the additional Insurance Agreement administration services having paid the fee set by the Insurer according to the Pricelist of Additional Insurance Agreement Services;

4.4.3. to receive all information related to the Insurance Agreement during the validity period of the Insurance Agreement;

4.4.4. to refer to the Insurer for amending conditions of the Insurance Agreement by completing an application in the form set by the Insurer and questionnaires necessary to assess the Insurance Risk. When amending conditions of the Insurance Agreement, the Insurer shall respectively change the Insurance Premium amount.

4.5. The Policyholder and/or the Insured shall undertake:

4.5.1. to provide the Insurer with detailed and correct information about the Policyholder and the Insured when concluding and amending the Insurance Agreement, completing an application in the form set by the Insurer and questionnaires necessary to assess the Insurance Risk;

4.5.2. to immediately notify of any change in the data indicated in the Application for Concluding an Insurance Agreement and questionnaires during the period from the application completion date till the conclusion of the Insurance Agreement;

4.5.3. to report an increase in the Insurance Risk:

4.5.3.1. when the occupation/nature of work or the field of activity of the Policyholder or the Insured changed;

4.5.3.2. when the Insured engages in/changes the type of Extreme and/or Professional Sport, where this coverage is provided according to the conditions of the concluded Insurance Agreement, and the changed risk requires amending the Insurance Agreement;

4.5.4. to duly perform other duties specified in the Insurance Agreement and legal acts.

4.6. The Policyholder and/or the Insured shall have the right:

4.6.1. the Policyholder shall have the right to change the Beneficiary before an Insured Event having notified the Insurer thereof in writing. The Policyholder and the Insurer may additionally include in the Insurance Agreement the cases when the Insured shall also have the right to change the Beneficiary by filing with

the Insurer an application in the form set by the Insurer and in observance of the requirements of Article 119 of the Law on Insurance;

4.6.2. to ask to amend conditions of the Insurance Agreement due to a decrease in the Insurance Risk, if the circumstances laid down in the Insurance Agreement, which lead or may lead to a reduction in the Insurance Risk, change in essence during the validity period of the Insurance Agreement.

4.7. The Beneficiary, the Insured and the Policyholder shall undertake:

4.7.1. to report Insured Events to the Insurer by completing a report in the form set by the Insurer within 30 days from the Event date and without any delay, as soon as he becomes aware thereof;

4.7.2. to provide the Insurer with complete and correct information about the Insured Event and to cooperate in obtaining information from third parties necessary for the investigation of the Insured Event.

4.8. The Beneficiary shall have the right:

4.8.1. to receive information on the course of the investigation of the Insured Event;

4.8.2. to demand the payment of an Insurance Benefit in accordance with the conditions and procedure established in the Insurance Agreement.

4.9. The Policyholder, the Beneficiary and the Insured shall also have other rights and duties established by legal acts.

4.10. The parties shall comply with the conditions of the concluded Insurance Agreement. The parties shall be liable for non-compliance with the conditions of the Insurance Agreement in accordance with the procedure established by the Insurance Agreement and legal acts of the Republic of Lithuania.

5. Procedure of payment of Insurance Benefits

5.1. The Insurer shall pay Insurance Benefits within 30 days from the date of receipt of all information relevant to determining the fact, circumstances, consequences of the Insured Event and the Insurance Benefit amount (including additional information from law enforcement agencies, health care institutions, etc.). If an Insurance Benefit has not been paid within 30 days from the date the Insured Event was reported, the Insurer shall inform the Policyholder (the Insured, the Beneficiary) on the course of the investigation of the Insured Event in detail in writing.

5.2. Insurance Benefits shall be paid to the Beneficiaries specified in the Insurance Agreement. If the Beneficiary is not specified in the Insurance Agreement, Insurance Benefits in case of death of the Insured shall be paid to successors of the Insured.

5.3. If having increased the Sum Insured, the Insurance Premium due calculated by the Insurer was not paid at the agreed time, in case of an Insured Event, the Sum Insured valid before its increase shall be paid.

5.4. The Premium or a part thereof overdue under the Insurance Agreement may be deducted from the Insurance Benefit amount payable in case of an Insured Event.

6. Provision of notices, applications and information

6.1. The Policyholder shall send all notices, statements, claims and/or requests related to the Insurance Agreement 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.

6.2. The Policyholder or the Insured shall serve to the Insurer all notices, statements, claims and requests relating to the Insurance Agreement and obligations arising therefrom in such a form and manner that the Insurer is able to clearly identify that the person having submitted the document is the Policyholder or the Insured.

6.3. The Insurer may send notices, information and claim-related notifications to the mailing address specified by the Policyholder and/or the Insured in the Insurance Agreement. The Insurer shall have the right to send the required information to the Policyholder and/or the Insured to the specified e-mail address, if the Policyholder and/or the Insured indicated that he agrees to receiving information related to the Insurance Agreement by this e-mail.

6.4. The Insurer may inform the Policyholder about any changes to the Insurer's contact details, the Insurance Rules and the requirements applicable to the Insurance Agreement, publishing the changes on the Insurer's website www.ergo.lt and/or by sending information on the said changes to the last known address or e-mail of the Policyholder.

7. Amendment, termination and expiry of the Insurance Agreement

7.1. The Policyholder and the Insurer may agree in writing on amending conditions of the Insurance Agreement.

7.2. The Insurance Agreement Period shall be indicated in the Insurance Certificate. The Insurance Agreement may be terminated at the initiative of the Policyholder by mutual agreement between the Policyholder and the Insurer or on other grounds established in the Insurance Rules, the Special Insurance Conditions and legal acts of the Republic of Lithuania.

7.3. The Policyholder shall file with the Insurer a request to terminate the Insurance Agreement in the set form. The Insurance Agreement shall be terminated on the next business day following the day of submission of such a request to terminate the Insurance Agreement to the Insurer.

7.4. The Policyholder shall have the right to unilaterally terminate the Insurance Agreement in the following cases:

7.4.1. the Policyholder, who is a natural person, – on preferential terms, by the Policyholder notifying the Insurer in writing within 30 calendar days from the moment when he was presented with an Insurance Certificate. The Insurer shall refund to the Policyholder the total Insurance Premium paid. The Policyholder shall be considered to have been issued an Insurance Certificate within 5 (five) business days from the day of conclusion of the Insurance Agreement.

7.4.2. The Policyholder shall pay the last Insurance Premium or a part thereof calculated for the period from the beginning of the last month of insurance till the date of termination of the Insurance Agreement. If the Policyholder has paid Insurance Premiums for the upcoming months, the Policyholder shall be refunded the paid Insurance Premiums for the unused period of validity of the Insurance Coverage within 10 days from the date of submission of a request to terminate the Insurance Agreement.

7.4.3. The Policyholder may indicate in his request the date as from which the Insurance Agreement is to be terminated. If the date has not been indicated, it shall be considered that the Policyholder wishes to terminate the Insurance Agreement from the date following the date of submission of his request to the Insurer.

7.4.4. If the Insurer violates essential conditions of the Insurance Agreement (having determined its fault), the Insurance Premiums paid shall be refunded to the Policyholder.

7.5. The Insurer shall have the right to unilaterally terminate the Insurance Agreement in the following cases:

7.5.1. in the cases provided for in clause 3 of Article 6.1010 of the Civil Code of the Republic of Lithuania (when circumstances that determined the Insurance Risk changed, and the Policyholder failed to notify the Insurer thereof) and clause 1 of Article 6.1009 (upon the disappearance of the object or risk). Having terminated the Insurance Agreement on these grounds, the Insurer shall refund to the Policyholder a part of the Insurance Premium for the unused Insurance Coverage Period;

7.5.2. on other grounds provided for in laws of the Republic of Lithuania;

7.5.3. when the suspension of Insurance Coverage under the Insurance Agreement lasts longer than 6 months.

7.6. The Insurance Agreement shall terminate:

7.6.1. when the Insured dies, and there are no other insured persons indicated in the Insurance Agreement;

7.6.2. when all Sums Insured have been paid;

7.6.3. if the Policyholder, who is a natural person dies, and the remaining insured persons do not express a wish to take over the rights of the Policyholder, or the Policyholder, who is a legal person, is liquidated, and there are no successors to its rights and duties;

7.6.4. having terminated the Insurance Agreement;

7.6.5. upon the expiry of the Insurance Agreement.

7.7. Notwithstanding other provisions of the Insurance Agreement, Insurance Coverage shall only be valid for as long as this does not conflict with any trade and economic sanctions, prohibitions or restrictions imposed by United Nations resolutions, any laws or regulations of the European Union, United Kingdom or United States of America. If the said sanctions, prohibitions or restrictions directly or indirectly interfere with our provision of services under the Insurance Agreement, we shall have the right to terminate the Agreement unilaterally by notifying the Policyholder thereof in writing.

8. Confidentiality of information and personal data processing

8.1. The Insurer shall ensure the confidentiality of information of the Policyholder, the Insured, their family members and the Beneficiary in accordance with the Insurance Agreement and the requirements of applicable regulatory legislation, except for cases when the Insurer has an obligation to disclose this information to third parties in accordance with applicable legal acts.

8.2. The Insurer shall process personal data received from the Insured, persons insured under the Insurance Agreement, family members or other participants in the Insurance Agreement in order to provide insurance services and to perform related actions.

8.3. In order to assess the Insurance Risk, to make an offer to conclude an Insurance Agreement or to conclude an Insurance Agreement, to assess circumstances of Insured Events and to determine the Insurance Benefit amount, the Insurer may provide personal data to and collect it in personal health care institutions, law enforcement authorities, the State Health Insurance Fund, the Disability and Working Capacity Assessment Office and the State Social Insurance Fund.

8.4. Personal data may be disclosed to third parties (law enforcement and other authorities, reinsurers, companies providing us with customer service and other services, other natural or legal persons), if this is necessary for concluding or executing the Insurance Agreement, or in presence of other legal grounds.

8.5. The Policyholder or another person whose personal data are processed shall have the right to refer to the Insurer's Data Protection Officer (by e-mail asmensduomenys@ergo.lt or by calling 1887) on all matters relating to the processing of personal data and the exercise of his rights.

8.6. The Policyholder or another person whose personal data are processed shall have the right to ask the Insurer to access his personal data, to have them rectified or erased, to restrict the processing of the data, also the right to object to the processing of his personal data, and the right to data portability. When personal data are processed on the basis of a consent, the Policyholder or another person whose data are processed shall have the right to revoke the given consent at any time.

8.7. If the Policyholder or another person whose personal data are processed believes that his rights regarding the processing and protection of personal data have been violated, he shall have the right to file a complaint with the State Data Protection Inspectorate.

8.8. More detailed information about the processing of personal data by the Insurer is presented in ERGO's Privacy Policy available on the Insurer's website www.ergo.lt.

9. Dispute settlement procedure

9.1. All disagreements regarding the conclusion, performance or termination of the Insurance Agreement shall be settled by mutual negotiation, and in case of a failure to reach an agreement, disputes may be settled in an out-of-court or judicial procedure in accordance with the procedure established by laws of the Republic of Lithuania.

9.2. The Policyholder shall have the right to refer to the supervisory authority of financial market participants the Bank of Lithuania for out-of-court settlement of disputes. Information on the procedure for settling disputes between consumers and financial market participants is available online at: http://www.lb.lt/gincu_nagrinejimas.

10. Procedure for Assigning Rights and Duties of the Insurer

10.1. The Insurer shall have the right to assign its rights and duties under the Insurance Agreement to another insurer in accordance with the procedure established by legal acts of the Republic of Lithuania.

10.2. The Insurer shall notify the Policyholder of its plans to assign its rights and duties two months before the planned assignment of rights and duties.

10.3. If the Policyholder does not agree with the assignment of rights and duties under the Insurance Agreement, he shall have the right to terminate the Insurance Agreement and shall be entitled to the unused part of the Insurance Premium proportionate to the remaining period of validity of the Insurance Agreement.

11. Procedure of application of conditions of insurance agreements

11.1. These Insurance Rules and Special Insurance Conditions shall form an integral part of the Insurance Agreement. In case of any contradictions between these Insurance Rules and the Special Insurance Conditions, Special Insurance Conditions shall apply. The Insurance Certificate shall indicate which general and special insurance conditions shall apply to the Insurance Agreement.

11.2. The Insurance Agreement shall be subject to law of the Republic of Lithuania.

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

Valid from 18 11 2019

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ERGO Life Insurance SE

Special Cancer Insurance Conditions No 028-01

(these conditions shall apply along with the Universal Life Insurance Rules No 028)

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.

8.3. The Insurer shall have the right to amend the Special Cancer Insurance Conditions for agreements concluded for 1 year by notifying the Policyholder thereof in writing not later than 30 days before the date of an automatic extension of the Insurance Agreement.

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

Valid from 18 11 2019

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ERGO Life Insurance SE

Special Life Insurance Conditions No 028-02

(these conditions shall apply along with the Universal Life Insurance Rules No 028)

1. Object of insurance

1.1. The object of insurance shall be the property interest related to life of the Insured.

2. Insured person

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.

3. Insured Event

3.1. Death of the Insured during the term of validity of Insurance Coverage, except for the cases provided for in clause 4 of these Conditions.

3.2. A court declaring the Insured dead shall be considered an Insured Event, if the date of death of the Insured indicated in the effective court judgement falls within the period of validity of Insurance Coverage. The court declaring the Insured missing shall not be considered an Insured Event.

4. Non-Insured Events

4.1. Non-Insured Events when Insurance Benefits shall not be paid:

4.1.1. suicide of the Insured within the first 3 years of validity of Insurance Coverage;

4.1.2. death of the Insured related to military actions, imposition of a state of war or a state of emergency, internal unrest, nuclear energy impact.

5. Sum Insured and Insurance Benefits

5.1. The Insured's Sum Insured shall be indicated in the Insurance Certificate and may vary.

5.2. If the Insured dies during the validity period of the Insurance Agreement, and this is an Insured Event, the Insurer shall pay an Insurance Benefit. In case of death of the Insured, an Insurance Benefit equal to the Sum Insured, which was valid at the time of the Insured's death, shall be paid. An Insurance Benefit shall not be paid after the expiry of the Insurance Agreement.

5.3. If the Sum Insured was increased, and the Insured commits a suicide within the first 3 years after the increase of the Sum Insured, except for the case provided for in clause 4.1 a) hereof, an Insurance Benefit to be paid shall be equal to the smallest Sum Insured of the Insured valid in the past 3 years.

6. Procedure of reporting an Insured Event

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

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

6.1.2. a medical statement on the cause of death;

6.1.3. a document confirming the right to an Insurance Benefit (inheritance document, court decision), if a beneficiary has not been indicated in the Insurance Agreement;

6.1.4. a statement on death of the Insured in the form prescribed by the Insurer;

6.1.5. other documents requested by the Insurer significant in determining the fact and circumstances of the Insured Event.

6.2. The person claiming the Insurance Benefit should notify the Insurer of the Insured Event in writing without any undue delay, but not later than within 30 days of the death of the Insured or within 30 days from the effective date of the court judgement to declare the Insured dead.

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

7. Procedure of paying Insurance Benefits

7.1. Insurance Benefits shall be paid to the beneficiaries indicated in the Insurance Agreement. If no beneficiaries have been indicated in the Insurance Agreement, Insurance Benefits in case of death of the Insured shall be paid to successors of the Insured.

7.2. In case of a non-insured event, no Insurance Benefits shall be paid and Insurance Premiums shall not be refunded.

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

Valid from 01 08 2022

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ERGO Life Insurance SE

Special Accident Insurance Conditions No 028-03

(these conditions shall apply along with the Universal Life Insurance Rules No 028)

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. daily allowance 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:

7.1.1. 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;

7.1.2. for agreements concluded for 1 year by notifying the Policyholder in writing not later than 30 days before the date of automatic extension of the Insurance Agreement;

7.1.3. for agreements which provide for annual recalculation of the premium according to the number of insured persons (renewal of an agreement), notifying the Policyholder thereof in writing no later than 30 days before the date of annual recalculation.

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

Item No	Injury	Insurance Benefit (% of the Sum Insured)
35.	Severe narrowing of oral cavity, salivary fistula formation.	15
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

Item No	Injury	Insurance Benefit (% of the Sum Insured)
40.2.	significant narrowing of ureters or urethra, urinary bladder volume reduction;	20
40.3.	complete obstruction of ureter or urethra, fistula of reproductive organs.	30
41.	Consequences of injury of reproductive organs:	
41.1.	ovary, fallopian tube or testicle removed;	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

Item No	Injury	Insurance Benefit (% of the Sum Insured)
46.	Complete shoulder joint immobility.	30
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
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

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

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

Item No	Injury	Insurance Benefit (% of the Sum Insured)
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
7.4.	Tear of one symphysis.	8
7.5.	Fracture of one bone.	7

Item No	Injury	Insurance Benefit (% of the Sum Insured)
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
10.5.	Cerebral contusion.	8
10.6.	Spinal cord commotion treated for at least 3 days in a hospital and then outpatiently.	5

Item No	Injury	Insurance Benefit (% of the Sum Insured)
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
12.6.	Tear of tendons, ligaments, muscles of the shoulder, elbow, hip, knee or intervertebral ligaments, if a surgery was required.	6

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

ERGO

Simple because it matters.

ERGO Life Insurance SE

Special Conditions of Cancer and Other Critical Illness Insurance of Adults No 028-04

(these conditions shall apply along with the Universal Life Insurance Rules No 028)

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.

9.3. The Insurer shall have the right to amend the Special Conditions of Cancer and Other Critical Illness Insurance of Adults for insurance agreements concluded for a period of 1 year, by notifying the Policyholder thereof at least 30 days before the date of automatic extension of the Insurance Agreement.

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Annex No 1 to Special Conditions of Cancer and Other Critical Illness Insurance of Adults No 028-04

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 028-01 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).

The need for the surgery shall be confirmed by a cardiologist or cardio surgeon, and this must be confirmed by echocardioscopy or cardiac catheterization.

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.

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

Valid from 01 07 2022

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Special Conditions of Cancer and Other Critical Illness Insurance of Children No 028-05

(these conditions shall apply along with the Universal Life Insurance Rules No 028)

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.

9.3. The Insurer shall have the right to amend the Special Conditions of Cancer and Critical Illness Insurance of Adults for insurance agreements concluded for a period of 1 year, by notifying the Policyholder thereof at least 30 days before the date of automatic extension of the Insurance Agreement.

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Annex No 1 to Special Conditions of Cancer and Other Critical Illness Insurance of Children No 028-05

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.

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

Valid from 01 11 2026

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Special Conditions of Insurance against Partial or Total Disability (Loss of Participation) No 028-06

(these conditions shall apply along with the Universal Life Insurance Rules No 028)

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 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	0,00 EUR
Change of investment programme/or the structure of accumulated capital	0,00 EUR
Withdrawal of a part of capital*	30,00 EUR

* 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.

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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