TRANSLATION OF INSURANCE TERMS AND CONDITIONS FOREIGNERS' COMPREHENSIVE MEDICAL INSURANCE

KZPC 1/16

effective as of 1 January 2016

Article 1
Introductory Provisions

1. The rights and responsibilities of parties to this **Foreigners' Comprehensive Medical Insurance** (hereinafter "Insurance") is governed by the laws of the Czech Republic, particularly by Act No. 89/2012 Coll., the Civil Code, as amended (hereinafter the "Code"), these Insurance terms and conditions, the provisions contained in the insurance policy and its annexes and in other documents which make up an integral part thereof.
2. Arrangements in the insurance policy that deviate from the Code or these Insurance terms and conditions shall prevail.
3. The contracting parties are on the one hand the Policyholder and on the other the Insurer.

Article 2
Definition of Terms

The following definitions of terms shall apply for the purposes of this Insurance:

1. The **Qualifying Period** is the period in which the Insurer has no obligation to provide Insurance Benefits for events which would otherwise be Insured Events. The Qualifying Period is counted as of the day agreed as the commencement of the Insurance Period.
2. The **Duration of the Insurance** is the actual period of time within the agreed Insurance Period for which the Insurance was in effect.
3. **One Insured Event** is an Insured Event arising from the Insurance of one person and from one and the same cause, at the same place and the same time, comprising all the facts and their consequences, amongst which there is a causal, territorial, chronological or other direct connection.
4. A **Single Insurance Premium** is the Insurance premium determined for the entire period for which the Insurance has been agreed.
5. A **Period** given in days is always understood to be the number of calendar days.
6. A **Random Event** is an event that is possible and in respect of which it is uncertain whether it will even occur within the Duration of the Insurance, or the time of its occurrence is unknown.
7. An **Illness** for the purpose of this Insurance is the onset of a disorder which threatens the health or the life of the Insured Person and requires the provision of medical care. The onset of Illness is deemed to be the moment the onset of Illness is medically established.
8. A **Newborn Baby** is understood for the purpose of this Insurance to be a child from the time of his/her birth to the end of the 3rd month of this child's age.
9. A **Beneficiary** is a party with a right to an Insurance Benefit as a result of an Insured Event.
10. An **Insurance Certificate** is a written confirmation that an insurance policy has been concluded, which the insurer issues to the policyholder.
11. The **Insurance Period** is the period for which the Insurance was agreed. This period is not reduced by the premature expiration of the Insurance.
12. An **Insured Event** is an accidental state of affairs brought about by the Insured Peril, associated with the establishment of an obligation on the part of the Insurer to provide an Insurance Benefit.
13. An **Insured Peril** is the possible cause of an Insured Event (the "cause"). An Insured Peril does not cease due to the Insured Person's absence at the place of Insurance.
14. An **Insurance Risk** is a measure of the probability of the occurrence of the Insured Event caused by an Insured Peril.
15. The **Policyholder** is the party which has concluded the insurance policy with the Insurer.
16. The **Insurer** is a legal entity entitled to carry on insurance activity according to special legislation.
17. The **Insured Person** is a person in respect to whose life or health the insurance relates.
18. **Postnatal Care for a Newborn Baby** is healthcare for a newborn baby immediately following the baby's birth and without interruption to the continuity of hospitalisation, with the exclusions detailed in Article 7.
19. **Professional Sporting Activity** is sporting activity performed under an employment or similar relationship which is the main source of the sportsperson's income.
20. The **Insured Person's Card** comprises written confirmation of the establishment of Insurance, which the Insurer issues for the requirements of the Insured Person; it is used to exercise the right to Insurance Benefits.
21. A **Contractual Healthcare Facility** is understood to mean a healthcare facility of such a healthcare provider with which the Insurer has concluded a contract for these purposes.
22. A **Loss Event** is an event resulting in damage which may constitute grounds for the establishment of a right to an Insurance Benefit.
23. **Loss Insurance** is insurance the purpose of which is to provide compensation for a loss arising from an Insured Event.
24. A **party to the Insurance** is understood to mean the Insurer and the Policyholder, as the contracting parties, as well as the Insured Person and every other person to whom a right or obligation arose under the private insurance.
25. An **Injury** is understood for the purpose of this Insurance to be the unexpected and sudden action of external forces or of one's own strength independent of the Insured Person's will, which resulted in damage to the Insured Person's health or his death. An Injury is also understood to be near-drowning, drowning and physical damage caused by high or low temperatures, lightening, radiation, electrical current, gases or vapours, toxic or corrosive substances, with the exception of the regularly repeating action of all of the above.
26. **Multiple Insurance** arises when two or more private insurance policies relate to the same insurance risk covered for the same period, if the sum of the Insurance Benefit limits exceeds the actual amount of the damage caused.
27. An **Interested Party** is a party interested in concluding an insurance policy with the Insurer.

Article 3
Purpose and Subject of the Insurance

1. The Insurer shall, in the event of the occurrence of an Insured Event, provide the Beneficiary with an Insurance Benefit to the extent of the loss affecting the subject of the Insurance up to the agreed amount.
2. The Beneficiary is the Insured Person.
3. The subject of the Insurance is the health of the Insured Person. Supplementary insurance can also be taken out to cover the health of the insured mother's Newborn Baby.
4. The Insurance is concluded as Loss Insurance.

Article 4
Insured Event

With the exception of the agreed exclusions, an Insured Event is a change in the medical condition of the Insured Person or other acts related to the medical condition of the Insured Person caused by an Illness or Injury occurring within the Duration of the Insurance and after the expiry of the Qualifying Period and during the Insured Person's stay at the place of Insurance.

Article 5
Extent and Place of Insurance

1. The extent of the agreed Insurance is determined by the Insurance terms and conditions and electable parameters stipulated in the insurance policy. These parameters are elected by the Policyholder upon concluding the insurance policy based on knowledge of the insurable interest of the Insured Persons.
2. Insurance is effective only in the agreed place of Insurance, which is the territory of the Czech Republic.
3. The Qualifying Period applied in cases of healthcare services for reason of:
   - pregnancy is three months,
   - birth is eight months.

   The Qualifying Period is not applied in the event of the conclusion of "Newborn Baby" cover.
4. If an event occurred that could have been or was an Insured Event under medical expenses insurance taken out with the Insurer and which requires medical care upon return to the Czech Republic, the condition of a change in the medical condition of the Insured Person during his stay in the Czech Republic shall not be applied to this event.
5. The Policyholder shall elect the Insurance Period, the upper Insurance Benefit limits, the type of Insurance and any supplementary insurance of medical expenses abroad, stipulated in the insurance policy, in the following extent:
   In the event of the:
   "***Standard***" cover being concluded, the Insurance does not apply to events for which the Insurance Benefit is conditional on the conclusion of the Newborn Baby or Professional Sports types of cover,
   "***Professional Sports***" cover being concluded, the exclusion set out in Article 7(2)(g) shall not be applied,
   "***Newborn Baby*** " cover being concluded, the exclusion set out in Article 7(2)(f) shall not be applied.

Article 6
Extent and Due Payment of the Insurance Benefit

1. The amount and extent of the Insurance Benefit is determined by the Insurer in accordance with the Insurance terms and conditions.
2. The payment of an Insurance Benefit is conditional on the occurrence of an Insured Event and the meeting of all the conditions and obligations ensuing from the insurance policy and parts thereof, namely the payment of the premium.
3. Unless otherwise agreed by the contracting parties, the financial performance shall be payable in the currency of the Czech Republic and its territory and the Insurer shall pay it to the person entitled to receive the financial performance by transfer to this person's bank account or by postal order to his name and address.
4. If the Insured Person was entitled to receive financial performance that he did not receive whilst alive, this unpaid Insurance Benefit shall become the subject of inheritance proceedings.
5. In cases of the conversion of a foreign currency, the Insurer shall use the exchange rate of the Czech National Bank valid at the time the Insured Event occurred.
6. An Insurance Benefit is payable within 15 days from the end of investigations of the notified event, with which the claim for the Insurance Benefit is connected. The investigations conclude upon the reporting of its results to the person who exercised the claim to the Insurance Benefit.
7. If it is not possible to conclude the investigations necessary to ascertain the Insured Event, the extent of the Insurance Benefit or to ascertain the person entitled to receive the Insurance Benefit within three months of the notification date, the Insurer shall inform the notifier why the investigations cannot be concluded; if requested by the notifier, the Insurer shall inform the notifier of the reasons in writing. The Insurer shall provide the person who exercised the claim to the Insurance Benefit with a reasonable advance on the basis of this person's request for the Insurance Benefit; this shall not apply if there are reasonable grounds to deny the provision of such an advance.
8. The Insurer is entitled to reduce the Insurance Benefit:
   a) as a consequence of the compensation which the Beneficiary has already received in another manner,
   b) if a lower premium was agreed as a consequence of a breach of a duty of the Policyholder or the Insured Person when negotiating the conclusion of the policy or its amendment, the Insurer shall be entitled to reduce the Insurance Benefit by an amount equal to the ratio of the premium it received to the premium it ought to have received,
   c) if the breach of the duty of the Policyholder, Insured Person or another party entitled to the Insurance Benefit had a material effect on the occurrence of the Insured Event, its course, on increasing the extent of its consequences or on ascertaining or determining the amount of the Insurance Benefit, the Insurer shall be entitled to reduce the Insurance Benefit proportionally to the effect that this breach had on the extent of the Insurer's duty to render benefits,
   d) in the event of the thwarting of the passing of the right to the Insurer pursuant to Article 20,
   e) if it paid the Insurance Benefit in the unreduced amount and has subsequently acquired a claim to reduce the Insurance Benefit. The Insurer is entitled to exercise a claim to the difference between the paid-out and the reduced Insured Benefit from the person in whose favour it was paid.
9. The Insurer may refuse to pay the Insurance Benefit if the Insured Event was caused by a fact
   a) of which it learned only after the occurrence of the Insured Event,
   b) which it was unable to ascertain during the conclusion of the policy or its amendment as a consequence of the culpable breach of the obligation stipulated in paragraph 1 or 2 of Article 17,
   c) the awareness of which at the time of the conclusion of the insurance policy would result in it not concluding it or concluding it under different terms and conditions.
10. The Insurer may also refuse to pay the Insurance Benefit if, when exercising its right to benefits under the Insurance, the Beneficiary knowingly gave false or grossly distorted information pertaining to the extent of the Insured Event or withheld material information pertaining to this Insured Event.
11. A loss comprises of the reasonable costs demonstrably incurred on healthcare provided to the Insured Person in the

place of Insurance in accordance with the valid healthcare and legal regulations, but only at healthcare facilities with which the Insurer has concluded an agreement with respect to this Insurance.

In the event of a sudden deterioration in the state of health of the Insured Person, where a delay may result in serious damage to health or a threat to life, the Insurer shall also defray costs to a healthcare facility on the territory of the Czech Republic which has not concluded an agreement with the Insurer with regard to this Insurance. Necessary and reasonable costs demonstrably incurred for healthcare services shall be defrayed, but only until such time as it was possible to arrange healthcare by the Insurer's contractual healthcare facility.

The Insurer shall provide Insurance Benefits up to the limits set out in paragraph 16 of this article to the following extent:

a) healthcare services to an extent similar to those of public medical insurance to the extent of comprehensive healthcare, though with the agreed exclusions from the Insurance and with the agreed Insurance Benefit limits; hence the Insurance does not provide compensation to the extent or in the amount that it would be provided under public medical insurance,
b) repatriation of a sick Insured Person, which is necessary from a medical standpoint and is carried out, upon the assessment and approval of the Insurer's supervising doctor and with the consent of the attending doctor, by a medical transportation organisation approved by the Insurer or by the Insurer's assistance service provider, to the state whose passport the Insured Person holds or to another state in which the Insured Person has been permitted residence. The Insurer may, upon prior approval, also cover the transportation costs of another person required to accompany the Insured Person in justified cases,
c) transportation of the remains of the Insured Person to the state whose passport the Insured Person holds or to another state in which the Insured Person has been permitted residence, performed by a specialist organization approved by the Insurer or the Insurer's assistance service provider. The Insurer may, upon prior approval, also cover other related costs in justified cases,
d) if, at the time of the occurrence of the Insured Event, the "***Professional Sports***" cover is in effect, the Insurer shall provide an Insurance Benefit even in the case of the operation of professional sporting activities and during preparations for such activities,
e) if, at the time of the occurrence of the Insured Event, the "***Newborn Baby*** " cover is in effect, the Insurer shall provide an Insurance Benefit even in the case of the Postnatal Care of a Newborn Baby of an insured mother born within the Duration of the Insurance,
f) dental treatment of the Insured Person to alleviate sudden pain or the consequences of an Injury to the extent of public medical insurance,
g) medicines and healthcare aids prescribed on an out-patient basis to the Insured Person by a doctor (hereinafter "Out-patient Medicines"),
h) assistance service to the extent of Article 21. The Insurer provides these services via a contractual provider without direct payment by the Insured Person to the provider.

12. In excess of the framework of the Insurance Benefit to the extent of paragraph 11 of this article, the Insurer shall pay the costs of the Insured Person incurred for the premium healthcare services hereinafter listed (Superior standard) up to the limit prescribed for Superior standard, which is stated in the insurance policy:
    a) vaccination (vaccine and its application) not covered as standard under this insurance (e.g. against tick-borne encephalitis
    b) medicines purchased over the counter and healthcare aids purchased at pharmacists (without prescription) and healthcare aid outlets,
    c) hormonal contraception,
    d) hearing aids, spectacles and contact lenses,
    e) wheelchairs (including those with electric propulsion)
    f) compensation of costs for the transportation of the insured person to a healthcare establishment due to treatment or hospitalization; besides submission of proof of the actual transportation costs, the compensation of the costs is also conditional on the submission of a medical report confirming the occurrence of an Insured Event to the extent of paragraph 11 of this article.

    Superior standard may also be utilized at any time within the duration of the insurance in individual amounts with a minimum of CZK 100.
13. The costs detailed in paragraph 11 of this article shall be paid by the Insurer directly or via the assistance service provider to the healthcare facility or another party that has demonstrably incurred these costs.
14. Direct defrayment of a loss:
    a) If the Insured Person directly defrayed a loss constituting an Insured Event, the Insurer shall subsequently settle the reasonable costs upon receipt of the originals of the required documents, i.e. it shall render financial performance. Originals of these documents remain with the Insurer and are not returned. If an original document has been submitted for payment to a party other than the Insurer, a copy will suffice if it records and confirms payments made by this party.
    b) The Insurer shall provide an Insurance Benefit for a prescription for doctor-prescribed out-patient medicines or a voucher for healthcare aids, if the amount of the claim for each prescription or voucher exceeds a limit of CZK 100. The Insurance Benefit is understood to be the amount specified in the VZP CR rates code list for mass-produced medicines, healthcare aids and individually prepared medicines, designated as MAX and valid at the time of the occurrence of the Insured Event.
15. If an Insured Event occurred and the continuous hospitalisation of the Insured Person exceeds the Duration of the Insurance, the Insurer shall decide on the subsequent procedure as follows:
    a) if the state of health of the Insured Person does not allow for his repatriation, the Insured Person shall be treated in a healthcare facility designated by the Insurer until such time as his state of health improves to such an extent as to allow for his repatriation,
    b) if the state of health of the Insured Person allows for his repatriation, the repatriation can proceed after the consent of the attending doctor is obtained.
16. The Insurance Benefit has an upper limit. The upper limit for the Insurance Benefit is determined by the benefit limits specified in the insurance policy:
    a) The benefit limit for costs under letters a) to d) of paragraph 11 of this article (*Healthcare services, including repatriation and transportation*) limits the Insurance Benefit for every single Insured Event.
    b) The partial limit detailed under letter a) of this paragraph is the benefit limit for costs under letter e) of paragraph 11 of this article (*postnatal care of a newborn baby*), which further limits the Insurance Benefit for the sum of all Insured Events occurring within the Duration of the Insurance.
    c) The partial limit detailed under letter a) of this paragraph is the benefit limit for costs under letter f) of paragraph 11 of this article (*dental treatment*), which further limits the Insurance Benefit for the sum of all Insured Events occurring within the Duration of the Insurance.
    d) The partial limit detailed under letter a) of this paragraph is the benefit limit for costs under letter g) of paragraph 11 of this article (*Out-patient Medicines*), which further limits the Insurance Benefit for the sum of all Insured Events occurring within the Duration of the Insurance,
    e) The benefit limit for costs under letters a) to f) of paragraph 12 of this article (Superior standard) limits the Insurance Benefit for the entire Duration of the Insurance. The Insurer provides this Insurance Benefit surplus to the framework of the limits under letters a) to d) of this paragraph. The partial Insurance Benefit limit for costs under paragraph 12 of letters f) further limits the Insurance Benefit to CZK 500 per one Insured Event.

Article 7
Exclusions from the Insurance

1. Unless it is otherwise agreed in writing by the contracting parties, the Insurer shall not provide Insurance Benefits, with the exception of preventative and dispensary healthcare and that associated with the pregnancy of the insured mother and the birth of her child, in the case of:
    A) costs for:
        a) spa treatment, homeopathy and acupuncture,
        b) regulatory fees and additional charges,
    B) if an Insured Event occurred as a consequence of in connection with the Insured Person's active participation:
        a) in the events of war and other armed conflicts, acts of violence or civil war,
        b) in deliberate criminal acts,
        c) in manipulating with weapons or explosives,
    C) if a Loss Event occurs as a result of or in connection with:
        a) disturbances or criminal activities committed or induced by the Insured Person; this exclusion does not apply in the case of Injury,
        b) use by the Insured Person of alcohol, medicines, narcotics or other psychotropic or addictive substances or in connection with their effects; this exclusion does not apply in the case of Injury,
2. The Insurer shall not provide Insurance Benefits:
    a) for events resulting from Illness or Injury, **the cause or symptoms of which arose outside the Duration of the Insurance or during the Qualifying Period**,
    b) if the Insured Person refuses to undergo treatment or the required examination or fails to abide by the treatment regime recommende by a doctor,
    c) for examinations, checks and other healthcare procedures the personal interest or upon the request of the Insured Person, including laboratory examinations (e.g. pertaining to, for example, cosmetic procedures, artificial termination of pregnancy, infertility contraception, compilation of a medical confirmation),
    d) for medicines and healthcare aids not prescribed by a doctor, i.e. purchased over the counter without a doctor's prescription, or the administration of which started before the commencement of the Insurance,
    e) for complications that arise in connection with the provision of healthcare for illnesses, states or injuries to which the Insurance does not apply,
    f) for the Postnatal Care of a Newborn Baby of an insured mother, if "**Newborn Baby**" cover was not in effect at the time the Loss Event occurred; the agreed type of insurance is detailed in the insurance policy,
    g) for events occurring during the performance of, or preparations for, Professional Sporting Activity, if "**Professional Sports**" cover was not in effect at the time the Loss Event occurred; the agreed type of insurance is detailed in the insurance policy.

    Exclusions from this paragraph do not apply to payments under Article 6(12).

Article 8
Insurable Interest

1. Insurable interest is a legitimate need for protection from the consequences of the Insured Event.
2. The Policyholder has an insurable interest in his own life and health. It is understood that the Policyholder also has an insurable interest in the life and health of another person, if he demonstrates an interest conditional on his relationship to this person, whether resulting from a family relationship or being conditional on the benefit or advantage he gains from a continuation of this person's life or preservation of this person's health.
3. If the Insured Person consented to the Insurance it is understood that the Policyholder's insurable interest was demonstrated.
4. The insurance policy shall be invalid if the Interested Party did not have an insurable interest and the Insurer knew or ought to have known this when concluding the insurance policy.
5. The insurance policy shall be invalid if the Policyholder has knowingly insured a non-existent insurable interest, but the Insurer did not or could not have known this; however, the Insurer shall be entitled to remuneration corresponding to the premiums until the time it learned of the insurance policy being invalid.
6. The insurable interest does not terminate upon the absence of the subject of the Insurance from the place of Insurance, the taking up of similar private insurance or for reason of plain disinterest.
7. The termination of the insurable interest must always be proven to the Insurer.

Article 9
Group Insurance

1. Group Insurance is Insurance pertaining to a group of Insured Persons, as further defined in the insurance policy, whose identity need not be known at the time of the insurance policy being concluded.
2. If the Insurance applies to members of a certain group, the insurance policy need not specify the names of the Insured Persons, on the condition that the Insured Persons can be identified beyond doubt at least at the time of the Insured Event.
3. In the case of group insurance, a breach of the duty to give truthful and complete answers to the Insurer's questions only impacts the Insurance of those persons to whom a breach of this duty applies.

Article 10
Conclusion of the Insurance Policy

1. The insurance policy is concluded upon acceptance of the Insurer's Insurance offer.

    The offer is accepted upon its signing by the contracting parties, unless another manner of acceptance is expressly stated therein. If the Policyholder accepted the offer by the timely payment of the premium, it shall be deemed that the written form of the insurance policy has been duly observed.
2. The insurance policy is concluded for a definite time period.
3. An integral part of the insurance policy, apart from the Insurance terms and conditions, are also all agreements, supplements and annexes to the insurance policy and all documents defining the terms and conditions of the establishment, duration, alteration and expiration of the

Insurance (e.g. applications, questionnaires, reports, medical examinations and checks, notices, records of the course of concluding the Insurance, the Insurer's information for the Interested Party on the conclusion of the insurance policy).

Article 11
Commencement and Duration of the Insurance – Insurance Period

1. The Insurance is concluded for a fixed Insurance Period from the commencement of the Insurance Period to the end of the Insurance Period. The Insurance Period is agreed in the insurance policy.
2. The Insurance commences at 0:00 hours on the day agreed as the commencement of the Insurance Period, but no earlier than on the day following the day on which Insurance premium is paid.
3. The Insurance lasts from its commencement until the actual expiration of the Insurance.
4. The Insurance cannot be suspended for reason of the non-payment of the premium.

Article 12
Amendments to and Termination of the Insurance Policy. Expiry of the Insurance

1. All amendments to the insurance policy are made in writing upon the mutual agreement of the contracting parties.
2. The Insurance expires upon the lapsing of the Insurance Period, i.e. at 24:00 hours on the day agreed as the date of the termination of the Insurance Period.
3. Personal Insurance expires upon the termination of the insurable interest, on the date when the Insured Person dies or on the date when the Insurer's notification of the refusal to pay the Insurance Benefit is received.
4. The Insurance expire as at the date of the Insurer receiving notification by the Policyholder of the Insured Person passing to the public medical insurance of the Czech Republic within the Duration of the Insurance, on the condition that this notification includes a copy of the insured person's valid ID card that he/she is a participant of public medical insurance of the Czech Republic
5. The Insurer or the Policyholder may terminate the Insurance in writing:
   a) within two months of the conclusion of the insurance policy. An eight day notice period shall commence running upon the serving of the termination, with the Insurance terminating upon the expiry of this period,
   b) within three months of the serving of the notification of the Insured Event. A one month notice period shall commence running upon the serving of the termination, with the Insurance terminating upon the expiry of this period.
6. The Policyholder may terminate the Insurance subject to an eight day notice period:
   a) within two months of learning that the Insurer applied a viewpoint contrary to the principle of equal treatment in determining the amount of the premium or for calculating the Insurance Benefit,
   b) within one month of receiving notification of the transfer of the insurance portfolio or part thereof or the transformation of the Insurer,
   c) within one month of the publishing of the notification that the licence enabling the Insurer to carry on its insurance business has been withdrawn.
7. If the Policyholder or the Insured Person breaches the duty stipulated in paragraph 1 or 2 of Article 17, either intentionally or through negligence, the Insurer shall be entitled to withdraw from the insurance policy if it can prove that it would not have concluded the insurance policy had the questions been answered truthfully and completely. The Policyholder shall be entitled to withdraw from the insurance policy if the Insurer breached the duty stipulated in paragraph 8 or 9 of Article 14. The right to withdraw from the insurance policy shall expire if not exercised by a party within two months of the day that it learned or ought to have learned of a breach of the duty stipulated in paragraph 1 or 2 of Article 17 or in paragraph 8 or 9 of Article 14.
8. If the insurance policy was concluded by means of a remote transaction, the Policyholder shall be entitled to withdraw from the policy, without giving any reason, within 14 days of its conclusion or of the date on which the terms and conditions were communicated to him, if such communication first occurs only upon his request after the conclusion of the policy.
9. The insurance policy may, in exceptional cases, be terminated by a written agreement of the contracting parties under the agreed conditions.
10. The insurance policy may be assigned only with the Insurer's consent.
11. If Insurance of another party's insurable risk is concluded, then the Insured Person shall take the place of the Policyholder on the date of the Policyholder's death or the date of it being wound up without a legal successor; however, if the Insured Person gives written notice to the Insurer within thirty days of the Policyholder's death or winding up that he is not interested in the Insurance, the Insurance shall expire on the date of the Policyholder's death or winding up. The effects of a delay shall not impact the Insured Person before the expiration of 15 days from the date that the Insured Person learned of his entry into the Insurance.
    However, if there is more than one Insured Person, the Insurance of all such parties shall terminate upon the expiry of the period in respect of which a premium was paid.
12. The Insurance does not expire due to the termination of the Insured Person's stay in the Czech Republic prior to the expiry of the Insurance Period.
13. The insurance policy terminates upon the expiry of all Insurance cover.

Article 13
Premium

1. The premium is the consideration for the Insurance cover provided. The amount of the premium is determined by the Insurer for the insurance policy. This is a Single Insurance Premium.
2. The premium is payable on the date of the conclusion of the insurance policy in the currency and the amount stated in the insurance policy.
3. The premium shall be considered as duly paid if demonstrably received by the Insurer's agent or credited to the Insurer's bank account.
4. The Insurer is entitled to the premium for the entire Duration of the Insurance. The Insurer acquires this right on the date on which the insurance policy is concluded.
5. If the Insurance is terminated according to Article 12 of these Insurance terms and conditions as a consequence of the Policyholder's termination or as a consequence of a notification by the Policyholder of the Insured Person passing to the public medical insurance of the Czech Republic within the Duration of the Insurance, the Insurer shall to the Policyholder, after calculating the total Insurance Benefit paid, but not later than 6 months from the date of the Insurance expiring, part of the premium corresponding to the unearned premium as at the expiry of the Insurance, after deducting:
   a) the costs associated with taking out and administering the Insurance.
   b) the costs associated with the Insurance Benefits, and
   c) the amount corresponding to the pro-rata part of the Superior standard, by which the Insured Person overdrew the deserved part of the Superior standard corresponding to the actual Duration of the Insurance.
6. If the Insurance is terminated as a consequence of an Insured Event, the Insurer shall be entitled to the entire Single Insurance Premium.
7. If the insurance policy is terminated by **agreement** before the date of the commencement of the Insurance, the Insurer shall return all received premiums to the Policyholder minus the costs associated with taking out and administering the Insurance, upon the return of the Insured Person's Card.
8. The Insurer is entitled to the premium until the time it learned of the expiry of the insurable interest.
9. If the Policyholder withdraws from the insurance policy, the Insurer shall return to the Policyholder the received premiums within 30 days of the date of the withdrawal taking effect less any Insurance Benefits it may have paid under the Insurance; if the Insurer withdraws from the insurance policy, it shall be entitled to also set off the costs associated with taking out and administering the Insurance. If the Insurer withdraws from the Insurance, the Policyholder, Insured Person or another party who had already received an Insurance Benefit shall reimburse the Insurer within this same time period the amount of the Insurance Benefit received that is surplus to the received premiums.
10. If the Policyholder withdraws from the insurance policy according to Article 12(8), the Insurer shall return to the Policyholder the received premiums without undue delay, but not later than 30 days from the date of the withdrawal taking effect; in so doing, the Insurer shall be entitled to deduct any Insurance Benefit it had already paid under the Insurance. However, if the amount of Insurance Benefit paid exceeds the amount of premiums received, the Policyholder, or the Insured Person or the beneficiary in the event of the Insured Person's death, as the case may be, shall be obliged to pay the Insurer the amount of the Insurance Benefit paid that is surplus to the premiums received.
11. The Insurer will set off its outstanding premiums in the order in which they were created rather than in the order in which reminder letters were sent.

Article 14
Rights and Obligations of the Insurer

1. The Insurer is entitled to verify the submitted documents, to demand the submission of expert reports compiled by specialists or to consult complicated Loss Events with healthcare facilities or other competent entities, even abroad.
2. The Insurer shall issue the Insurance Certificate to the Policyholder after the conclusion of the insurance policy and payment of the premium.
3. If the event of the loss, damage or destruction of a valid Insurance Certificate, the Insurer shall issue a duplicate thereof to the Policyholder at the Policyholder's request; the same applies to the issue of a copy of the insurance policy concluded in writing.
4. The Insurer shall notify the Interested Party, information about the Insurer and the Insurance taken out prior to the conclusion of the insurance policy.
5. The Insurer is also obliged to accept the payment of outstanding premiums and other outstanding receivables under the Insurance from the Policyholder's pledgee, from a Beneficiary or from the Insured Person.
6. Within the Duration of the Insurance, the Insurer shall provide information to the Policyholder at his address stipulated in the insurance policy or via the Insurer's web site. If the correspondence address is different from the address of the registered office or residential address, then it is designated as the correspondence address. The address may also be an address designated for electronic communication.
7. The Insurer shall not return originals of the documents. If the Insurer is not obliged to provide an Insurance Benefit, ait shall return the originals of the documents upon request.
8. If the Insurer ought to be aware of the inconsistencies between the Insurance being offered and the Interested Party's requirements when concluding the insurance policy, it shall alert the Interested Party of them. In so doing, the circumstances and the manner in which the insurance policy is concluded, as well as whether the other contracting party is being assisted in the conclusion of the policy by an agent independent of the insurer shall be taken into account.
9. If the Insurer asks the Interested Party or the Policyholder in writing whilst negotiating the conclusion of the insurance policy about facts pertaining to the Insurance, the Insurer shall answer these questions truthfully and completely.
10. If the Policyholder asks the Insurer in writing to provide him with information that is material for rendering benefits under the policy, the Insurer shall provide such information in writing without undue delay.

Article 15
Obligations of the Policyholder

The Policyholder shall:

1. Pay the Insurance premium to the Insurer.
2. Inform all Insured Persons, in a timely manner, of the contents of the insurance policy, including all annexes and parts thereof, and provide them with all materials and information which it has received on their behalf from the Insurer.
3. Inform every Insurer without undue delay in the event of Multiple Insurance occurring, providing details of the other insurers and the insured amounts or the Insurance Benefit limits agreed in the other insurance policies.
4. Inform the Insurer without undue delay of a change in correspondence address.
5. Always return the Insured Person's Card to the Insurer within five calendar days of the expiration of the Insurance, if the Insurance expires before the end of the agreed Insurance Period.
6. If the Policyholder is also the Insured Person, all the obligations of the Insured Person shall apply to the Policyholder as well.

Article 16
Obligations of the Insured Person

The Insured Person shall:

1. **contact the** Insurer's **assistance service provider** in a Loss Event, **always and without delay**, if his state of health permits, and follow its instructions,
2. do everything to avert the occurrence of an Insured Event and to reduce the extent of their consequences,
3. release the healthcare provider in writing, at the request of the Insurer, from its obligation to maintain confidentiality and provide the Insurer with written authorisation to obtain information from healthcare staff which is subject to the obligation to maintain confidentiality and which is required for the Insurer's investigations if any Loss Event has occurred,
4. undergo treatment or necessary medical examinations by a doctor designated by the Insurer or by the Insurer's assistance service provider,
5. always follow the instructions of the attending doctor,
6. abide by the safety measures for the Duration of the Insurance,
7. use suitable protective aids and equipment required for the

maximum safe performance of all activities performed,
8. have the appropriate valid licence for the performance of all activities carried out at the place of Insurance,
9. ensure proper supervision or escort, should this be usual for the performed activity,
10. not stand in places designated inappropriate by the organiser,
11. comply with the legislation in force at the place of Insurance,
12. seek out medical treatment, should the need arise, and identify himself to the healthcare provider by showing the Insured Person's Card,
13. in the event that he is required, on rare occasions, to participate directly in the settlement of the loss that is the Insured Event:
    a) pay reasonable and demonstrable costs to the authorised recipient,
    b) collect the originals of the required documents and to store them safely until their submission to the Insurer,
    c) submit the required documents to the Insurer without undue delay.

Article 17
Other Rights and Obligations of the Parties to the Insurance

1. If the Insurer asks the Interested Party in writing whilst negotiating the conclusion of the insurance policy or asks the Policyholder in writing whilst negotiating the amendment of the insurance policy about facts that are relevant to the Insurer's decision on evaluating the insurance risk, whether it will insure them and under what conditions, the Interested Party or the Policyholder shall answer these questions truthfully and completely. The duty shall be deemed to have been duly met if nothing material had been concealed as part of the answer.
2. The provisions contained in paragraph 1 of this article regarding to the duty of the Policyholder shall also apply to the Insured Person.
3. Should an event occur with which the person who considers himself to be a Beneficiary links his claim to an Insurance Benefit, he shall notify this fact to the Insurer without undue delay, give the Insurer a truthful explanation of the cause, the origin and the extent of the consequences of such an event, the rights of third parties and any Multiple Insurance; at the same time, he shall also submit to the Insurer the required documents and proceed in the manner agreed in the insurance policy. If this person is not simultaneously the Policyholder or the Insured Person, the Policyholder and the Insured Person shall also have the duties.
4. The same notification may be made by any person with a legal interest in the Insurance Benefit.
5. The notification under paragraph 3 and 4 of this article shall be deemed received after the Insurer:
    I.) was notified of the event on the Insurer's form that has been duly completed,
    II.) was handed originals (unless stated otherwise hereinafter) of all the required documents or documents requested by the Insurer.
    The required documents are:
    A) documents demonstrating:
        a) the cause, time, place and circumstances of the occurrence of the Insured Event, its extent and the direct connection of the Insured Event with the Insured Person, at least detailing the first name, surname and date of birth of the Insured Person,
        b) a detailed specification of the subject of compensation (e.g. a medical report with the diagnosis, description and date of the procedures performed and the medicines administered),
        c) the subject of the payment (e.g. bills or invoices issued by a doctor or bills issued by a pharmacy on the basis of a prescription issued by the attending doctor) and detailing the date and amount of the payment (e.g. receipts on a cash payment, account statements),
    B) in the case of Insurance Benefits for Out-patient Medicines prescribed by a doctor, also copies of the prescriptions made out in the name of the Insured Person, specifying the date of issue, the quantity and description of the medicines and healthcare aids, and the signature and stamp of the issuer,
    C) for an Insured Event investigated by the police, also a police report or confirmation of the investigation of an accident,
    D) in the case of the death of the Insured Person, also a copy of an official death certificate and medical certification of the cause of death.

    All documents must be made out in the name of the Insured Person and must contain the date of issue and also the signature and stamp of the issuer, if prescribed on the document.
6. The Insurer shall commence investigations necessary to ascertain the existence and extent of its duty to perform without undue delay of the receipt of the notification under paragraph 5 of this article. The investigations shall be deemed as duly concluded upon the reporting of their outcome to the person who exercised the claim to the Insurance Benefit; at the request of this person, the Insurer shall justify the amount of the Insurance Benefit in writing, or the reason for this claim being refused, as the case may be.
7. If the notification contains knowingly false or grossly distorted material information pertaining to the extent of the notified event, or if information pertaining to this event has been knowingly concealed therein, the Insurer shall be entitled to compensation for the costs it purposefully incurred in investigating the facts in regards to which this information was given to or concealed from him. It is understood that the demonstrable costs of the Insurer were incurred purposefully.
8. If the Policyholder, the Insured Person or another party exercising a claim to the Insurance Benefit causes investigation costs or an increase therein by breaching a duty, the Insurer shall be entitled to claim reasonable compensation from such a person.
9. The Policyholder and the Insured Person are obliged:
    a) to notify the Insurer in writing at any time within the Duration of the Insurance of a change of any and all particulars made in the insurance policy,
    b) to enable the Insurer to conduct investigations into the causes of the Loss Event and the extent of their consequences and to co-operate with the Insurer as required,
    c) to notify the Insurer the details of all insurance policies valid at the time of the Loss Event occurring, the subject of which is insurance of the same Insured Peril.

Article 18
Delivery of Documents

1. Documents designated for the parties to the Insurance (hereinafter the "addressee") shall be delivered by the holder of a postal licence (hereinafter the "Post Office"), by ordinary or registered mail to the residential address or registered office stated in the insurance policy. Should the addressee give an address that is different to his residential address or registered office (hereinafter the "correspondence address"),delivery shall be made to this address, with the addressee not being able to claim that his actual his residential address or registered office is in another place.
2. Correspondence sent by mail is deemed to be delivered on the third business day following dispatch. Correspondence sent to an addressee by registered mail with a delivery slip is deemed to be delivered on the date of receipt stated on the delivery slip.
3. Correspondence sent to an email address is deemed to be delivered on the date that it was delivered to the email box of the addressee; in the event of doubts, it shall be understood that it was delivered on the date that it was sent by the sender.
4. Correspondence sent to a data mailbox is deemed to be delivered the moment that this data mailbox is logged on by the person who, in view of the extent of his/her authority, has access to the correspondence.
5. Documents of the parties to the Insurance may also be delivered via an employee of the Insurer or by other parties authorised by the Insurer; in these cases the document is deemed to be delivered on the date it is accepted.
6. If the addressee deliberately thwarts the delivery of a document, it shall be deemed to have been duly delivered on the day that its receipt was thwarted by the addressee.
7. If the addressee thwarts the receipt of correspondence in another manner, e.g. by failing to take delivery of this correspondence or by failing to mark his/her/its letter box by his/her first name and surname or company name, it shall be deemed to have been duly delivered on the date on which it was returned to the insurer.
8. The Insurer's or Policyholder's place of delivery is the address stated in the insurance policy.

Article 19
Rescue Costs

1. If the Policyholder purposefully incurs costs in averting the immediate threat of an Insured Event or to mitigate the consequences of an Insured Event that has already occurred, it shall be entitled to compensation for these costs from the Insurer, as well as compensation for the loss suffered by the Policyholder in connection with this activity.
2. Compensation for rescue costs incurred in order to save lives or the health of persons is limited to 30% of the agreed insured amount or Insurance Benefit limit.
    The amount of compensation for rescue costs for the Period of Validity of the insurance policy is limited to CZK 100,000, with the exception of costs incurred by the Policyholder with the Insurer's consent.
3. Compensation for rescue costs is in excess of the framework of the agreed Insurance Benefit limit.
4. If the Insured Person or another person incurred rescue costs in excess of the framework of duties stipulated by law, they shall have the same right to compensation against the Insurer as the Policyholder.

Article 20
Assignment of rights to the Insurer

1. If a person entitled to the Insurance Benefit, the Insured or a person incurring rescue costs, became entitled to compensation from another party for a loss or another similar right in connection with an Insured Event which is imminent or has already occurred, this claim, including appurtenances, security and other rights connected therewith, shall pass to the Insurer upon the payment of the Insurance Benefit, up to the amount of the benefits rendered by the Insurer to the Beneficiary. The above shall not apply if this person became entitled to this right against someone with whom he lives in a joint household or is dependent on him, unless he caused the Insured Event intentionally.
2. The person whose right passed to the Insurer shall release the required documents to the Insurer and disclose it all that is necessary in order to exercise the claim. Should this person thwart the passing of this right to the Insurer, the Insurer shall be entitled to reduce the benefits under the Insurance by the amount it could otherwise have received. If the Insurer has already rendered benefits, it shall be entitled to compensation up to this amount.
3. The Beneficiary is obliged to take measures to ensure that the right to compensation which pass to the Insurer under the law do not expire or become stature-barred.
4. The Beneficiary must not enter into an agreement with a third party to relinquish a claim for compensation against this third party if such claims pass to the Insurer.
5. The Beneficiary is obliged to confirm the assignment of rights to the Insurer in writing upon the Insurer's request.
6. If, in connection with the exercise of the claim, the Insurer incurs additional costs due to the fault of the Beneficiary, then the Insurer is entitled to require the Beneficiary to pay such costs.

Article 21
Assistance Service

1. The assistance services are the services provided to the Insured Person in connection with the Insurance cover taken out and are provided by an organisation contracted by the Insurer. The assistance services are provided 24 hours a day. Contact details for the assistance service provider are contained in the Insured Person's Card.
2. The assistance services are provided to the following extent:
    - recommendation of a contractual healthcare facility,
    - arranging admission at a contractual doctor for treatment during office hours,
    - recommendation of an appropriate procedure in the case of a Loss Event,
    - monitor developments in the medical condition during the course of hospitalisation,
    - provision of a liquidity guarantee to the contractual healthcare facility in the event of a claim for an Insurance Benefit,
    - ensuring the repatriation of the client in the event of a medical reason,
    - arranging for a professional companion in the context of repatriation,
    - arranging for the transportation of the remains in the event of death.

Article 22
Final Provisions

1. Representations and notifications with respect to the Insurer are only valid if submitted in writing.
2. The language of communication is Czech.
3. Persons with restricted legal capacity shall be represented by their guardian. It is understood that persons who have yet to attain full legal capacity act with the consent of their statutory representative or that this statutory representative acts on their behalf.
4. If payment is made in cash, the date of payment is the date the sum is deposited in favour of the recipient. If the payment is not made in cash, the date of payment is the date the sum is credited to the account of the recipient.
5. The Insurer's costs associated with taking out and administering the Insurance come to 20% of the unearned premium.
6. All disputes arising out of or in connection with this Insurance which are not resolved by agreement or out-of-court settlement shall be dealt with by any court having jurisdiction in the Czech Republic in compliance with Czech law.