BUNDA
Baltic Underwriting Agency

LLOYD'S

Personal Accident Insurance Terms and Conditions

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I. INSURED EVENTS

An insured event means personal accident (or the accident) defined in the insurance contract, occurring within the insurance territory during the period of insurance, upon occurrence of which the Insurer is obligated to pay insurance benefit. The parties agree on the list of accidents covered by insurance under a specific insurance contract (insurance coverage clauses) (choosing from the groups listed in clauses 1–6) to be specified in the insurance policy (its annexes) and the Terms.

Personal accident (or the accident) means any sudden, unexpected event, during which an external physical force affects the body of the Insured Person against his will and causes damage to the latter's health or results in the accidental death or disability of the Insured Person.

1. Accidental Death

1.1. An insurance benefit shall be paid in the event of the Insured Person's death resulting from damage to health caused by an insured event and occurring within one year from the date of the accident.

1.2. Where a court declares the Insured Person dead, an insurance benefit shall only be paid if the court judgement states that the Insured Person has gone missing and there are circumstances suggesting that the Insured Person has died as a result of an insured event during the term of the insurance contract.

1.3. If the Insured Person dies as a result of an insured event, the insurance benefit payable shall be equal to the amount indicated in the insurance policy for the case of accidental death. If the Insured person has already been paid insurance benefits under the Injury or Disability insurance clauses for the same personal accident that resulted in the death of the Insured Person, the insurance benefit payable for the death of the Insured Person shall be reduced by already paid benefits;

1.4. If the Insured Person dies as a result of the an insured event, the Policyholder, Beneficiary or Heir (authorized person) shall apply to the Insurer for the payment of an insurance benefit and submit the following documents (preliminary list of documents):

1.4.1. A completed damage report form;

1.4.2. Consent for the processing of personal data;

1.4.3. An accident at work report form (if applicable);

1.4.4. Documentary evidence of the accident issued by police, a fire and rescue authority or another competent authority (if applicable);

1.4.5. A certificate of death;

1.4.6. Documentary evidence of the insured event issued by a medical establishment or forensic examination findings (if applicable);

1.5. The Insurer may, at its own discretion, request other documents required to determine the fact, causes, circumstances and consequences of an insured event and the insurance benefit to be paid.

1.6. If the Insured Person dies as a result of wilful acts of the Beneficiary indicated in the insurance policy and this is confirmed by the court, no insurance benefit shall be paid to the Beneficiary. In this case, the share of the insurance benefit payable to the guilty person shall be paid to other Beneficiaries, and where the Insured Person has failed to indicate other Beneficiaries, the insurance benefit shall be paid to an Heir.

1.7. If the Insured Person dies as a result of wilful acts of the Heir and this is confirmed by the court, the share of the insurance benefit payable to the Heir shall be paid to other Heirs of the Insured Person.

2. Accidental Disability

2.1. This insurance shall only cover disability directly caused by an insured event (personal accident) where, based on the bodily injuries sustained as a result of the personal accident, a competent authority confirms:

2.1.1. a degree of disability of an Insured Person under 18 years of age, which may be:

2.1.1.1. low or

2.1.1.2. moderate or

2.1.1.3. high or

2.1.2. the working capacity of an Insured Person aged between 18 years and retirement age to be lower than it was before the insured event, i.e. loss of the working capacity expressed as a percentage:
2.1.2.1. 100%–60% working capacity – a person capable of work or
2.1.2.2. 59%–30% working capacity – a person partially capable of work or
2.1.2.3. 29%–0% working capacity – an incapacitated person or
2.1.3. An Insured Person of retirement age to have special needs:
2.1.3.1. the special need for regular nursing or
2.1.3.2. the special need for regular care (assistance) or
2.1.3.3. the special need for compensation for vehicle acquisition costs and its technical adjustment costs or the special need for compensation for transport costs.
2.2. An insurance benefit shall only be paid in the event of the Insured Person's long-term or permanent disability (as defined in clauses 2.3 and 2.4 below) and only if the respective degree of disability of the Insured Person is determined by a competent authority within one year from the date of personal accident.
2.3. Long-term disability means a condition where the degree of disability, working capacity (loss of working capacity) or special needs are established for a period no shorter than 1 year.
2.4. Permanent disability means a condition where the degree of disability, working capacity (loss of working capacity) or special needs are established for a period no shorter than 2 years. If the Insured Person is first confirmed to have a long-term disability which is then extended, permanent disability shall mean a condition established for an uninterrupted period of at least 2 years. In any case, only the first 2 years from the date of the determination of the disability determined due to the insured event are assessed.
2.5. If the Insured Person becomes disabled as a result of an insured event, an insurance benefit shall be paid. The amount of the insurance benefit to be paid is expressed as a percentage of the sum insured payable in the case of disability specified in the insurance policy (annexes thereto) and is equal to:
2.5.1. Insurance benefits for Insured Persons from 18 years old to retirement age are calculated based on the degree of loss of working capacity (as a percentage):
2.5.1.1. In the event of permanent loss of working capacity, the insurance benefit shall be equal to a part of the sum insured in the case of disability equal to the lost working capacity (as a percentage), or
2.5.1.2. In the event of long-term incapacity for work, the insurance benefit shall be equal to a part of the sum insured in the case of disability equal to one-third of the lost working capacity (as a percentage). If the experts of the Insurer have no doubt about extension of long-term incapacity for work, the insurance benefit payable in the case of permanent loss of working capacity may be paid (in such a case, the insurance benefit for permanent disability shall not be paid once again);
2.5.2. Insurance benefits for Insured Persons up to 18 years of age shall be calculated in view of the degree of disability established:
2.5.2.1. The insurance benefit in the event of a low degree of disability shall be equal to 40% of the sum insured in the case of disability;
2.5.2.2. The insurance benefit in the event of a moderate degree of disability shall be equal to 70% of the sum insured in the case of disability;
2.5.2.3. The insurance benefit in the event of a high degree of disability shall be equal to 100% of the sum insured in the case of disability;
2.5.3. The insurance benefit in the event of disability of Insured Persons of retirement age shall be calculated in view of the determined special needs, provided that the special needs are established for a minimum period of 2 years (in the case of permanent disability only):
2.5.3.1. In the event of the special need for compensation for vehicle acquisition costs and its technical adjustment costs or the special need for compensation for transport costs, the insurance benefit is equal to 10% of the sum insured in the case of disability or
2.5.3.2. In the event of the special need for regular care (assistance), the insurance benefit is equal to 30% of the sum insured in the case of disability or

2.5.3.3. In the event of the special need for regular nursing, the insurance benefit is equal to 100% of the sum insured in the case of disability.

2.6. If the degree of disability, working capacity (loss of working capacity) or special needs determined by a competent authority raises reasonable doubts to the Insurer, the Insurer shall have the right to hire experts and/or specialists in the relevant field at its own expense and to pay the insurance benefit based on the findings of the experts and/or specialists regarding the degree of disability, working capacity (loss of working capacity) or special needs of the Insured Person.

2.7. The insurance benefit shall be paid in view of the established degree of disability, working capacity (loss of working capacity) or special needs of the Insured Person as at the date of payment of the insurance benefit (provided that the disability is due to an insured event).

2.8. Where disability (a degree of disability or loss of working capacity) of the Insured Person was already established prior to the insured event and the degree of disability has increased as a result of the insured event, the insurance benefit shall be calculated based on the difference between the degree of disability or the degree of loss of working capacity as a percentage before and after the insured event.

2.9. Where any special needs of an Insured Person of retirement age are established prior to the insured event, no disability insurance benefit shall be paid to such a person.

2.10. Disability for the Insured Person shall be established no less than 6 months and no more than 12 months from the date of the accident. If disability raises no doubt, the Insurer shall have the right to pay the insurance benefit before the established deadline (in this case, the insurance benefit for the established disability will not be paid once again afterwards).

2.11. In the event of disability of the Insured Person as a result of an insured event, the Policyholder, the Insured Person or a Heir (authorized person) shall apply to the Insurer for the payment of the insurance benefit and submit the following documents (preliminary list of documents):

2.11.1. A completed claim application form;

2.11.2. Consent for the processing of personal data;

2.11.3. An accident at work report form (if applicable);

2.11.4. Documentary evidence of the accident issued by police, a fire and rescue authority or another competent authority (if applicable);

2.11.5. Certificates issued by a medical establishment;

2.11.6. Documentary evidence of disability, working capacity or special needs (degree thereof) issued by a competent authority;

2.11.7. The Insurer may, at its own discretion, request other documents required to determine the fact, causes, circumstances and consequences of the insured event and the insurance benefit.

ADDITIONAL BENEFITS (ONLY COVERED IF BOUGHT AND STATED ON THE POLICY)

3. Critical Illnesses

3.1. An insurance benefit shall be paid if the Insured Person is, for the first time in his life during validity of the insurance contract, diagnosed with a critical illness, which is confirmed by medical documents and is included in the description of critical illnesses contained in the Table of Insurance Benefits provided at the end of these Terms, as well as meets the criteria for diagnosing critical illnesses.

3.2. No insurance benefit shall be paid if:

3.2.1. A critical illness is diagnosed, and/or its first symptoms occur within 90 days from the entry into force of the insurance contract (except where the insurance contract in respect of the Insured Person continues in force without interruption);

3.2.2. The diagnosis does not match all the signs of the respective critical illness contained in the Table of Insurance Benefits;

3.2.3. The critical illness occurs at a time when the Insured Person is infected with the human immunodeficiency virus (HIV) or has the acquired immune deficiency syndrome (AIDS);

3.3. The insurance benefit payable to one Insured Person for one or several insured events may not exceed 100% of the sum insured payable in the case of critical illnesses fixed in the insurance policy.

3.4. If the diagnosed illness is not included in the Table of Insurance Benefits, no insurance benefit shall be paid.

3.5. If the Insured Person dies as a result of a critical illness, the insurance benefit payable in the case of death specified in the insurance policy shall not be paid (insurance benefit specified in the policy shall be paid for the critical illness, provided that it meets the terms and conditions of insurance and the relevant insurance benefit has not been paid earlier).
3.6. Upon the occurrence of an insured event, the Policyholder, the Insured Person or a Heir (authorised person) shall apply to the Insurer for the payment of insurance benefits and submit the following documents (preliminary list of documents):
3.6.1. A completed claim application form;
3.6.2. Consent for the processing of personal data;
3.6.3. Document issued by a health care institution and confirming the diagnosis, anamnesis documents, description of examinations and treatment showing the date when the illness was diagnosed for the first time and whether the illness meets the criteria specified in the description of critical illnesses;
3.7. The Insurer may, at its own discretion, request other documents required to determine the fact, causes, circumstances, and consequences of the insured event and the insurance benefit;
3.8. Where a critical illness is diagnosed in respect of one of the Insured Persons, insurance cover against critical illnesses shall end in his/her respect.

4. Injuries

4.1. An insurance benefit shall be paid for bodily injuries (traumas) sustained by the Insured Person during an insured event that do not cause the death or disability of the person, as defined in these Terms. The amount of the insurance benefit payable in the event of a trauma shall be expressed as a percentage of the sum insured payable in the case of injuries indicated in the insurance policy and shall be fixed according to the Table of Insurance Benefits provided at the end of these Terms.
4.2. The insurance benefit payable for one or several insured events may not exceed 100% of the sum insured payable in the event of injuries specified in the insurance policy, and the insurance benefit payable for all injuries of one part of the body may not exceed the insurance benefit payable in the case of loss of this part of the body.
4.3. If the injury sustained is not included in the Table of Insurance Benefits, no insurance benefit shall be paid.
4.4. Upon the occurrence of an insured event, the Policyholder, the Insured Person (a person authorised by them) shall apply to the Insurer for the payment of insurance benefits and submit the following documents (preliminary list of documents):
4.4.1. A completed claim application form;
4.4.2. Consent for the processing of personal data;
4.4.3. Statements issued by an inpatient or outpatient treatment establishment specifying the diagnosis, the nature and duration of treatment;
4.4.4. An accident at work report (if applicable);
4.4.5. A documentary proof of the issuance of a sick-leave certificate or a certificate e of absence from an educational establishment;
4.4.6. Documentary evidence of the accident issued by police, a fire and rescue authority or another competent authority (if applicable);
4.4.7. An X-ray or its description in the case of bone fractions.
4.5. The Insurer may, at its own discretion, request other documents required to determine the fact, causes, circumstances and consequences of the insured event and the insurance benefit.

5. Hospital Daily Allowance

5.1. The hospital daily allowance shall be paid if the Insured Person is hospitalized for inpatient treatment due to bodily injuries or health disorders resulting from an insured event.
5.2. The amount of the insurance benefit payable for each day spent in hospital shall be equal to the sum insured indicated in the insurance policy under the hospital daily allowance clause.
5.3. The hospital daily allowance shall not be paid in cases where inpatient treatment takes less than 24 hours a day and less than three consecutive days.

5.4. The hospital daily allowance for one accident shall be paid to one Insured Person for a maximum of 30 days.
5.5. The hospital daily allowance for all accidents occurring during the term of the insurance contract shall be paid to one Insured Person for a maximum of 90 days.
5.6. If the Insured Person is hospitalized as a result of an insured event, the Policyholder or the Insured Person (a person authorized by them) shall apply to the Insurer for the payment of insurance benefits and submit the following documents (preliminary list of documents):
5.6.1. A completed claim application form;
5.6.2. Consent for the processing of personal data;
5.6.3. An accident at work report (if applicable);
5.6.4. Documentary evidence of the accident issued by police, a fire and rescue authority or another competent authority (if applicable);
5.6.5. Documentary evidence of inpatient treatment issued by a medical establishment and specifying the diagnosis and the duration of treatment;
5.7. The Insurer may, at its own discretion, request other documents required to determine the validity and amount of the insurance benefit;
5.8. Where the insurance contract provides for the payment of both hospital daily allowance and daily allowance for the same insured event and for the same days, only the hospital daily allowance shall be paid for the respective days.

6. Daily Allowance
6.1. The daily allowance shall be paid in cases where the Insured Person temporarily loses capacity for work due to bodily injuries or health disorders resulting from an insured event.
6.2. The amount of the insurance benefit for each day of incapacity for work shall be equal to the sum insured indicated in the insurance policy (or annexes thereto) under the daily allowance clause.
6.3. The daily allowance shall be paid from the date of an accident, but no earlier than the date on which the Insured Person starts receiving medical assistance. The daily allowance shall be paid for all days of incapacity for work, including days off and holidays.
6.4. No daily allowance shall be paid in cases where incapacity for work lasts less than 7 consecutive days.
6.5. The daily allowance per accident per person insured shall be paid for a maximum of 60 days.
6.6. The daily allowance for all accidents occurring during the term of the insurance contract shall be paid to one Insured Person for a maximum of 180 days.
6.7. The daily allowance for underage persons, if he/she does not work, shall be paid on the basis of documentary evidence of incapacity for work issued to the person taking care of the Insured Person.
6.8. Where the Insured Person temporarily loses capacity for work as a result of an insured event, the Policyholder or the Insured Person (a person authorized by them) shall apply to the Insurer for the payment of insurance benefits and submit the following documents (preliminary list of documents):
6.8.1. A completed claim application form;
6.8.2. Consent for the processing of personal data;
6.8.3. An accident at work report (if applicable);
6.8.4. Documentary evidence of the accident issued by police, a fire and rescue authority or another competent authority (if applicable);
6.8.5. Statements issued by an inpatient or outpatient treatment establishment specifying the diagnosis, the nature and duration of treatment;
6.8.6. A documentary proof of the issuance of a sick-leave certificate or a certificate of absence from an educational establishment;
6.9. The Insurer may, at its own discretion, request other documents required to determine the validity and amount of the insurance benefit;
6.10. The Insurer shall have the right to refuse to pay the daily allowance if the medical establishment does not issue a relevant sick-leave certificate or a certificate of absence from an educational establishment.

II. UNINSURED EVENTS

7. Uninsured Event

Uninsured event means any event which is not considered to be an insured event under these Terms and any event specified in these Terms which shall not oblige the Insurer to pay an insurance benefit. An event shall be regarded as uninsured, and no benefit shall be payable, if:

7.1. The Insured Person commits a suicide or attempts to commit a suicide;

7.2. An accident is intentionally caused by the Insured Person or other persons at the request of the Insured Person;

7.3. The Insured Person takes part in a fight or initiates it (except where such actions are socially valuable (self-defense, necessity, and the limits of those are not overstepped, performance of civic duties) or the use of physical power is directly related to the performance of official duties (except for cases as set forth in clause 7.4));

7.4. The insured person is on compulsory or alternative military service in the army or in any other similar formation;

7.5. The Insured Person uses alcohol, toxic, narcotic or other psychoactive substances or takes potent drugs without the relevant medical prescription; this clause shall apply where there is a direct causal relationship between the said circumstances and the occurrence of an accident;

7.6. After the Accident, the Insured Person avoids to undergo a test for the presence of alcohol or other substances, if circumstances set forth in clause 7.5. had or could have a direct causal relationship between the said circumstances and the occurrence of an accident;

7.7. The Insured Person operates a motor vehicle without the right to drive the respective vehicle or being under the influence of alcohol (blood alcohol concentration exceeds the permissible limit fixed in the legislation of the country where the vehicle was driven), narcotic or toxic substances; this clause shall apply where there is a direct causal relationship between the said circumstances and the occurrence of an accident;

7.8. The Insured Person gives control of a motor vehicle to a person who has no right to drive the respective vehicle or who is under the influence of alcohol (blood alcohol concentration exceeds the permissible limit fixed in the legislation of the country where the vehicle was driven), narcotic or toxic substances, as well as cases when the Insured Person knowingly (being aware or supposed to be aware) travels in a motor vehicle driven by a person who has no right to drive the respective vehicle or who is under the influence of alcohol (blood alcohol concentration exceeds the permissible limit fixed in the legislation of the country where the vehicle was driven), narcotic or toxic substances; this clause shall apply where there is a direct causal relationship between the said circumstances and the occurrence of an accident;

7.9. The Insured Person fails to observe a treatment regimen or medical recommendations following the occurrence of the insured event;

7.10. The Insured Person was injured as a result of spinal disc herniation, abdominal or abdominal cavity hernias, except cases described in these Terms;

7.11. Surgical scars as a result of a critical illness, other illness or disease;

7.12. The accident results from nuclear reaction, nuclear radiation, radioactive contamination, war, military training actions, declaration of the state of war or emergency, a revolution, rebellion, revolt, riot, mass unrest, sabotage;

7.13. The accident occurs during the Insured Person's sports activities (as described in more detail in these Terms) or increased-risk leisure activities (as described in more detail in these Terms), unless otherwise provided in the insurance policy (annexes thereto) (information on sports activities or increased-risk leisure activities provided in the application for the insurance contract is not regarded as an agreement on insurance coverage for sports activities or increased-risk leisure activities);

7.14. The accident occurs due to congenital, chronic or degenerative diseases, congenital or acquired physical defects, except for physical defects caused by another insured event during the term of the insurance contract;

7.15. The accident occurs as a result of acts of the Insured Person declared by a court or another competent authority or officer to be an intentional criminal offence subject to criminal liability of the Insured Person;
7.16. The accident occurs during the effective period of penal sanctions, procedural coercive measures (sentences, provisional and other measures) imposed on the Insured Person (including detention operations and time spent in a custodial institution etc.);
7.17. The accident, a health disorder or death of the Insured Person is caused by diseases or disease-induced seizures (e.g. diabetes, epilepsy or convulsions of the whole body, diseases inducing loss of consciousness and other diseases);
7.18. The accident is caused by mental reactions (affective state), mental trauma, illness or any other mental disorder;
7.19. Health disorder or death of the Insured Person is caused as a result of snakebite, animal or insect bites and/or stings infectious disease (except for cases provided for in Additional insurance cover clause "10 Daily allowance in the event of contracting an infectious disease", if this insurance cover clause is set out in the insurance policy (its annexes));
7.20. Insured Person's injuries related to unprescribed medical treatment and/or treatment not recognized by official medicine;
7.21. The accident, a health disorder or death of the Insured Person occurs as a result of surgery, treatment or other medical procedures, except where such procedures are performed to treat health disorders caused by an insured event;
7.22. A court declares the Insured Person missing;
7.23. A court declares the Insured Person dead, except for the cases deemed to be insured events under these Terms;
7.24. Death as a result of sickness;
7.25. This insurance does not cover claims in any way caused or contributed to by: nuclear reaction, nuclear radiation or radioactive contamination (LSW1210);
7.26. This insurance does not cover any claim(s) in any way caused or contributed to by an act of terrorism involving the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent. For the purpose of this exclusion an act of terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious, ideological or ethnic purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear. If the Insurer allege that by reasons of this exclusion any claim is not covered by this insurance the burden of proving the contrary shall be upon the Insured (2/02 LSW1175).
7.27. This insurance does not cover any claim(s) in any way caused or contributed to by Cyber act. However, this insurance will cover claims (s) which is accidently caused by or arises out of a cyber incident.

For purpose of this clause:

7.27.1. Cyber Act means:
7.27.1.1. a deliberate, unauthorised, malicious or criminal act;
7.27.1.2. a series of related deliberate, unauthorised, malious or criminal acts; or
7.27.1.3. any threat or hoax relating to 7.27.1.1. and/or 7.27.1.2. paraphs above,regardless of time and place, involving access to or the processing, use or operation of any computer system.

7.27.2. Cyber Incident means:
7.27.2.1. any error or omission or series of related errors or omissions involving access to or the processing, use, or operation of any computer system; or
7.27.2.2. any partial or total unavailability or failure or series of related partial or total unavailability or failures to access, process, use or operate any computer system.

7.27.3. Computer System means any computer, hardware, software, communications system, electronic device (including, but not limited to, smart phone, laptop, tablet, wearable device), server, cloud or microcontroller, including any similar system or any configuration of the

aforementioned and including any associated input, output, data storage device, networking equipment or back up facility, owned or operated by you or any other party.

7.28. Superior force (force majeure)

7.28.1.The parties to the insurance contract shall be exempted from liability for non-performance of the insurance contract if the party concerned proves that the non-performance was due to the circumstances which were beyond its control and could not have been reasonably expected by it at the time of the conclusion of the contract, and the arising of such circumstances or consequences thereof could not be prevented. A superior force (force majeure) shall not include such circumstances as the lack of the necessary financial resources on the part of the party, or violation by policyholder contrahents of their own obligations in respect of the Policyholder and the resulting failure by the latter to perform his obligations under the insurance contract.

7.28.2.Where the impedimental circumstance is temporary, the non-performing party of the insurance contract shall be exempted from liability only for such a period which is reasonable taking in regard the effect of that impedimental circumstance on the performance of the contract.

7.28.3.The party failing, whether now in the future, to perform any of its obligations under the insurance contract shall be obliged to inform the other party in writing about the impedimental circumstances within 14 days from the occurrence of force majeure, concurrently indicating the obligations that are or will be not performed. The provisions of this Article shall not deprive the other party to the insurance contract of exercising the right to dissolve the contract, or to suspend its performance, or to require interest due.

7.28.4.Where force majeure circumstances last for a period exceeding 2 months, the insurance contract shall cease in any case.

III. ADDITIONAL INSURANCE COVERAGE CLAUSES

The parties agree on the list of additional insurance coverage clauses applicable to a specific insurance contract (choosing from the groups listed in clauses 8-16) to be set out in the insurance policy (its annexes):

8. Insurance at Work Only

8.1. The insurance coverage shall only be valid for personal accidents occurring when:

8.1.1. The Insured Person is doing the work assigned by the employer;

8.1.2. The Insured Person is performing other work process-related tasks assigned by the employer or during a business trip;

8.1.3. The Insured Person is attending training or exercises organized by the employer;

8.1.4. The Insured Person is having lunch or taking any additional or special breaks;

8.1.5. The Insured Person is preparing or tidying his/her workspace during business hours, before or after work;

8.1.6. The Insured Person is going to or from work.

8.2. A report on the accident at work or on the way to or from work issued by a competent authority is required to get an insurance benefit under this additional clause.

8.3. In the event of choosing this insurance clause, the insurance coverage shall be applicable under the insurance coverage clauses set out in the insurance policy (annexes thereto) and only if accidents occur during the insurance period and within the insurance territory in the cases provided for in clauses 8.1.1–8.1.6.

9. Limit on the Number of Insured Events under the Death Insurance Coverage Clause

9.1. Under this clause, the insurance coverage shall only apply to the number of deaths caused by insured events indicated in the insurance policy. This means that insurance benefits in the event of death shall only be paid for the cases of death occurring first in the chronological order. If an Insured Person dies on a day other than the day of the accident, the chronological order of insured events (death cases) falling within the limit shall be formed using the date of death and not the date of the insured event.

10. Infectious disease cover

Daily allowance in the event of contracting an infectious disease

This additional clause, if included in the insurance policy (annexes thereto), shall only apply if combined with the Death and Injury clauses in the insurance policy (annexes thereto):

10.1. The insurance cover shall apply if the Insured Person contracts an infectious disease as a result of a bite or sting of snakes, mammals or insects (including mites) and there is objective data proving that the infection occurred during the period of insurance.

10.2. The insurance cover applies if the first symptoms of the disease appear 30 (thirty) calendar days from the coming into force of the insurance contract. This clause shall not apply in the event of renewing (extending), under the same conditions, an insurance contract containing the clause on the daily allowance in the event of contracting an infectious disease, under which the insurance cover in respect of the Insured Person contracting the infectious disease continues in force without interruption.

10.3. The amount of the insurance benefit shall be expressed as a percentage of the sum insured indicated in the insurance policy in case of injuries and shall be established in view of the length of treatment of the infectious disease:

10.3.1. Where the length of treatment is 3 to 4 days – 2%;

10.3.2. Where the length of treatment is 5 to 9 days – 4%;

10.3.3. Where the length of treatment is 10 to 19 days – 7%;

10.3.4. Where the length of treatment is 20 days or more – 10%.

10.4. When the insurance benefit is paid on the basis of treatment length, if only the outpatient treatment was used and the Insured Person was incapable to work for less than 3 days, the maximum benefit is 500 €.

10.5. If the Insured Person dies as a result of a snakebite, mammal or insect (including mites) bite/sting or infectious diseases borne by them, the insurance benefit to be paid shall be equal to the sum insured indicated in the insurance policy payable in the case of death.

10.6. If home-grown animals (pets) attack their master or his/her family members, the insurance benefit is reduced by 50%.

10.7. The insurance benefit under this additional coverage clause is paid only in case of Death and/or Injuries coverages. In case of Death insurance benefit is deducted from the insurance benefit payable for the same insured event under the injury insurance clause.

10.8. The insurance cover shall not apply if the Insured Person contracts an infectious disease as a result of sexually transmitted, parenteral, airborne and/or droplet-transmitted diseases or of complications thereof.

11. Minor Injuries

This additional clause, if included in the insurance policy (annexes thereto), shall only apply if combined with the Injury clause in the insurance policy (annexes thereto):

11.1. Insurance coverage due to ligaments sprain is not valid for the first 14 (fourteen) calendar days counting from the policy inception date. This insurance clause is not applicable to renewal policies if the same insurance cover (minor injuries) was applicable previously and insurance cover in respect of Insured person was valid without interruptions.

11.2. An insurance benefit shall be paid for bodily injuries and/or health disorders suffered by the Insured Person during an insured event that do not cause the death or disability of the person, as defined in these Terms, and are not included in the Table of Insurance Benefits provided at the end of these insurance Terms, if these injuries or disorders occur as a result of the following minor injuries:

11.2.1. Straining of the ligament of any part of the body where immobilization in a plaster cast or plastic splint or any equivalent immobilization is necessary or where the Insured Person was incapable to work (unable to go to an educational establishment) for 10 days or longer and this is confirmed by documents issued by the respective establishments;

11.2.2. Acute intoxication where the Insured Person needed outpatient treatment for more than 7 days or inpatient treatment for at least 3 days;

11.2.3. Finger or toe wounds with nail lesions where the Insured Person was incapable to work (unable to go to an educational establishment) due to the injury for 3 days or longer;

11.2.4. Finger or toe dislocation and injuries of finger or toe tendons or nerves where the Insured Person was incapable to work (unable to go to an educational establishment) due to the injury for 3 days or longer;

11.2.5. Traumatic asphyxia, injuries caused by an electric current (electrical systems, equipment, atmospheric electric discharge), a snake bite, mammal bite, etc., if they require inpatient treatment, except for cases where the treatment is given for an infectious disease (in this case, the additional insurance coverage clause on the daily allowance in the event of contracting an infectious disease will apply if specified in the insurance policy (its annexes)).

11.3. The amount of the insurance benefit payable for the injuries listed above shall be expressed as a percentage of the sum insured indicated in the insurance policy payable in the case of injuries and shall be determined as follows:

11.3.1. 1% - if the Insured Person:

11.3.1.1. was not incapable of work as a result of the injury and the length of minimal incapacity for work, inpatient treatment or immobilization is not determined in clauses 11.2.1.-11.2.5. or

11.3.1.2. was incapable of work (unable to go to an educational establishment), or was hospitalized or immobilization was necessary as a result of the injury sustained for a period of up to 14 days;

11.3.2. 2% - if the Insured Person was incapable of work (was unable to go to an educational establishment), or was hospitalized or immobilization is necessary as a result of the injury sustained for a period of 14 days or longer.

11.4. In the event of a foreign body in the respiratory tract, digestive tract, when the foreign body removed endoscopically (excluding the foreign bodies in the eyes, oral and nasal cavities, mouth, nasopharynx, pharynx, rectum, vagina, urethra), the insurance benefit is equal to 2% of the sum insured indicated in the insurance policy payable in the case of injuries.

11.5. In the event of soft tissue lesions (wounds) resulting in surgical treatment where the scars remaining (the overall length/surface area of the scars is measured) are less than 1.5 cm in length or 1 sq. cm in area (in the front or side surface area of the face or in the under-jaw area) or 5 cm in length (in the area of the scalp, extremities and torso), the insurance benefit is equal to 1% of the sum insured indicated in the insurance policy payable in the case of injuries.

11.6. In the event of bruising of any part or organ of the body where the Insured Person was incapable to work (unable to go to an educational establishment) due to the injury for 3 days or longer, or it was medically diagnosed hematoma, or when immobilization in a plaster cast or plastic splint or any equivalent immobilization is necessary for 10 days or long , the insurance benefit is equal to 1% of the sum insured indicated in the insurance policy payable in the case of injuries.

11.7. An insurance benefit of 1% of the sum insured indicated in the insurance policy payable in the case of injuries shall be paid when:

11.7.1. remaining pigment spots/ scars in the area of the face, frontal or lateral parts of the neck, or in the under-jaw area are less than 1.5 cm but more than 0.5 cm in length or less than 1 sq. cm but more than 0.5 sq. cm in area (the overall length/surface area of the pigment spots/scars is measured) as a result of a thermal, chemical burn;

11.7.2. remaining pigment spots/ scars in the scalp, extremities or trunk area are less than 5 cm but more than 2 cm (less than 2 cm but more than 1 cm for children up to the age of 10) in length or less than 0,5% or more than 0,25% of the body surface area (the overall length/surface area of the pigment spots/scars is measured) as a result of a thermal, chemical burn.

Pigment spots and scars (except for scars formed after surgical closure of the wound) are measured after a healing period. If the recovering period is not specified in the medical documents, not earlier than 1 month from the date of injury.

11.8. Where an insurance benefit is paid for any of the bodily injuries sustained by the Insured Person during an insured event under the Injury insurance coverage clause, no insurance benefit shall be

payable under this additional insurance coverage clause, irrespective of the injury for which an insurance benefit is paid under the Injury insurance coverage clause.

11.9. If several injuries occur during one event, for which the insurance benefit shall be paid under this additional clause, only one, the highest insurance indemnity shall be paid.

12. Insurance of All Employees

12.1. The insurance cover shall apply to all employees of the Policyholder who have entered into an employment contract with the Policyholder or hold an elective or appointed office in the management or supervisory bodies of the Policyholder (including new positions in the company).

12.2. All newly employed staff of the Policyholder shall be deemed insured automatically from the date of employment.

12.3. The insurance cover shall automatically cease to apply to all dismissed employees of the Policyholder from the date of their dismissal (termination of employment).

12.4. At the end of the term of the insurance contract (or within other time limits set out in the insurance contract), the Policyholder shall provide the Insurer with data on any changes in the number of the Policyholder's employees over the previous insurance period and with supporting documents, if required by the Insurer. Based on the data submitted, the Insurer shall revise the annual insurance premium in proportion to the actual number of employees covered in the period in question.

13. Extended Disability Insurance

This additional clause, if included in the insurance policy (annexes thereto), shall only apply if combined with the disability insurance coverage clause in the insurance policy (annexes thereto):

13.1. If the Insured Person loses more than 70% of working capacity (in the case of a high degree of disability for children under 18 years of age) as a result of an insured event, the payable insurance benefit shall be doubled. This additional insurance cover clause shall not apply to Insured Persons of retirement age.

14. Extension Regarding Alcohol Intoxication

14.1. If the alcohol concentration in the blood of the Insured Person does not exceed 0.6‰ and this is confirmed by medical documents, it shall be deemed that there is no causal link between alcohol intoxication and the accident.

15. Extension Regarding Sports

15.1. Sports activities means participation in any kind of sports exercises, training or competitions organized by a sports organisation. Sports organisations are deemed to include incorporated sports clubs, sports centres, sports schools, sports facilities, sports federations, associations and societies, other organisations and institutions engaged in sports activities and creating conditions for engaging in physical education and sports, training of athletes, holding sports competitions and other physical education and sports events.

16. Crew Insurance

16.1. Under this additional cover clause, the driver and passengers of a motor vehicle specified in the insurance policy shall be deemed Insured Persons.

16.2. Under this additional cover clause, an accident involving the Insured Person and occurring during the term of the insurance contract shall be deemed an insured event, provided that all of the following conditions are satisfied:

16.2.1. The accident occurs during a traffic incident when the Insured Person is in the motor vehicle indicated in the insurance policy, and

16.2.2. The traffic incident involves at least two vehicles or other third parties are injured, or third-party property is damaged, and

16.2.3. The Insured Person (driver of the vehicle) is the guilty party in the traffic incident, as well as under the compulsory motor third party liability insurance contract, and

16.2.4. The traffic incident is registered with the police in accordance with the procedure prescribed by legislation.

16.3. If the insurance contract provides for the payment of an insurance benefit to the Insured Person for an insured event both under this additional insurance cover clause and under another insurance coverage clause, the insurance benefit under this additional insurance coverage clause shall not be paid.

17. Insurance for Medical Expenses Due to Accident

This additional clause, if included in the insurance policy (annexes thereto), shall only apply if combined with the Injury clause in the insurance policy (annexes thereto):

17.1. An insurance benefit shall be paid for medical expenses incurred by the Insured Person (by one of the parents, adoptive parents or guardians if the person insured is underage) during an insured event in the Insured Person's country of permanent residency for medically substantiated health care services and equipment prescribed by the physician necessary as a result of an Injury included in the Table of Insurance Benefits or a Minor Injury as defined in the clause 11. Minor Injuries in these Terms, if the Minor Injury clause is included in the insurance policy.

In the case of declaring the medical services received by the Insured Person an insured event, the sum of medical expenses which are confirmed by financial documents shall be paid for:

17.1.1. consultations with specialised physicians (trauma surgeons, surgeons, neurologists, radiologists, ultrasound doctors, odonatologists', etc.);

17.1.2. surgeries and procedures (surgical closures of wounds, changing wound dressings, injections, infusions);

17.1.3. diagnostic tests (laboratory, functional, radiology, instrumental) necessary to confirm the injuries and provide treatment;

17.1.4. treatment of dental injuries;

17.1.5. treatment and services not compensated from the budget of the Compulsory Health Insurance Fund (comfort services, additional care, nursing, surcharge for medical equipment and medicine) in an outpatient health care institution;

17.1.6. Purchase of medicine, medical assistance or technical orthopaedic supplies (dressings, bandages, syringes, casts, canes, crutches, purchase or rent of medical aid equipment to look after yourself) registered by the State Medicines Control Agency and purchased in a pharmacy;

17.1.7. Medically substantiated outpatient and/ or inpatient treatment of trauma consequences (physiotherapy procedures, individual or group kinesiotherapy, medical massage, consultations with a kinesitherapist, ergo therapist or a speech therapist) as prescribed by a physician.

17.2. An insurance benefit shall not be paid for medical expenses incurred by the Insured Person for:

17.2.1. An event declared uninsured under the clauses of these Terms;

17.2.2. Health care services and/or treatment whose duration and substantiality may not be proven by the provided or available medical documents;

17.2.3. Health care services provided by a provider unlicensed by the respective institution of the Insured Person's country of permanent residence and/ or applying unapprobated methods of diagnosis and treatment;

17.2.4. Organ transplantations, bone marrow transplantations, haemodialysis procedures;

17.2.5. Cosmetic and plastic surgeries, cosmetic and beauty procedures, laser eye corrections;

17.2.6. Purchase of glasses, contact lenses, products for their care, the production of glasses, fake lenses;

17.2.7. Purchase of food supplements, anabolic steroids, weight-reducing, potency increasing medicinal products, medicinal products for hygiene, cosmetic and contraceptive means, products for treatment of various addictions, as well as medicinal products not registered in the European Union;

17.2.8. purchase of medical means (such as thermometers, inhalers, testers, warmers, hearing aids, scales, blood pressure measuring devices, glucometers etc.);

17.2.9. Medically unsubstantiated psychiatric and/or psychologic services and consultations;

17.2.10. The provision of medical and other documentation.

17.3. The insurance benefit payable for one insured event may not exceed 1500 EUR.

17.4. The insurance benefit payable for several insured events may not exceed 100% of the sum of medical expenses fixed in the insurance policy, which may not be higher than 3000 EUR.

17.5. Upon the occurrence of an insured event, the Policyholder, the Insured Person (a person authorised by them) shall apply to the Insurer for the payment of insurance benefits and submit the following documents (preliminary list of documents):

17.5.1. A completed damage report form;

17.5.2. Consent for the processing of personal data;

17.5.3. Financial documentary evidence of medical expenses (checks, paid bills, bank statements, etc.)

IV. COMPLAINTS HANDLING PROCEDURE

FOR LITHUANIAN CUSTOMERS

Any complaint should be addressed to:

Kristina Penkaitienė, CEO
Baltic Underwriting Agency, AB
Kestucio str. 59, 2nd floor, Vilnius 08124, Lithuania

T +370 5 266 7799
info@bunda.eu

Your complaint will be acknowledged, in writing, within 5 (five) business days of the complaint being received.

A decision on your complaint will be provided to you, in writing, within 15 (fifteen) working days of the complaint being received. In exceptional cases, a final decision will be provided to you within 35 (thirty-five) business days of the complaint being received.

If you are a consumer and should you remain dissatisfied with the final response or if you have not received a final response within 15 (fifteen) business days or in exceptional cases 35 (thirty-five) business days, you may be eligible to refer your complaint to the Bank of Lithuania.The contact details are as follows:

Bank of Lithuania
Supervision Service
Žirmūnų g. 151
Vilnius 09128
Lithuania

T +370 5 268 0029
F +370 5 268 0038
info@lb.lt
www.lb.lt/consumer_protection

If you have purchased your contract online, you may also make a complaint via the EU's online dispute resolution (ODR) platform. The website for the ODR platform is www.ec.europa.eu/odr.

The complaints handling arrangements above are without prejudice to your right to commence a legal action or an alternative dispute resolution proceeding in accordance with your contractual rights.

LBS0041A
01/01/2019

FOR LATVIAN CUSTOMERS

Any complaint should be addressed to:

Kristina Penkaitienė, CEO
Baltic Underwriting Agency, AB
Kestucio str. 59, 2nd floor, Vilnius 08124, Lithuania

T +370 5 266 7799
info@bunda.eu

Your complaint will be acknowledged, in writing, within 5 (five) business days of the complaint being made.A decision on your complaint will be provided to you, in writing, within 8 (eight) weeks of the complaint being made.

Should you remain dissatisfied with the final response or if you have not received a final response within 8 (eight) weeks of the complaint being made, you may be eligible to refer your complaint to the Consumer Rights Protection Centre or the Financial and Capital Markets Commission. The contact details of these organisations are as follows:

Consumer Rights Protection Centre
Brivibas Street 55
Riga
LV-1010
Latvia

T +371 6545 2554
F +371 6738 8634
ptac@ptac.gov.lvwww.ptac.gov.lv/en/content/consumer-protection-0

Financial and Capital Market Commission
Kungu iela 1
Riga
LV-1050
Latvia

T +371 67774800
fktk@fktk.lv
www.fktk.lv/en/commission/about-us/2011-10-19-consumer-complaints-hand.html

If you have purchased your contract online, you may also make a complaint via the EU's online dispute resolution (ODR) platform. The website for the ODR platform is www.ec.europa.eu/odr.

The complaints handling arrangements above are without prejudice to your right to commence a legal action or an alternative dispute resolution proceeding in accordance with your contractual rights.

LBS0055A
01/01/2019

FOR ESTONIAN CUSTOMERS

Any complaint should be addressed to:

Kristina Penkaitienė, CEO
Baltic Underwriting Agency, AB
Kestucio str. 59, 2nd floor, Vilnius 08124, Lithuania

T +370 5 266 7799
info@bunda.eu

Your complaint will be acknowledged, in writing, within 5 (five) business days of the complaint being made.

A decision on your complaint will be provided to you, in writing, within 8 (eight) weeks of the complaint being made.

Should you remain dissatisfied with the final response or if you have not received a final response within 8 (eight) weeks of the complaint being made, you may be eligible to refer your complaint to the Consumer Protection Board in Estonia. The contact details are as follows:

Consumer Disputes Committee
Consumer Protection Board
Pronksi 12,
10117 Tallinn
Estonia

T +372 6201 920
avaldus@komisjon.ee or info@tarbijakaitseamet.ee
www.tarbijakaitseamet.ee/en/consumer-disputes-committee

If you have purchased your contract online, you may also make a complaint via the EU's online dispute resolution (ODR) platform. The website for the ODR platform is www.ec.europa.eu/odr.

The complaints handling arrangements above are without prejudice to your right to commence a legal action or an alternative dispute resolution proceeding in accordance with your contractual rights.

LBS0053A
01/01/2019

FOR POLAND CUSTOMERS

Any complaint should be addressed to:

Kristina Penkaitienė, CEO
Baltic Underwriting Agency, AB
Kestucio str. 59, 2nd floor, Vilnius 08124, Lithuania

T +370 5 266 7799
info@bunda.eu

Your complaint will be acknowledged, in writing, within 5 (five) business days of the complaint being made.

A decision on your complaint will be provided to you in writing by post, within 30 (thirty) days of the complaint being received. The decision may be sent to you by e-mail if you requested this and provided an e-mail address.

If it is not able to provide you with a decision within 30 days because it is a complex complaint, you will be contacted. You will be advised of the reason for the delay, the circumstances that must be established to handle the case and the expected timescale within which a response will be provided, which will not be more than 60 (sixty) days after the complaint has been received.

Should you remain dissatisfied with the final response or if you have not received a final response within 30 (thirty) days of the complaint being made, you may be eligible to refer your complaint to the Financial Ombudsman. The contact details are as follows:

Financial Ombudsman
Al. Jerozolimskie 87
02-001 Warsaw
Poland

T +48 22 333 73 26/27
F +48 22 333 73 29
biuro@rf.gov.pl
www.rf.gov.pl/

If you have purchased your contract online, you may also make a complaint via the EU's online dispute resolution (ODR) platform. The website for the ODR platform is www.ec.europa.eu/odr.

The complaints handling arrangements above are without prejudice to your right to commence a legal action or an alternative dispute resolution proceeding in accordance with your contractual rights.

LBS0039A
01/01/2019

FOR FINLAND CUSTOMERS

Any complaint should be addressed to:

Kristina Penkaitienė, CEO
Baltic Underwriting Agency, AB
Kestucio str. 59, 2nd floor, Vilnius 08124, Lithuania

T +370 5 266 7799
info@bunda.eu

Your complaint will be acknowledged, in writing, within 5 (five) business days of the complaint being made.

A decision on your complaint will be provided to you, in writing, within 8 (eight) weeks of the complaint being made.

Should you remain dissatisfied with the final response or if you have not received a final response within 8 (eight) weeks of the complaint being made, you may be eligible to refer your complaint to the Financial Ombudsman Bureau or the Consumer Disputes Board. The contact details of these organisations are as follows:

Financial Ombudsman Bureau
Porkkalankatu 1
00180 Helsinki
Finland

T +358 9 6850 120
F +358 9 6850 1220
info@fine.fi
www.fine.fi/en/frontpage.html

Consumer Disputes Board
Hämeentie 3
P.O. Box 306
00531 Helsinki
Finland

T +358 29 566 5200
F +358 29 566 5249
kril@oikeus.fi
www.kuluttajariita.fi/en/index/kuluttaja-asiat/kuluttaja-asiat/vakuutuksetjapankit.html

If you have purchased your contract online you may also make a complaint via the EU's online dispute resolution (ODR) platform. The website for the ODR platform is www.ec.europa.eu/odr.

The complaints handling arrangements above are without prejudice to your right to commence a legal action or an alternative dispute resolution proceeding in accordance with your contractual rights. You are entitled to institute a claim in the district court of your place of residence in Finland if you are Finnish resident and a policyholder, insured or beneficiary under your insurance contract. Such claim may be instituted within three years after receiving a written information on the final response.

LBS0054A
01/01/2019

FOR NETHERLANDS CUSTOMERS

Any complaint should be addressed to:

Kristina Penkaitienė, CEO
Baltic Underwriting Agency, AB
Kestucio str. 59, 2nd floor, Vilnius 08124, Lithuania

T +370 5 266 7799
info@bunda.eu

Your complaint will be acknowledged, in writing, within 2 (two) weeks of the complaint being received.

A decision on your complaint will be provided to you, in writing, within 6 (six) weeks of the complaint being received.

Should you remain dissatisfied with the final response or if you have not received a final response within 6 (six) weeks after the complaint has been received by the insurer, you may be eligible to refer your complaint to the Complaints Institute for Financial Services (Kifid) in the Netherlands. The contact details are as follows:

Complaints Institute for Financial Services (Kifid)
Postbus 93257
2509 The Hague
The Netherlands

Tel: +31 (0) 70 333 8 999
E-mail: consumenten@kifid.nl
Website: www.kifid.nl

If you have purchased your contract online you may also make a complaint via the EU's online dispute resolution (ODR) platform. The website for the ODR platform is www.ec.europa.eu/odr.

The complaints handling arrangements above are without prejudice to your right to commence a legal action or an alternative dispute resolution proceeding in accordance with your contractual rights.

LBS0028
01/01/2019

V. GENERAL PROVISIONS

Only the insurance coverage clauses, additional insurance coverage clauses and instructions for the Policyholder set out in the insurance policy shall apply upon concluding the insurance contract. If the insurance policy clauses differ from the insurance coverage clauses, additional insurance coverage clauses or instructions for the Policyholder laid down in these Terms, the insurance policy clauses shall prevail.

18. Definitions

18.1. **Insurer** means: Lloyd's Insurance Company S.A. a Belgium limited liability company (*société anonyme / naamloze vennootschap*) with its registered office at 14th Floor, Bastion Tower, Place du Champ de Mars 5, 1050 Brussels, Belgium and registered with Banque-Carrefour des Entreprises / Kruispuntbank van Ondernemingen under number 682.594.839 RLE (Brussels). It is an insurance company subject to the supervision of the National Bank of Belgium. Its Firm Reference Number(s) and other details can be found on www.nbb.be.
Website address: www.lloyds.com/brussels
E-mail: enquiries.lloydsbrussels@lloyds.com

18.2. **Policyholder** means any person who has applied to the Insurer to sign the insurance contract or to whom the Insurer has proposed to sign the insurance contract or any person who has signed the insurance contract with the Insurer in accordance to these Terms for the pecuniary interests of his own or any other person who becomes an Insured Person after signing the insurance contract.

18.3. **Insured Person** means a natural person indicated in the insurance policy (its annexes) who is entitled to an insurance benefit payable by the Insurer upon the occurrence of an insured event. The Insured Persons may be identified in the insurance policy (its annexes) as:

18.3.1. Specific insured natural persons;

18.3.2. Insured workplaces in a particular company, institution or organisation;

18.3.3. Insured positions in a particular company, institution or organisation;

Where the insurance contract covers workplaces or positions in a particular company, institution or organisation, the Insured Persons shall mean natural persons who occupy the respective workplaces or hold the respective positions in the indicated company, institution or organisation during the insurance period. If a person works in a specific workplace or position in the indicated company, institution or organisation during part of the insurance period, the person shall be considered to be an Insured Person for the period of work in the specific position or workplace. The Policyholder may only change a particular Insured Person, insured workplaces or insured positions with the written consent of the Insurer. The consent of the Insurer is not required where the insurance contract contains the additional insurance cover clause "5. Insurance of all employees" or where the persons working in a specific insured workplace or position are replaced in the cases specified in clauses 18.3.2 and 18.3.3.

18.4. **Beneficiary** means a person indicated in the insurance policy (its annexes) or appointed by the Policyholder (or by the Insured Person in the cases provided for in the insurance contract) who acquires the right to an insurance benefit upon the occurrence of an insured event. If the Beneficiary is not indicated in the insurance contract, the insurance contract shall be considered to be concluded for the benefit of the Insured Person. The Beneficiary shall be appointed in accordance with the procedure prescribed in these Terms.

18.5. **Heir** means a person who takes over all or part of the Insured Person's rights (including the right to receive an insurance benefit) and obligations under the insurance contract upon the death of the Insured Person in accordance with the procedure prescribed in legislation and who provides a relevant certificate of inheritance or other document certifying his right of inheritance and issued in accordance with the procedure prescribed in legislation.

18.6. **Authorised person** means a person who has a power of attorney meeting the legislative requirements and issued in accordance with the procedure prescribed in legislation for representing the Policyholder, the Insured Person or the Beneficiary in relations with the Insurer in respect of the insurance contract concluded on the basis of these Terms.

18.7. **Group of Insured Persons** means a situation where the pecuniary interests of at least two Insured Persons are insured under one insurance contract.
18.8. **Insurance premium** means an amount of money specified in the insurance policy (its annexes) which shall be paid by the Policyholder for the insurance cover provided under the insurance contract concluded in accordance with these Terms.
18.9. **Insurance benefit** means an amount of money which Insurer shall pay to a person entitled to an insurance benefit under the insurance contract upon the occurrence of an insured event. The following persons shall be entitled to an insurance benefit under the insurance contract:
18.9.1. An Insured Person whose pecuniary interests are insured under the insurance contract and affected by an insured event, as well as a Heir in the case of death of the Insured Person; the Policyholder shall also be considered to be an Insured Person where his pecuniary interests are insured under the insurance contract and affected by an insured event;
18.9.2. The Beneficiary in the event of the death of the Insured Person, provided that the Beneficiary is specified in the insurance policy (its annexes) or appointed in accordance with the procedure laid down in these Terms;
18.10. **General Terms and Conditions (the Terms)** mean these General terms and conditions on personal accident insurance governing the insurance contract, the terms of which apply to the insurance contract unless the insurance policy (its annexes) provides otherwise.
18.11. **Insured event** means personal accident (or the accident) an event specified in the insurance contract, occurring in the territory and during the period of insurance, as a result of which the Insurer shall pay an insurance benefit. Insured events are specified in Chapter I of these Terms.
18.12. **Uninsured event** means any event which is not considered to be an insured event under these Terms and any event specified in these Terms which shall not oblige the Insurer to pay an insurance benefit. The list of uninsured events (exclusions) is provided in Chapter II of these Terms.
18.13. **Disabled person** means a person with a degree of disability or 55% or lower working capacity or special needs confirmed by a competent state institution in accordance with the procedure prescribed by law as well as a person assigned disability group I, II or III before 30^{t} June 2005.
18.14. **Disability** means long-term health deterioration or limited participation in public life and reduced operating possibilities resulting from a combination of body composition and function disorders and adverse environmental factors. The insurance shall only cover disability directly caused by an insured event.
18.15. **Degree of disability** means the extent of deterioration in a person's health condition and loss of independence in daily activities and self-development possibilities evaluated by a competent authority during a comprehensive assessment in accordance with the procedure prescribed by law. The insurance shall only cover disability directly caused by an insured event.
18.16. **Working capacity level** means a person's ability to execute his previously acquired professional competence or gain a new professional competence or do jobs requiring a lower professional competence; the working capacity level is determined by a competent authority in accordance with the procedure prescribed by law.
18.17. **Loss of working capacity** means a decrease in the working capacity level of the Insured Person. The insurance shall only cover loss of working capacity directly caused by an insured event.
18.18. **Special need** means a need for special assistance resulting from congenital or acquired long-term health disorders (disability or loss of working capacity) and adverse environmental factors; special needs and the level of special needs is determined by a competent authority in accordance with the procedure prescribed by law. The insurance shall only cover special needs-related disability directly caused by an insured event.
18.19. **Instructions for the Policyholder** means actions specified in the insurance policy (its annexes) and/or in these Terms which the Policyholder, the Insured Person and/or the Beneficiary shall perform or actions from which the Policyholder, the Insured Person and/or the Beneficiary shall refrain or other circumstances the existence or absence of which shall be ensured by the Policyholder, the Insured Person and/or the Beneficiary; the Policyholder, the Insured Person and/or the Beneficiary shall

execute such instructions of the Insurer throughout the insurance period, unless provided otherwise in a specific case.

18.20. **Insurance coverage clauses** means the general insurance coverage clauses specified in these Terms (Chapter I of these Terms); only the insurance cover clauses specified in the insurance policy (its annexes) are applicable to the insurance contract.

18.21. **Additional insurance coverage clauses** means the additional insurance coverage clauses specified in these Terms which extend or reduce the insurance cover provided under the general insurance coverage clauses (Chapter III of these Terms) and which are only valid in combination with the general insurance coverage clauses; only the additional insurance coverage clauses specified in the insurance policy (its annexes) are applicable to the insurance contract.

18.22. **Application form** means an application for concluding an insurance contract in the form determined by the Insurer, which shall be provided by the Policyholder in the cases provided for in these Terms prior to concluding the insurance contract.

18.23. **Insurance contract** means the personal accident insurance contract concluded between Insurer and the Policyholder in accordance to these Terms, which may consist of part or all of the following documents:

18.23.1. Application form;

18.23.2. Insurance policy (its annexes);

18.23.3. These Terms;

18.23.4. Other documents if specified as part of the insurance contract;

18.24. **Increase in insurance risk** means an increase in insurance risk in cases where:

18.24.1. The number of Insured Persons (the number of insured persons or insured workplaces or insured positions) specified in the insurance policy (its annexes) increases by more than 10% (except where the insurance contract contains the additional insurance cover clause "5. Insurance of all employees") or

18.24.2. The insured positions specified in the insurance policy (its annexes) change (except where the insurance contract contains the additional insurance cover clause "5. Insurance of all employees") or

18.24.3. The nature of the Insured Person's job changes or

18.24.4. The Insured Person undertakes sports activities or goes in for a sport other than specified in the insurance policy (the term "sports activities" is defined in clause 18.25 of the General Provisions) or

18.24.5. The Insured Person is engaged in increased-risk leisure activities (the term "increased-risk leisure activities" is defined in clause 18.26 of the General Provisions) or

18.24.6. The Insured Person becomes disabled or the established degree of his disability or loss of working capacity or special needs increase, or new special needs are determined, or

18.24.7. The Insured Person develops or is diagnosed with mental or behavioural disorders or#

18.24.8. A court declares the Insured Person to be legally incapable or partly capable or

18.24.9. During the insurance period, the Insured Person develops very serious, incurable or hardly curable diseases, such as third or fourth stage cancer, renal failure, multiple sclerosis, etc. which were not diagnosed when concluding the insurance contract, or

18.24.10. The Policyholder (legal entity) is reorganised (or participates in reorganisation), restructured, liquidated, is sold in part or in whole as a complex of assets, or change of the persons controlling the Policyholder (who have 50% or more votes at the General Meeting of Shareholders of the Policyholder);

18.24.11. Other circumstances specified in the insurance contract that increase or may increase insurance risk change substantially.

18.25. **Sports activities** means participation in any kind of sports exercises, training or competitions organised by a sports organisation. Sports organisations are deemed to include incorporated sports clubs, sports centres, sports schools, sports facilities, sports federations, associations and societies, other organisations and institutions engaged in sports activities and creating conditions for engaging in physical education and sports, training of athletes, holding sports competitions and other physical education and sports events. Individual or group sports activities that are held on health purpose, is a part of curriculum, that are just a form of the Insured Person's leisure activities shall not be classified

as sports activities, provided that competitions and marathons are not participated in and such leisure activities are not increased-risk leisure activities, as defined in these Terms.

18.26. **Increased-risk leisure activities** mean the development of or engagement in a sport dangerous to life or health (extreme sport or activities) or activities that usually require special equipment or gears. Sports and activities dangerous to life or health are considered to include the following and similar sports or activities: different forms of martial arts and contact sports (boxing, wrestling and similar sports); piloting an aircraft (gliding, acrobatic flying, paragliding, air-ballooning or operating other light aircraft); aviation sports (parachuting, kite-boarding and other similar sports or activities); water sports (scuba diving, ocean sailing, river-boarding, surfing,); auto-motor sports; bicycle sports (bicycle cross-country racing, mountain biking; BMX biking); sports and activities involving the use of firearms; speleology, expeditions to mountains, jungles, deserts or other uninhabited places; mountaineering; bungee-jumping; downhill skiing on unmarked slopes; riding a quad riding a motorcycle with a capacity of over 74 kW (100 HP).

18.27. **Insurance cover** means the Insurer's obligation to pay an insurance benefit upon the occurrence of an insured event under the insurance contract.

18.28. **Insurance period** means the period of time form the effective date of the insurance cover to the expiry of the insurance coverage, as specified in the insurance policy (its annexes).

The terms used and defined in these Terms that are stated in the singular shall include the plural, and vice versa; terms in the masculine or feminine gender shall be understood as including any of those genders. The terms defined in these Terms shall be understood as defined in these Terms regardless of whether they are used in upper or lower case. The headings and names of parts of these Terms are for convenience only and do not have any essential effect on the interpretation of these Terms. Except where these Terms explicitly refer to the Insured Person or the Beneficiary, all instructions for the Policyholder shall apply both to the Insured Person and the Beneficiary as long as it does not conflict with the essence of personal accident insurance and the rights and obligations of the Insured Person and the Beneficiary.

In case of any conflict or discrepancies in the between the insurance cover clauses, the Terms and the policy (it's annexes), the provisions of the policy (it's annexes) shall have priority.

18.29.**Fraud**

If a claim made by Insured Person, Policyholder or anyone acting on Insured Person or Policyholders behalf, or any person claiming to be indemnified is fraudulent or exaggerated, whether ultimately material or not or if a false declaration or statement is made or if a fraudulent device is used in support of a claim Insurer may at Insurer's option cancel the Policy from the date of the claim or alleged claim and repudiate the claim**.**

19. Object of Insurance

19.1. The object of insurance is pecuniary interest related to the Insured Person's health, injuries and life of insured under the terms of the insurance contract.

20. Sum Insured

20.1. The sum insured is an amount of money specified in the insurance policy (its annexes) which shall not be exceeded by an insurance benefit. Unless the insurance contract provides otherwise, the sum insured for the rest of the insurance period is reduced by the amount of a paid insurance benefit, and the total amount of insurance benefits paid by the Insurer under the insurance contract during the insurance period shall not exceed the sum insured fixed in the insurance contract.

20.2. A separate sum insured shall be fixed for each insurance coverage clause.

20.3. The sums insured shall be fixed by a mutual agreement between the Policyholder and the Insurer and shall be indicated in the insurance policy (its annexes).

20.4. Unless the insurance contract provides otherwise, the sums insured shall apply to each Insured Person individually, i.e. where more than one person is insured under the insurance contract, upon the occurrence of an insured event, each Insured Person may be paid an insurance benefit up to the specified sum insured. This clause shall not apply in the case of insured events under the death insurance clause which provides that the insurance coverage shall only be valid for the number of deaths caused by insured events indicated in the insurance policy.

20.5. Unless the insurance contract provides otherwise, the sums insured indicated in the insurance policy (its annexes) shall be equal for all persons insured under the insurance contract.

21. Insurance Coverage Limits and Territory

21.1. The insurance cover shall be valid for all insured events all over the world during the insurance period, unless the insurance contract provides otherwise.

21.2. The insurance cover shall be valid during the insurance period 24 hours per day, unless the insurance contract provides otherwise.

22. Pre-Contractual Obligations of the Parties and the Procedure for Concluding an Insurance Contract

22.1. In order to enter into an insurance contract, the Policyholder shall present the Insurer with an application of an established form. The Application may not be submitted if the Policyholder provides the Insurer with information considered to be sufficient for the Insurer to assess insurance risks and includes all material circumstances, as specified in clause 22.7 below.

22.2. The Insurer has the right to request additional documents and information required to assess insurance risks and enter into an insurance contract. The Insurer has the right to request the Policyholder to provide documentary evidence of the Insured Persons' age, health conditions, profession and other circumstances relevant to insurance risk assessment. The Insurer shall not have a right to request any data from genetic studies.

22.3. Where the Policyholder is a company, institution or organisation which seeks to insure its employees, workplaces or positions, the Insurer shall also have the right to inspect the workplaces and working conditions of the persons requested to be insured prior to concluding an insurance contract. Failure by the Insurer to exercise the right provided for herein shall not limit other rights of the Insurer under the insurance contract.

22.4. Prior to entering into an insurance contract, the Policyholder shall provide the Insurer with all available information on the Policyholder and the persons to be insured:

22.4.1. Whether the person to be insured is disabled (an degree of disability, loss of working capacity or special needs are established), has mental or behavioural disorders (is mentally ill) or has been declared by a court to be legally incapable or partially capable;

22.4.2. Whether the person to be insured intends to engage in sports activities or increased-risk leisure activities during the term of the insurance contract;

22.4.3. Whether there are any other accident insurance contracts concluded or planned to be concluded for the Insured Person requested to be insured.

The above requirements shall not apply to employers insuring groups of employees.

22.5. The Policyholder shall provide the Insurer with all available information on any circumstances that may have a substantial effect on the probability of occurrence of insured events and the amount of potential losses resulting from such an event (insurance risk).

22.6. The Policyholder shall ensure that the personal data of the persons requested to be insured, including sensitive personal data (data on health), are transferred to the Insurer with the prior written consent of the persons concerned.

22.7. The material circumstances to be reported by the Policyholder to the Insurer shall include:

22.7.1. The information specified in clause 22.4 of this chapter;

22.7.2. The information requested to be provided in the application, except in cases where the application is not completed;

22.7.3. Other information requested by the Insurer to be provided in writing;

22.7.4. Information on any other accident insurance contracts covering the same Insured Person where the insurance period under the contracts fully or partially coincides with the term of the insurance contract to be entered into.

22.8. The Insurer shall present the Policyholder with a proposal on the terms and conditions of the insurance contract on the basis of the information and documents submitted by the Policyholder and received during the inspection of the workplace and working conditions of the persons requested to be insured (if applicable).

22.9. The insurance contract shall be concluded under the proposed terms and conditions accepted by the Policyholder. In the event of any discrepancy between the insurance policy (its annexes) and the application form (if submitted), the terms and conditions set out in the insurance policy (its annexes) shall prevail.

22.10. The Insurer shall have a right to refuse to provide a proposal on the terms and conditions of the insurance contract and refuse to enter into the insurance contract without indicating any reasons for such refusal;

22.11. The Policyholder may enter into the insurance contract in respect of the pecuniary interests of his own or another person (Insured Person) and for the benefit of his own, the Insured Person or another third party (Beneficiary). Unless the insurance contract provides otherwise, the Policyholder shall, in any case, remain liable to the Insurer for the proper execution of the insurance contract. The Insurer shall have the right to request the Insured Person to undertake the execution of his part of obligations under the insurance contract if Policyholder does not execute this part of the insurance contract. The Insurer shall also have the right to request the Beneficiary to undertake the execution of his part of obligations under the insurance contract if the Policyholder does not execute this part of the insurance contract and the Beneficiary presents the Insurer with a claim for an insurance benefit under the insurance contract.

22.12. The insurance contract shall, at the discretion of the Insurer, be concluded in one of the following ways:

22.12.1. By both parties to the insurance contract signing the insurance policy in the established form;

22.12.2. Upon the issuance by the Insurer to the Policyholder of the insurance policy signed by the Insurer and upon the payment by the Policyholder of the insurance premium fixed in the insurance policy or the first instalment of the insurance premium in accordance with the terms and conditions set out in the insurance policy.

22.13. The insurance contract shall be signed by a person authorised to sign the insurance contract on behalf of the Insurer. A facsimile signature of the person authorised by the Insurer shall be deemed to be equivalent to the signature of the Insurer.

22.14. In the event that prior to concluding the insurance contract, the Policyholder knowingly submits false information to the Insurer, this shall be deemed a material breach of the insurance contract. In this case, the Insurer shall have the right to cancel the insurance contract or request invalidation of the insurance contract. The Insurer shall also enjoy these rights in cases where the Insured Person knowingly provides false information, regardless of whether or not the Policyholder is aware of the false nature of the information.

22.15. In the event of establishing after the conclusion of the insurance contract that Policyholder did not submit the information specified in clause 22.7 of this chapter prior to entering into the insurance contract through negligence or inattention, then Insurer shall have the right to propose the Policyholder to change insurance contract within two months of the date of becoming aware of these circumstances. If the Policyholder refuses to change the contract or does not respond to the proposal within one month, the Insurer shall have the right to request cancellation of the insurance contract. If the insurance contract is not terminated due to the circumstances specified herein, in the case of an insured event, the Insurer shall pay the part of the insurance benefit that would have been paid if the Policyholder had properly provided the information on the essential circumstances prior to entering into the insurance contract in proportion to the ratio of the agreed insurance premium to the insurance premium that would have been fixed for the Policyholder if the Policyholder had properly provided the information on the essential circumstances. This clause shall be also applicable in cases where the information is not submitted through the negligence or inattention of the Insured Person.

22.16. Where the Insurer, being aware of the circumstances that were not reported by the Policyholder through negligence or inattention, would not have entered into the insurance contract, the Insurer shall have the right to request cancellation of the insurance contract within two months of the date of becoming aware that the Policyholder did not provide the information specified in clause 22.7 above through negligence or inattention. Upon the occurrence of an insured event, the Insurer shall have the right to refuse to pay an insurance benefit if none of the Insurers licensed to engage in insurance

activities in Lithuania and offering personal accident insurance services would not have entered into an insurance contract if they had known the circumstances not reported by the Policyholder through negligence. This clause shall also be applicable in cases where the information is not submitted through the negligence or inattention of the Insured Person.

22.17. Where the insurance contract covers a group of persons (workplaces, positions) and knowingly false information on part of the Insured Persons is provided or no information on part of the Insured Persons is provided through negligence or inattention prior to entering into the insurance contract, the provisions of clauses 22.14–22.16 shall only apply to the Insured Persons whose information was knowingly false or was not submitted through negligence or inattention, and not to the entire insurance contact.

22.18. The Policyholder shall:

22.18.1. Provide accurate information required for insurance risk assessment and for entering into an insurance contract;

22.18.2. Pay the insurance premium (parts thereof) specified in the insurance policy (its annexes) in a timely manner;

22.18.3. Ensure that when entering and executing the insurance contract, any sensitive personal data of Insured Persons are submitted to Insurer and processed with the prior approval from the Insured Persons.

22.19. The Policyholder shall have the right to:

22.19.1. Get access to these Terms and a copy thereof;

22.19.2. Refuse to conclude the insurance contract without specifying the reasons.

22.20. The Insurer shall:

22.20.1. Acquaint the Policyholder with these Terms and give a copy thereof;

22.20.2. Issue an insurance policy or other documentary evidence of conclusion of the insurance contract to the Policyholder.

22.21. The Insurer shall have a right to:

22.21.1. Request the Policyholder to provide all available correct information required for insurance risk assessment and for entering into an insurance contract;

22.21.2. Process the personal data of the Policyholder, the Insured Person, the Beneficiary and the insurance premium payer without their consent for the purpose of entering into and executing an insurance contract, except for sensitive personal data to be processed by the Insurer with the consent of these persons;

22.21.3. Refuse to conclude an insurance contact without specifying the reasons;

22.21.4. Inspect the workplaces and working conditions of the persons requested to be insured.

23. Beneficiaries

23.1. The Policyholder and the Insured Person shall have the right to appoint the Beneficiary that would be entitled to an insurance benefit upon the occurrence of an insured event in accordance with the terms and procedure set out in the insurance contract. Several Beneficiaries may be appointed. In the event that several Beneficiaries are appointed by the same Insured Person and their share of the insurance benefit is not specified, the shares of these Beneficiaries shall be deemed to be equal.

23.2. An insurance benefit shall be paid to the Beneficiary indicated in the insurance contract exclusively in the case of the Insured Person's death. In all other cases, the insurance benefit shall be paid to the Insured Person.

23.3. A Beneficiary may be appointed both when concluding an insurance contract and during the term of the insurance contract. A Beneficiary shall be considered to be appointed if the Beneficiary is specified in the insurance policy or its annexes or a certificate of appointment of the Beneficiary issued by the Insurer.

23.4. If the Insured Person is under 18 years of age or is declared to be legally incapable or partly capable, only a close relative of the Insured Person can be appointed as a Beneficiary. This clause is also applicable where the Beneficiary is replaced with another person.

23.5. The Beneficiary may be replaced with another person. The Policyholder (or the Insured Person where the Beneficiary is appointed by the Insured Person) wishing to replace the Beneficiary shall provide a written notice to the Insurer.
23.6. The Beneficiary may not be replaced with another person if the Beneficiary has fulfilled any obligations under the insurance contract or has presented the Insurer with a claim for an insurance benefit payable under the insurance contract upon the occurrence of an insured event.
23.7. Where the insurance contract covers more than one Insured Person, each of them can appoint a Beneficiary that would be entitled to an insurance benefit upon the occurrence of an insured event involving an Insured Person. However, an Insured Person may only appoint a Beneficiary in respect of another Insured Person with the prior written consent of this Insured Person. This clause shall also apply in the event of replacing the Beneficiary with another person.
23.8. Where an insurance contract is concluded by a company, institution or organisation and a group of Insured Persons is covered by such an insurance contract, the Policyholder shall have the right to appoint the Beneficiary that would be entitled to an insurance benefit payable upon the occurrence of an insured event to another Insured Person, all or part of the Insured Persons under the insurance contract only with the prior written consent of these Insured Persons. This clause shall also apply in the event of replacing the Beneficiary with another person.
23.9. An irrevocable Beneficiary may be appointed under an insurance contract. The irrevocable Beneficiary may not be unilaterally cancelled and replaced by the Policyholder (or the Person Insured) without the consent of the Beneficiary.

VI. TERM OF THE INSURANCE CONTRACT AND INSURANCE PREMIUM

24. Term of the Insurance Contract, the Insurance Period, and the Payment of Insurance Premiums

24.1. The Insurance period shall be specified in the insurance policy (its annexes) and shall start no earlier than at 00 h. 00 min. of the day specified in clause 24.2 below.
24.2. The insurance contract shall enter into force:
24.2.1. On the date of proper signing of the insurance policy or on a later date fixed in the in insurance policy where the insurance contract is concluded by signing the insurance policy in the established form by both parties to the contract;
24.2.2. On the date specified in a properly issued insurance policy where the insurance contract is concluded by issuing an insurance policy signed by the Insurer and subject to the payment by the Policyholder of the whole insurance premium or the first instalment of the insurance premium, on the condition that the insurance premium or part thereof is paid no later than the deadline for the payment of the insurance premium or part thereof fixed in the insurance policy.
24.3. Unless otherwise specified in the insurance policy (its annexes), the insurance contract shall be deemed to be concluded and effective in accordance with the procedure set out in clause 24.2.2 above.
24.4. If the insurance premium or part thereof is not paid by the due date indicated in the insurance policy, the Insurer shall notify the Policyholder thereof in writing, warning the Policyholder that if the latter fails to pay the insurance premium or part thereof within 30 days of the date of dispatch of the notice, the insurance coverage will be suspended without any separate notice of the Insurer and will only be renewed after the Policyholder pays the insurance premium or part thereof. If an insured event occurs during the period of suspension of the insurance coverage, the Insurer shall not be obliged to pay an insurance benefit. In the event that the suspension of the insurance coverage due to failure to pay the insurance premium lasts longer than 3 months, the Insurer shall have the right to terminate the insurance contract unilaterally.
24.5. The insurance premium and the terms and condition of payment thereof shall be set out in the insurance contract.
24.6. The insurance premium shall be calculated by the Insurer taking into account the information submitted by the Policyholder, other relevant information, insurance risk, and the terms and conditions set out in the insurance contract.

24.7. The insurance premium or any part thereof shall be considered to be paid after a relevant amount is credited in the Insurer's bank account or paid to a cash register of the Insurer, unless the insurance contract provides otherwise.
24.8. The insurance contract shall expire:
24.8.1. Upon the end of the insurance period indicated in the insurance policy (the insurance contract expires at 12:00 a.m. on the date stated in the insurance policy as the date of expiry of the contract);
24.8.2. If the Policyholder (legal entity) is liquidated or ceases to exist on other grounds and there is no successor to its rights and obligations;
24.8.3. If the parties agree on this in writing or if the insurance contract is terminated on the grounds and in accordance with the procedure laid down in the law or the terms and conditions of these Terms;
24.8.4. Where the Insurer pays all insurance, benefits provided for in the insurance contract. If the insurance contract is concluded for the benefit of a group of Insured Persons, the insurance contract shall only expire in respect of the Insured Person that has been paid all due insurance benefits;
24.8.5. If the Insured Person (natural person) dies or the insured position or workplace is eliminated. Where the insurance contract is concluded for the benefit of a group of Insured Persons, the insurance contract shall only expire in respect of the deceased Insured Person or the insured position or workplace eliminated;
24.8.6. On other grounds for the expiry of contracts provided for in the law.
24.9. If an insurance contract is concluded under the conditions specified in clause 24.2.2 above and the whole insurance premium (the first instalment of the insurance premium) is not paid within the time limit fixed in the insurance policy, the insurance cover under the insurance contract shall not be provided until the actual date of payment of the insurance premium (the first instalment thereof) without any separate notice to the Policyholder.
24.10. Upon the expiry or termination of the contract, the obligation of the Policyholder to pay the insurance premiums for the insurance coverage period shall remain in force.

25. Cooling-Off Period

25.1. You have the right to cancel this insurance back to the start of the period of insurance without giving any reason, providing your instruction to cancel is submitted to us within 14 days of either:
25.1.1. the date you receive the policy documentation, or
25.1.2. the start of the period of insurance, whichever is the later. The refund is subject to no incidents having occurred, which could give rise to a claim. To cancel please contact Baltic Underwriting Agency AB.

26. Conditions for Modification and Termination of the Insurance Contract

26.1. The insurance contract may be amended by an agreement between the Insurer and the Policyholder. Amendments to the insurance contract shall only be valid if properly documented as annexes to the insurance contract. Amendments to the insurance contract shall come into force from the date indicated in a relevant annex.
26.2. The Policyholder shall have the right to terminate the insurance contract in any case. If the Policyholder terminates the insurance contract prematurely, the Policyholder shall be refunded insurance premiums for the remaining term of the insurance contract after deducting the insurance contract conclusion and performance costs (25% of the insurance premium).
26.3. If the object of insurance disappears for reasons other than an insured event, the Policyholder shall be refunded insurance premiums for the remaining term of the insurance contract.
26.4. The Insurer shall have the right to terminate the insurance contract unilaterally without applying to court in the event of a material breach of the terms and conditions of the insurance contract committed by the Policyholder. The definition of a material breach of the terms and conditions of the insurance contract by the Policyholder shall include:
26.4.1. Failure to pay the insurance premium or any part thereof on time. In this case, the contract shall be terminated in accordance the procedure set out in these Terms;
26.4.2. Failure to report an increase in insurance risk within a specified time limit;

26.4.3. Other material breaches of the insurance contract specified in the insurance policy (its annexes) or in these Terms;

26.5. The insurance contract shall be terminated by sending a relevant notice of the Insurer to the Policyholder. If there is a Beneficiary, the Insurer shall also send the notice of contract termination to the Beneficiary.

26.6. Where the insurance of risks becomes incompatible with trade restrictions, embargoes or sanctions applied by the United Nations, the European Union or the United States of America (US), the insurance cover in respect of all such risks shall become invalid from the date the said restrictions, embargoes or sanctions come into effect. Where the sanctions imposed by the United Nations, the European Union or the US continue to prevent, either directly or indirectly, the Insurer from providing insurance services under a particular insurance contract, the Insurer shall be entitled to terminate the insurance contract upon written notice to the Policyholder. The contract shall be terminated 14 days after the receipt of the termination notice by the Policyholder. Where it is impossible to deliver the notice (or the addressee cannot be reached) due to communication failures and the Insurer is not informed thereof and no alternative means of communication with the Policyholder are indicated, the termination notice shall be deemed received by the Policyholder on the date of the dispatch thereof.

27. Automatic Renewal of the Insurance Contract

27.1. Upon the end of the insurance period, the insurance contract shall be automatically renewed for another period of one year, provided that the Insurer and the Policyholder individually agree on the clause regarding the automatic renewal of the insurance contract and it is included in the insurance policy (its annexes).

27.2. The insurance contracts for the next period shall be deemed concluded when the Insurer signs the insurance policy and sends or hands it to the Policyholder before the expiry of the valid insurance contract and the Policyholder pays in the premium fixed in the insurance policy or the first instalment of the premium within the time limits set out in the insurance policy. If the Policyholder fails to pay the insurance premium specified in the insurance policy of the first instalment thereof within the time limits specified in the insurance policy, the insurance contract shall not be valid and shall not be considered to have been concluded for another one-year period;

27.3. If the renewal of the insurance contract is planned to involve amendments to the material terms of the insurance contract (insurance amount, insurance premium, deductible) or application of another wording of these Terms, the insurance policy and the new wording of the Terms shall be sent or delivered to the Policyholder no later than 2 months before the end of the insurance period or the Policyholder shall be informed in any other way in writing no later than 2 months before the expiry of the insurance contract.

27.4. Where the need to amend the material terms of the insurance contract, as specified in clause 27.3 above, could not be foreseen for objective reasons beyond the control of the Insurer, the automatic insurance contract renewal clause shall not apply. In this case, the Insurer shall send a proposal on the conclusion of a new insurance contract to the Policyholder no later than 5 (five) business days before the expiry of the valid insurance contract.

27.5. The Policyholder may refuse to automatically renew the insurance contract by giving a written notice at any time before the expiry of the valid insurance contract.

27.6. The Insurer may refuse to automatically renew the insurance contract by giving a written notice to the Policyholder no later than 1 month before the expiry of the valid insurance contract or, where the term of the insurance contract is shorter than 3 months, no later than 1 week before the expiry.

VII. RIGHTS AND OBLIGATIONS OF THE PARTIES DURING THE TERM OF THE INSURANCE CONTRACT

28. Rights and Obligations of the Policyholder

28.1. The Policyholder shall:

28.1.1. Pay the insurance premium or premium instalments on time;

28.1.2. Provide the Insurer with correct information related to the insurance contract;

28.1.3. Follow the instructions for the Policyholder (such as risk reduction and safety measures) set out in the insurance contract throughout the term of the insurance contract;
28.1.4. Inform the Insurer about an increase in insurance risk within five business days (unless the insurance contract provides otherwise);
28.1.5. Acquaint the Insured Person and/or the Beneficiary (Beneficiaries) with the terms and conditions of the insurance contract, the rights and obligations of the Insured Person and/or the Beneficiary, modifications of the insurance contract, and notify them about the termination of the insurance contract.
28.2. In the event of an increase in insurance risk, the Insurer shall be entitled to request amendment of the terms of the insurance contract or increase of the insurance premium. If the Policyholder does not agree to amend the terms of the insurance contract and/or to pay a higher insurance premium, the Insurer shall be entitled to apply to court for the termination or amendment of the insurance contract on the basis of material changes in the circumstances. Failure to inform the Insurer about any increase in risk shall be considered to be a material breach of the insurance contract, and the Insurer shall have the discretion to:
28.2.1. Terminate the insurance contract unilaterally;
28.2.2. Reduce the payable insurance benefit or
28.2.3. Refuse to pay the insurance benefit.
28.3. The Insurer shall only gain the rights specified in clauses 28.2.2 and 28.2.3 above if an insured event or increased losses result from failure to notify the Insurer of the circumstances determining the increase in the insurance risk.
28.4. Upon the occurrence of an accident, the Insured Person no later than during 48 (forty-eight) hours shall apply to the health care institution and receive appropriate treatment.
28.5. Upon the occurrence of an accident, the Policyholder, the Insured Person or any person authorised by them shall:
28.5.1. Notify the Insurer immediately, but no later than within 10 business days of the event or the occurrence/establishment of the consequences thereof (where they occur/are established later) or of the date of becoming aware of the accident (where the Policyholder becomes aware of it later);
28.5.2. Inform the Insurer of the diagnosis of a critical illness of the Insured Person within 20 business days. If the Insured Person is hospitalised for inpatient treatment at a health care institution, the Insurer must be informed of the critical illness within 20 business days from the last day of the Insured Person's inpatient treatment.
28.5.3. Inform the Insurer of the death of the Insured Person as a result of the accident or a critical illness within 20 business days irrespective of whether or not the even has already been reported;
28.5.4. Keep and present the Insurer all correctly completed documents related to the event;
28.5.5. Undertake a medical examination at Insurer's expense where the presented documents are not sufficient to properly identify injuries suffered due to external effects;
28.5.6. Enable the Insurer or its authorised representative to investigate the causes, consequences and circumstances of the event;
28.5.7. On Insurer's demand, return the Insurer the paid down benefit or the overpaid portion thereof within 30 calendar days, if it turns out that the insurance benefit should not have been paid or could have been reduced under the terms and conditions of the contract.

29. Rights and Obligations of the Insurer

29.1. The Insurer shall:
29.1.1. Issue a copy of the insurance policy or other documentary evidence of the conclusion of the insurance contract at the request of the Policyholder;
29.1.2. Pay insurance benefits upon the occurrence of an insured event in accordance with the terms and conditions of the insurance contract.
29.2. Upon the occurrence of an insured event, the Insurer shall be entitled to delegate specialists (doctors) designated by the Insurer to examine the state of health of the Insured Person.

29.3. Information presented by the Policyholder, Insured Person and/or Beneficiary to the Insurer must be kept in secret and used exclusively for the purposes to conclude the insurance contract and implement the rights and obligations of the Policyholder, Insured Person and/or Beneficiary agreed hereunder, to administer the concluded insurance contract and events related thereto that are likely to be accepted as events insured, as well as for other statutory purposes.
29.4. Information relating to the Policyholder, Insured Person and/or beneficiary may be disclosed to:
29.4.1. Insurer's employees for whom such information is necessary in order to conclude and/or administer the insurance contract, to investigate events related to the insurance contract and likely to be recognised as events insured;
29.4.2. Courts, law enforcement institutions and other institutions in statutory cases;
29.4.3. pre-trial dispute resolution bodies, arbitration tribunal(s), intermediaries, lawyer(s), other persons involved in hearing a dispute between the Policyholder, Insured Person and/or Beneficiary and the Insurer;
29.4.4. Reinsurers, employees of corporate shareholders of the Insurer;
29.4.5. Experts hired by the Insurer;
29.4.6. On written consent or request of the Policyholder, Insured Person and/or Beneficiary.

30. Insurance Benefit Payment Deadlines

30.1. Upon the receipt of all documents necessary to determine the fact, causes, circumstances and consequences of an insured event and to calculate the insurance benefit, the Insurer shall pay the insurance benefit within 30 days of the date of receipt of the last information and documents necessary to determine the fact, causes, circumstances and consequences of the insured event and to calculate the insurance benefit from the Policyholder, the Insured Person, the Beneficiary, state institutions or other natural persons or legal entities.
30.2. The Insurer shall have the right to withhold payment of an insurance benefit until:
30.2.1. All information and documents necessary to determine the fact, causes, circumstances and consequences of the insured event and to calculate the insurance benefit are received;
30.2.2. Where a pre-trial investigation or legal proceedings have been initiated in connection with the insured event, until the completion of the proceedings or determination of relevant circumstances, but only if the pre-trial investigation or legal proceedings are carried out to determine any circumstances that could serve as a basis for declaring the event to be an uninsured event (exclusion) or due to which the Insurer would have the right to refuse to pay an insurance benefit.
30.3. Where the event is an insured event and the Policyholder and the Insurer fail to reach agreement on the amount of the insurance benefit, at the request of the Policyholder, the Insurer shall pay an amount equal to an insurance benefit not disputed by the parties, if the process of determination of the precise amount of damage lasts longer than 3 months.

31. Restrictions on the Payment of Insurance Benefits

31.1. No insurance benefit shall be paid for uninsured events.
31.2. The calculated insurance benefit may be reduced by the amount of outstanding insurance premiums, unless the insurance contract provides otherwise.
31.3. The Insurer shall be entitled to reduce or refuse to pay an insurance benefit in the following cases:
31.3.1. The Policyholder concealed information or submitted incorrect data, which might have determined the decision of the Insurer to enter into the insurance contract or the terms of insurance (in accordance with clauses 22.14 – 22.17 of the General Provisions);
31.3.2. The Policyholder failed to inform Insurer of an insured event in a timely manner, except where proven that the Issuer learned about the insured event on time or where failure to report the insured event had no effect on the obligation of the Insurer to pay the insurance benefit;
31.3.3. Documents provided by the Policyholder, the Insured Person, the Beneficiary or other natural or legal person are insufficient to determine the date and circumstances of the insured event important for recognising the event as insured, as well as the nature of the injuries sustained; in addition, where the information on the event provided to the Insurer is misleading and this affects the calculation of the amount of the insurance benefit;

31.3.4. The Policyholder, the Insured Person or the Beneficiary impedes or prevents the Insurer from examining medical and other documentation related to the event (including documents on the Insured Person's health) or the state of health of the Insured Person;
31.3.5. The Policyholder, the Insured Person or the Beneficiary did not execute or improperly executed the Insurer's instructions for the Policyholder;
31.3.6. The Policyholder, the Insured Person or the Beneficiary violated other conditions of the insurance contract;
31.3.7. In other cases prescribed by law.

32. Penalties for Violations of the Insurance Contract

32.1. In the event of delayed fulfilment of pecuniary obligations, the parties of the insurance contract shall be entitled to require each other to pay penalties if such penalties are specified in the insurance policy (its annex).

33. Notices

33.1. All notices communicated by the parties to the insurance contract to each other shall be provided in writing. Notices shall be deemed properly delivered to the other party if delivered in one of the following ways:
33.1.1. Delivered by hand to the other party against signature at the registered address of the party indicated in the insurance policy or in a notice of the party on a changed address of its registered office;
33.1.2. Sent by post at the registered addresses of the other party indicated in the insurance policy or in a notice of the party on a changed address of its registered office;
33.1.3. Sent by fax to a number indicated in the insurance policy or in a notice of the parties on a changed fax number;
33.1.4. Sent by e-mail indicated in the insurance policy or in a notice of the parties on a changed e-mail address.
33.2. A notice shall be considered delivered on the date marked by the addressee as the date of receipt of the notice(s) (document(s)). If a notice is sent by post, the date of receipt of the notice shall be determined according to the official postal stamp affixed by the post office entitled to affix the same. Where there is no evidence of the receipt of documents sent by post, the dates of receipt shall be determined on the basis of the date of dispatch plus the period of time usually required delivering a notice (5 working days).
33.3. The parties to the insurance contract shall immediately inform each other about any changes in their registered address, fax number or e-mail. If the parties fail to fulfil this obligation, notices shall be sent to the last address known by the party and shall be considered to be delivered. Refusal to accept a notice or to confirm the receipt thereof by signature shall be equivalent to the receipt thereof.
33.4. Notices may be sent by fax or e-mail where this is individually agreed by the parties and the fax number and/or e-mail address is specified in insurance policy (its annexes).
33.5. If a Beneficiary is appointed under the insurance contract, the Beneficiary shall be also provided with all notices as set forth in these Terms.

34. Final Provisions

34.1. Where insurance benefits, deductibles (franchises), premiums and other amounts are indicated in the insurance contract in a currency other than euro, the relevant payments under the insurance contract shall be made in euro according to the official exchange rate of euro against the relevant foreign currency established by the Bank of Lithuania and valid on the date of payment.
34.2. The Insurer may transfer the Insurer's the rights and obligations under the insurance contract to another insurer in accordance to the procedure prescribed by law. The Policyholder shall have a right to submit, in accordance with the procedure prescribed by law, a written objection to the transfer of the rights and obligations under the insurance contract. Such an objection by the Policyholder shall not be binding on the Insurer. If Policyholder objects to the transfer of the rights and obligations under the insurance contract, the Policyholder shall have the right to terminate the insurance contract in

accordance with the standard procedure (this is also applicable to payments between the Insurer and the Policyholder) where the insurance contract is terminated by the Policyholder prematurely.

34.3 It is agreed that this Insurance shall be governed exclusively by the law and practice of Lithuania /Latvia/Estonia /Poland/Finland and any disputes arising under, out of or in connection with this Insurance shall be exclusively subject to the jurisdiction of any competent court in Lithuania /Latvia/Estonia /Poland/Finland.
Lloyd's Insurance Company S.A. hereby agrees that all summonses, notices or processes requiring to be served upon it for the purpose of instituting any legal proceedings against them in connection with this Insurance shall be properly served if addressed to it and delivered to it care of:

Mr Tomas Kontautas,
Lloyd's General Representative for Lithuania,
c/o Sorainen, Jogailos 4, 01116 Vilnius, Lithuania.
Tel: + 370 52 649 376.
Fax + 370 52 685 041.
Email: tomas.kontautas@lloyds.com

who in this instance, has authority to accept service on its behalf.

Lloyd's Insurance Company S.A. by giving the above authority does not renounce its right to any special delays or periods of time to which it may be entitled for the service of any such summonses, notices or processes by reason of its residence or domicile in Belgium.

VIII. TABLE OF INSURANCE BENEFITS

The following percentages apply only to the sub limit for any additional benefits purchased.

Clause	Bodily injury (trauma) or condition	Benefit,%
	General notes:	
Note:	1. Insurance benefits shall be paid only for bone fractures and dislocations confirmed by X-ray and/or computerised tomography (CT), magnetic resonance imaging (MRI). 2. Insurance benefits for bone (joint) dislocations shall be paid only if it is the primary dislocation which has been repaired at a medical care establishment. 3. In case of bone, divisions, sub-periosteal fractures involving non-surgical (conservative) treatment, insurance benefits shall be equal to 50% of the benefit payable in case of total fracture of the respective bone. In case of fracture and dislocation of the same bone, one amount of insurance benefit (the largest one) shall be payable. 4. In case of fractures of the cartilage part or surface of the bone, cracks, splits (tears), tangential violations of the integrity of the surface of the bone, avulsive or impression fractures of the bone in one area, 1% is paid from Injuries sum insured. 5. Multiple fractures of one bone shall be considered as one fracture (one largest amount of benefit shall be paid). If bone (joint) dislocation or fracture requires surgical treatment, the amount of benefit shall be increased by 50%. 6. In case of surgical treatment, the benefit may be increased only once in respect of one insured event and/ or the same broken bone. Surgery (operation) is understood as a surgical procedure involving fixation of broken bones with surgical nails, wire, plates or external fixators. An operation involving repair of several bones of one areaof the body shall be considered as one operation (the amount of benefit for surgery shall be calculated on the basis of the larger benefit). 7. Closed restoration of bones and joints shall not be considered an operation. 8. In case of repeated bone fractures at the place of bone scar or metal fixation, insurance benefit shall amount to 50% of the benefit payable in respect of the corresponding bone fracture. 9. In case of pathological fractures, insurance benefit shall amount to 50% of the benefit payable in respect of the corresponding bone fracture. 10. In case of bone sub-luxation, insurance benefit shall amount to 50% of the benefit payable in respect of the corresponding bone dislocation, but no more than 300 EUR. 11. In case of pseudo arthrosis persistent at least 9 months after the accident, insurance benefit shall amount to 70% of the benefit payable in respect of the corresponding bone fracture. 12. In case of dislocation and/or fracture of bones and in the same area, injuries to soft tissues, muscles, tendons, ligaments during one event insured, insurance benefit shall be paid for one most severe outcome.	
1.	**Cranium:**	
1.1.	Fracture of the cranial fornix bones	20
1.2.	Fracture of the base bones	25
1.3.	Fracture of the fornix and base bones	45
Note	1. Multiple fractures of base or cranial fornix bones shall be considered as one fracture.	
2.	**Facial bones:**	
2.1.	Fracture of the nasal bones	3
2.2.	Mandibular fracture	8
2.3.	Fracture of the maxilla, zygomatic bone	8
2.4.	Fracture of the other facial bones (ethmoid bone, orbit, hyoid bone, sinus walls	5
2.5.	Mandibular dislocation	5
Note	1. Bilateral jaw fractures shall be considered as one fracture. 2. In case of maxillary and mandibular fractures, insurance benefits shall be summed up.	

	3. Jaw fracture during dental procedures undergone as a result of the event insured shall entitle to insurance benefit. 4. Fracture of the alveolar process of the mandible shall not be considered as a jaw fracture. 5. Fracture of the maxilla and zygomatic bone shall be considered to be one fracture. 6. The maximum amount of benefit payable for all fractures of the facial bones shall be 15% of the sum insured.	
3.	**Sternum and rib-bones:**	
3.1.	Fractures of 1-2 rib-bones	3
3.2.	Fractures of 3-5 rib-bones	5
3.3.	fractures of 6 or more rib-bones	10
Note	1. Insurance benefit shall be also paid in cases of rib fractures during resuscitation irrespective of the reason thereof. 2. The amount of benefit shall be determined on the basis of the total number of rib-bone fractures in both sides.	
3.4.	Sternal fractures	5
Note	1. Insurance benefit shall be also paid in cases of sternal fractures during resuscitation irrespective of the reason thereof.	
4.	**Spine:**	
4.1.	Fracture of the body or arches of the cervical, thoracic or lumbar vertebrae	
4.1.1.	1 vertebra	15
4.1.2.	2 vertebrae	20
4.1.3.	3 and more vertebrae	25
4.2.	Dislocation/subluxation of the cervical, thoracic or lumbar vertebrae, (transverse or spinous) vertebral process fracture:	
4.2.1.	1 vertebra	5
4.2.2.	2 or more vertebrae	7
4.3.	sacrum fracture	10
4.4.	Coccyx fracture (broken tailbone)/ dislocations	3
Note	1. Where insurance benefit is payable due to a fracture of the vertebral bodies and/or arches, no benefit shall be payable for the injury to spinal processes. 2. Surgery in connection with fractures of the vertebral bodies and/or arches shall not increase the amount of insurance benefit. 3. In case of both spinal and cerebral injuries, insurance benefit shall be paid taking into account both injuries.	
5.	**Arm:**	
5.1.	Fracture of the clavicle, scapula	6
5.2.	Dislocation of the clavicle	5
5.3.	Humeral fractures	12
5.4.	Deep dislocation of the joint (humerus)	5
Note	1. In case of a recurring dislocation, insurance benefit shall only be paid once and only provided that the recurring dislocation is a relapse of the primary dislocation that occurred during the insurance period and also provided that the recurring dislocation based on which the diagnosis was made occurred not later than after one year from the date of the primary dislocation. If the primary dislocation occurred prior to the date when the insurance cover took effect, recurring dislocations shall not be regarded as events insured and no insurance benefits shall be paid.	
5.5.	Fractures of forearm bones:	
5.5.1.	ulnar fracture	5
5.5.2.	radial fracture	5
Note	1. The insurance benefit payable for fractures of both forearm bones (ulnar and radial) in one hand shall not exceed 8% of the sum insured.	

5.5.3.	fracture of the ulnar or radial styloid process or process coronoideus	2
5.6.	Dislocation of forearm bones	5
5.7.	Fractures/dislocations of carpal bones:	
5.7.1.	fracture/dislocation of the scaphoid bone	5
5.7.2.	fracture/dislocation of other carpal bones	3
Note	1. The insurance benefit payable for all fractures/dislocations of the carpal bones (except for the scaphoid bone) shall not exceed 10% of the sum insured.	
5.8.	Fractures/dislocations of metacarpal bones	3
Note	1. The insurance benefit payable for all fractures of the metacarpal bones in one hand shall not exceed 8% of the sum insured.	
5.9.	Fractures of phalanges:	
5.9.1.	thumb fracture	3
5.9.2.	fracture of other digits	2
Note	1. Fracture of more than one of the phalanges in one finger is treated as one fracture. 2. The insurance benefit payable for fractures of all the fingers in one hand shall not exceed 5% of the sum insured.	
5.10.	Losses	
5.10.1.	loss of the arm up above the elbow joint	75
5.10.2.	loss of the hand up above the wrist joint	65
5.10.3.	loss of the hand	50
5.10.4.	loss of both phalanges of the first digit (thumb)	20
5.10.5.	loss of nail phalanx of the first digit (thumb)	10
5.10.6.	loss of three phalanges of the second digit (index finger)	15
5.10.7.	loss of two phalanges of the second digit (index finger)	10
5.10.8.	loss of one phalanx of the second digit (index finger)	5
5.10.9.	loss of three phalanges of the third, fourth or fifth digit (middle finger, ring finger, little finger)	5
5.10.10	loss of two phalanges of the third, fourth or fifth digit (middle finger, ring finger, little finger)	4
5.10.11.	loss of one phalanx of the third, fourth or fifth digit (middle finger, ring finger, little finger)	3
Note	1. Insurance benefit paid down under this paragraph shall be deducted from insurance benefit payable for the same loss under the Disability Clause of the Terms of Accident Insurance.	
6.	**Pelvic bones:**	
6.1.	Fractures of the iliac, pubic, ischial, coxal bones	7
6.2.	Fracture of the acetabulum	15
6.3.	Rupture of symphysis:	
6.3.1.	unilateral rupture of symphysis	7
6.3.2.	bilateral rupture of symphysis	12
Note	1. The insurance benefit payable for all injuries to the pelvic bones shall not exceed 20% of the sum insured.	
7.	**Leg:**	
7.1.	Femoral fractures:	
7.1.1.	femoral trochanteric fracture, fractures of femur corpus and/or distal end	10
7.1.2.	femur head and/or neck fracture	15
		15
7.2.	Femoral dislocation	7
7.3.	Patellar fracture	7
7.4.	Patellar dislocation	4

7.5.	Tibial (lower leg) fractures:	
7.5.1.	fracture of the posterior, medial malleolus	5
7.5.2.	tibial fracture (excl. posterior and medial malleolus)	6
7.6.	Fibular fracture (incl. lateral malleolus)	4
7.7.	Dislocation of tibial bones	5
7.8.	Fractures of tarsal bones (excl. calcaneus , talus)	4
7.9.	Fracture of the calcaneus, talus	6
Note	1.The insurance benefit payable for fractures of both - calcaneus and talus, in one leg shall not exceed 10% of the sum insured.	
7.10.	Dislocation of talus	5
Note	1. The insurance benefit payable for all injuries to the tibial (lower leg) and tarsal bones shall not exceed 20% of the sum insured.	
7.11.1.	Metatarsal fractures	3
7.11.2.	Dislocations of metatarsal bones	4
Note	1. The insurance benefit payable for all injuries to metatarsal bones in one foot shall not exceed 10% of the sum insured.	
7.12.	Fractures of foot phalanges:	
7.12.1.	a) fracture of a big toe	3
7.12.2.	b) fractures of other foot phalanges	2
Note	1. Fracture of more than one of the phalanges in a toe is treated as one fracture. 2. The insurance benefit payable for fractures of all the toes in one foot (except for the big toe) shall not exceed 5% of the sum insured.	
7.13.	Losses	
7.13.1.	Loss of the leg above the knee joint	70
7.13.2.	Loss of the foot above the subtalar joint	60
7.13.3.	Loss of the foot	45
7.13.4.	loss of the first toe	5
7.13.5.	loss of one phalanx of the first toe	3
7.13.6.	loss of the second, third, fourth or fifth toes	4
7.13.7.	loss of one or two phalanges of the second, third, fourth or fifth toes	2
Note	1. Insurance benefit paid down under this paragraph shall be deducted from insurance benefit payable for the same loss under the Disability Clause of the Terms of Accident Insurance.	
8.	**Soft tissue:**	
8.1.	Soft tissue injuries in the area of the face, frontal or lateral parts of the neck, sub-mandibular area (caused by a mechanical, chemical, thermal or other acute violent impact, as well as conditions after skin transplantation):	
8.1.1.	Visual changes in the face without disfigurement and changes in the natural appearance; pigment spot/scar measures (1.5 to 5 cm in length or 1 to 2 sq. cm in area)	2
8.1.2.	Visual changes in the face without disfigurement and changes in the natural appearance; pigment spot/scar measures 5 cm or more cm in length or 2 sq. cm or more in area	5
Note	1. Pigment spots and scars (except for scars formed after surgical closure of the wound) are measured after a healing period. If the recovering period is not specified in the medical documents, not earlier than 1 month from the date of injury. 2. If there are more than one pigment spots/ scars, then the overall length/surface area of the pigment spots/scars is measured. 3. If the insured person is attacked by animals kept in the insured's home, the insurance benefit is reduced by 50%.	

8.2.	Soft tissue injuries in the scalp, extremities or trunk area:	
8.2.1.	Soft tissue injuries resulting in scars exceeding 5 cm in length (2 cm for children up to the age of 10):	
8.2.1.1.	from 5 cm to 0.5% of the body surface area (2 cm for children up to the age of 10)	2
8.2.1.2.	from 0.5% to 1% of the body surface area inclusively	3
8.2.1.3.	from 1% to 2% of the body surface area inclusively	5
8.2.1.4.	from 2% to 4% of the body surface area inclusively	8
8.2.1.5.	from 4% to 15% of the body surface area inclusively	10
8.2.1.6.	exceeding 15% of the body surface area inclusively	15
8.2.2.	Soft tissue injuries resulting in pigment spots:	
8.2.2.1.	a) from 0.5% to 1% of the body surface area inclusively	2
8.2.2.2.	b) from 1% to 10% of the body surface area inclusively	5
8.2.2.3.	c) exceeding 10% of the body surface area	10
8.2.3.	Burn diseases (burn shock, burn intoxication, anuria, toxemia) diagnosed in an in-patient treatment establishment	10
Note	1. Pigment spots and scars are measured after a healing period. If the recovering period is not specified in the medical documents, not earlier than 1 month from the date of injury. 2. If there are more than one pigment spots/ scars, then the overall length/surface area of the pigment spots/scars is measured. 3. Palmar surface (including palm and digits) of the insured person's hand is deemed to correspond to 1% of the surface of the body. This area is measured in square centimetres by multiplying the length of hand (measured from the radiocarpal joint to the top of the distal (third) phalanx of the third digit) and the width of hand (measured along the head of MTC II-V (neglecting the first digit). 4. Insurance benefit shall not be paid for open fractures, post-operative and amputation scars. 5. Insurance benefit under paragraphs 8.2.1 – 8.2.3 shall be paid only for one outcome which is the most serious. 6. Insurance benefit for bruising, abrasions not requiring putting in stitches and/or gluing shall not be paid. 7. If the insured person is attacked by animals kept in the insured's home, the insurance benefit is reduced by 50%.	
8.3.	Injuries to soft tissues with resultant non-resolved hematoma, periostitis (inflammation of the membrane enveloping a bone), osteomyelitis, other purulent processes	3
8.4.	Costs of cosmetic-plastic surgeries to treat cosmetic defects or disfigurements caused by soft tissue injuries in the area of face or neck suffered in an accident	up to 10
Note	1. Insurance benefit shall be payable only for a non-resolved haematoma covering at least 5 cm^2, provided it is found present at least 3 months after the trauma. 2. Where the event insured required auto transplantation (of skin, muscle, tendon), the amount of benefit shall be increased by 5% of the sum insured. 3. Medical expenses for plastic surgeries shall be reimbursed in accordance with invoices issued by the medical establishment, but the maximum insurance benefit shall not exceed 10% of the sum insured. 4. If the insured person is attacked by animals kept in the insured's home, the insurance benefit is reduced by 50%.	
9.	**Ligamentous, muscular, tendonous, meniscal ruptures:**	
9.1.	Muscular, ligamentous, tendonous ruptures caused by trauma	
9.1.1.	a) shoulder, upper arm, forearm	4
9.1.2.	b) hip, knee, lower leg, upper leg	4
9.1.3.	c) carpus, hand	2
9.1.4.	d) tarsus, foot	2

9.1.5.	e) lateral and/or cruciate ligaments of the knee joint	4
9.1.6.	f) abdominal	2
9.2	Meniscal rupture	5
9.3.	Rupture of menisci and lateral and/or cruciate ligaments of the knee joint	6
Note	1. In case of repeated ligamentous, muscular, tendonous, meniscal ruptures, insurance benefit shall not be paid if the original rupture occurred during the valid cover and surgical treatment was not applied. However, if the repeated injury requires surgical treatment, additional benefit set forth in Note 8 shall be paid once. 2. In case of repeated ligamentous, muscular, tendonous, meniscal ruptures, if the original rupture occurred when insurance cover was not valid, the insurance benefit shall be equal to 50% of the benefit set in the relevant paragraph for the corresponding injury and shall be payable only if the repeated rupture occurs at least 1 month after the moment of full recovery. 3. In case of diagnosed degenerative changes in the ligaments, muscular, tendons and/or menisci -, the total insurance benefit payable for this area shall be reduced by 50%, unless there are objective evidence of injury of this area (eg abrasions, bruises, etc.)confirmed by medical documents 4. Tears of both menisci in one knee shall be regarded as one meniscal tear. 5. In case of fractures of the muscles, tendons, tears, partial splits, 1% of the sum insured is paid. 6. Insurance benefits shall be paid only if the rupture of menisci and lateral and/or cruciate ligaments of the knee joint, muscles, ligaments or tendons is confirmed by instrumental research - ultrasound (UG), or nuclear magnetic resonance (NMR), or magnetic resonance (NMR). 7. If the rupture is confirmed only by a specialist doctor (surgeon / traumatologist) and the above tests have not been performed, 1% of the amount of the Injury sum insured shall be paid. 8. If muscular, ligamentous, tendonous or meniscal injuries required surgical treatment, the insurance benefit shall be increased by 50% of the benefit set in the relevant paragraph for the corresponding injury. The insurance benefit shall be increased according to these Terms item corresponding to the operated injury. 9. In case of muscular, ligamentous, tendonous or meniscal injuries, caused by physical exertion (including load lifting), the insurance benefit shall be reduced by 50%	
9.4.	Rupture of the Achilles tendon	4
Note	1. Insurance benefits for non-surgical treatment of the Achilles tendon shall not exceed 150 EUR. 2. If an operation was performed due to an injury to the Achilles tendon, an additional insurance benefit of 2% of the Injury sum insured shall be paid. 3. In case of repeated injury to the Achilles tendon, insurance benefit shall not be paid if the original rupture occurred during the valid cover. 4. In case of repeated injury to the Achilles tendon, insurance benefit shall not be paid if the original rupture occurred during the valid cover and surgical treatment was not applied. However, if the repeated injury requires surgical treatment, additional benefit equal to 2% of the sum insured shall be paid once). 5. In case of repeated rupture of the Achilles tendon, if the original rupture occurred when insurance cover was not valid, the insurance benefit shall be equal to 50% of the benefit and shall be payable only if the repeated rupture occurs at least 1 month after the moment of full recovery.	
10.	**Central and peripheral nervous system:**	
10.1.	Cerebral injury:	

10.1.1	Cerebral commotion requiring outpatient treatment of more than 10 days or hospitalisation of less than 5 days	2
10.1.2.	Cerebral commotion requiring at least 5 days' hospital treatment	4
10.1.3.	Cerebral contusion and compression diagnosed on the basis of computerised tomography (CT) or magnetic resonance imaging (MRI)examination undertaken during in-patient treatment	10
10.1.4.	Traumatic subarachnoid haemorrhage	10
10.1.5.	Traumatic subdural haemorrhage	12
10.1.6.	Epidural haemorrhage	18
Note	1. Only one paragraph of cerebral injuries may apply in respect of one trauma. 2. Where cerebral injuries required surgical treatment, additional benefit equal to 5% of the sum insured shall be paid. 3. Commotion/contusion must be diagnosed by a medical professional (neurologist/ neurosurgeon).	
10.2.	Spinal cord injuries:	
10.2.1.	Spinal cord commotion	5
10.2.2.	Spinal cord contusion diagnosed on the basis of computerised tomography (CT) or magnetic resonance imaging (MRI) examination undertaken during in-patient treatment	10
10.2.3.	Spinal cord compression, haemorrhage to spinal cord (compression)	15
10.2.4.	Traumatic transverse myelitis	20
Note	1. Where spinal cord injuries required surgical treatment, additional benefit equal to 5% of the sum insured shall be paid (only once).	
10.3.	Traumatic cranial nerve injuries with resulting reconstructive surgeries or persistent clinical picture of neuropathy:	
10.3.1.	Cranial nerve injuries in one side	5
10.3.2.	Cranial nerve injuries in both sides	10
Note	1. Insurance benefit shall be paid on a one-off basis irrespective of the number of injured nerves. 2. Insurance benefit shall be paid without any delay if a traumatic cranial nerve injury required reconstructive surgery. 3. Where cranial nerve injuries do not require surgical treatment, insurance benefits shall be paid only in case of persistent signs of the nerve injury for a period exceeding 6 months. 4. Once paid for the fracture of the cranial base, no other insurance benefits shall be paid for cranial nerve injuries. 5. Once paid for dysfunction and/or disease of the hearing and/or vision apparatus, no other insurance benefits shall be paid.	
10.4.	Traumatic injuries to peripheral nerves:	
10.4.1.	Nerve injuries in the brachial/humeral area (*N. ulnaris, N. medianus, N. radialis, N. axillaris, N. musculocutaneus, N.cutaneus brachialis in the area of upper arm*)	10
10.4.2.	Nerve injury in the area of forearm/wrist (injuries of *N. ulnaris, N. medianus, N. radialis, N. cutaneus brachialis* in the area of forearm*)*	5
10.4.3.	Nerve injury in the area of lower leg/tarsus (*N. tibialis, N. peroneus, N. suralis cutaneus*)	5
10.4.4.	Coxa-femoral nerve injuries (*N. ischiadicus, N. femoralis, N. cutaneus femoralis*)	10
10.4.5.	Nerve plexus injuries (*plexus cervicalis, plexus brachialis, plexus lumbalis, plexus sacralis)*	25
Note	1. Traumatic injuries to peripheral nerves are deemed to include nerve commotion, contusion, compression, strain, rupture, and/or neurectomy. 2. In case of peripheral nerve injuries in several extremities, injuries in each of them shall be assessed separately.	

	3. In case of multiple nerve injuries in one extremity, insurance benefit shall be paid for one injury only. 4. Where peripheral nerves and/or nerve plexus are injured due to a closed nerve trauma, insurance benefit shall only be paid if the signs of the nerve injury are persistent for a period exceeding 6 months after the trauma and are confirmed by objective testing methods. 5. No insurance benefit shall be paid for nerve injuries in fingers and the palm. 6. Where injuries in Section 4 required surgical treatment (nerve sewing, nerve plastics, plexus re-innervation, etc.), the insurance benefit shall be increased by 5% of the sum insured irrespective of the number of operations.	
11.	**Hearing apparatus and respiratory system:**	
11.1.	Consequences of auricle injuries, unilateral (injury, burn, chilblain):	
11.1.1.	Traumatic deformation of the auricle as a result of the scars or loss of 1/3 of the auricle	3
11.1.2.	Loss of more than 1/3 to 1/2 of the auricle	5
11.1.3.	Loss of more than half of the auricle	7
Note	1. Consequences of auricle injuries shall be assessed after completion of the recovery period, at least 1 month after the trauma. 2. Where insurance benefit is paid for the consequences of auricle injuries, it shall not be payable for injuries to soft tissues.	
11.2.	Traumatic rupture of ear drum	1
Note	1. The diagnosis of the traumatic rupture of ear drum must be based on the indications of fresh trauma.	
11.3.	Nasal injuries:	
11.3.1.	Loss of nostril and nasal tip	7
11.3.2.	Loss of nostril(s) or nasal tip	5
Note	1. The insurance benefit paid under this section shall be deducted from the benefit payable for the same event insured under Disability clause of this insurance wording.	
11.4.	Injuries (trauma) to the chest or thoracic organs requiring:	
11.4.1.	Thoracentesis (puncture of the pleural cavity),	3
11.4.2.	drainage	1
11.4.3.	Thoracoscopy (examination of the pleural cavity)	5
11.4.4.	Thoracotomy	10
Note	1. Insurance benefit for the same trauma shall be paid only under one paragraph of Section 4. 2. In case of repeated thoracotomies, additional benefit in the amount of 10% of the sum insured shall be paid only once (irrespective of the number of re-thoracotomies). 3. Where injuries to chest or thoracic organs resulted in a surgery/removal of the lung or any segment thereof, insurance benefit shall be paid for the lung surgery/removal only and this section shall not apply. 4. Where insurance benefit is paid for thoracoscopy or thoracotomy, no benefit shall be paid for injuries to the lungs.	
11.5.	Traumatic laryngeal, tracheal or bronchial injuries	5
Note	1. In case of tracheostomy, insurance benefit shall be increased by 5% of the sum insured.	
11.6.	Traumatic pneumothorax, haemothorax, pneumohaemothorax:	
11.6.1.	Unilateral	3
11.6.2.	Bilateral	6
12.	**Digestive system:**	
12.1.	Tongue, oral cavity injuries (injuries, burns):	
12.1.1.	Diagnosed and closed lingual wound	3

12.1.2.	Tongue, oral cavity, oesophagus or pharynx injuries resulting in the formation of scars	5
12.2.	Traumatic teeth injuries:	
12.2.2.	To one tooth	2
12.2.3.	To 2-3 teeth	5
12.2.4.	To 4-6 teeth	8
12.2.5.	to 7 and more teeth	10
Note	1. Traumatic injury of teeth is understood as splitting of at least 1/4 of the tooth crown, fracture of tooth or its root, tooth subluxation (partial dislocation), including tooth inclination (displacement into the alveolar bone). 2. No insurance benefit shall be paid for the loss of parodontal teeth. 3. In case of accidental tooth fracture during medical manipulations, insurance benefit shall be paid if the medical manipulations are related to the consequences of the event insured. 4. In case of traumatic injury to milk teeth: 4.1. the full amount of insurance benefit shall be paid to children under 5 years old to 4.2. the full amount of insurance benefit shall be paid in case of injury to III, IV and V milk teeth to children under 8 years old. In case of any other traumatic injury to milk teeth, 1/2 of the benefit shall be paid, but no more than 150 EUR, irrespective of the number of injured teeth. 5. In case of injuries to the teeth damaged (carious, filled) prior to the trauma, the insurance benefit shall be reduced by 50%, except in cases when there are objective signs of the presence of oral and/or facial injuries. 6. If the teeth are damaged during eating / biting, the insurance benefit shall be reduced by 50% 7. A maximum of 300 EUR is payable for a traumatic violation of one teeth. 8. No insurance benefit is payable in case of break of or damage to dental prosthesis/ implants caused by an injury (trauma).	
12.3.	Traumatic teeth loss:	
12.3.1.	Loss of 1 tooth	5
12.3.2.	Loss of 2-3 teeth	7
12.3.3.	Loss of 4-6 teeth	12
12.3.4.	Loss of 7 and more teeth	15
Note	1. In case of accidental tooth loss during medical manipulations, insurance benefit shall be paid if the medical manipulations are related to the consequences of the event insured. 2. Insurance benefit shall be paid for the lost teeth which is re-implantable. However, no benefit shall be paid in case of later removal of the re-implanted tooth. 3. Insurance benefit shall not be paid if a detachable denture is broken or damaged as a result of trauma. 4. In case of teeth loss due to broken permanent (non-removable) denture or fixed dental bridges, insurance benefit shall only be paid for the traumatic loss of the supporting teeth. 5. In case of traumatic loss of milk teeth: 5.1. the full amount of insurance benefit shall be paid to children under 5 years old; 5.2. the full amount of insurance benefit shall be paid in case of loss of III,IV and V milk teeth to children under 8 years old. In case of any other traumatic injury to milk teeth, 1/2 of the benefit shall be paid, but no more than 150 EUR, irrespective of the number of injured teeth. 6. In case of injuries to the teeth damaged (carious, filled) prior to the trauma, the insurance benefit shall be reduced by 50%, except in cases when there are objective signs of the presence of oral and/or facial injuries. 7. If the teeth are damaged during eating / biting, the insurance benefit shall be reduced by 50%	

	8. In case if traumatic loss of one upper front teeth (13, 12, 11, 21, 22, 23) insurance benefit is not more than 1.000 EUR. 9. In case of traumatic loss of one teeth excluding front teeth (excluding front teeth - 13, 12, 11, 21, 22, 23), insurance benefit is not more than 500 EUR. 10. No insurance benefit is payable in case of loss of dental prosthesis/ implants caused by an injury (trauma).	
12.4	Traumatic injuries to the abdominal organs:	
12.4.1.	Traumatic injury to the internals without surgical treatment	3
12.4.2.	Traumatic injury to the internals requiring:	
12.4.3.	laparocentesis	5
12.4.4.	laparoscopy	7
12.4.5.	laparotomy	10
12.4.6.	Anterior abdominal wall, diaphragmic herniation or postoperative hernia at the area of scar (when operation was due to trauma), as well as conditions after operation of such hernias.	10
Notes:	1. No insurance benefit is payable for hernias (umbilical, epigastric, inguinal, inguinoscrotal hernias) occurring as a result of physical exertion (including load lifting). 2. Benefit under paragraph 12.4.6. shall be paid in addition to the benefit payable for abdominal trauma, if hernia is a direct outcome of the trauma.	
	Urinary and genital system:	
13.1.	Traumatic injuries of urinary system of whatsoever type causing (tears, burns, chilblains, acute nephrotoxic changes)	5
13.2.	Consequences of injuries to the genital system:	
13.2.1.	Injuries to the scrotum, penis, labia, and/or vagina without complications	3
13.2.2.	Injuries to the scrotum, penis, labia, and/or vagina with complications (traumatic loss of the testicle, penis or any part thereof, perforation of the vaginal wall, etc.)	10
13.3.	Foetal loss following trauma	25
Note	1. The insurance benefit paid under paragraph 13 of this section shall be deducted from the benefit payable for the same event insured under Disability clause of this wording.	
	Cardiovascular system:	
14.	Cardiovascular injuries:	
14.1.	not followed by a hypovolemic shock	3
14.2.	followed by a shock of mild and medium severity	5
14.3.	followed by a severe shock	10
Note	1. Where injuries to the great arteries involved surgery with artificial blood circulation, the insurance benefit shall be increased by 50% (only once). 2. The insurance benefit per one event insured shall be paid only for one injury which is the most serious.	
	Vision apparatus:	
15.1.	Conjunctival and/or corneal injuries, foreign bodies	1
15.2.	3rd degree eye burns	5
15.3.	Consequences of eye trauma persistent 3 months after the trauma:	
15.3.1.	eyelid scars affecting the eyelid function, rupture of the lacrimal duct, injury/paralysis of extraocular muscles	10
15.3.2.	hyphema (anterior *chamber* haemorrhage), changes in the size of the iris and pupil, changes in the ciliary body (paralysis of accommodation), rupture of the ciliary body, changes in the location of the pupil, changes in the vitreous humour (haemophtalmus), traumatic retinal detachment, choroidal rupture, traumatic cataract	15
15.4.	Traumatic dislocation of the eyeball	5

<table>
<tr><td>15.5.</td><td colspan="4">Perforated injuries of the eyeball (cornea, sclera)</td><td>5</td></tr>
<tr><td>15.6.</td><td colspan="5">Traumatic vision impairment (unaided)</td></tr>
<tr><td colspan="2">Vision acuity</td><td rowspan="2">%</td><td colspan="2">Vision acuity</td><td rowspan="2">%</td></tr>
<tr><td>Before trauma</td><td>After trauma</td><td>Before trauma</td><td>After trauma</td></tr>
<tr><td rowspan="8">1.0</td><td>0.7</td><td>1</td><td rowspan="6">0.6</td><td>0.4</td><td>1</td></tr>
<tr><td>0.6</td><td>3</td><td>0.3</td><td>3</td></tr>
<tr><td>0.5</td><td>5</td><td>0.2</td><td>10</td></tr>
<tr><td>0.4</td><td>10</td><td>0.1</td><td>15</td></tr>
<tr><td>0.3</td><td>15</td><td><0.1</td><td>20</td></tr>
<tr><td>0.2</td><td>20</td><td>0.0</td><td>25</td></tr>
<tr><td>0.1</td><td>30</td><td rowspan="4">0.5</td><td>0.3</td><td>1</td></tr>
<tr><td><0.1</td><td>40</td><td>0.2</td><td>5</td></tr>
<tr><td rowspan="6">0.9</td><td>0.0</td><td>45</td><td>0.1</td><td>10</td></tr>
<tr><td>0.6</td><td>1</td><td><0.1</td><td>15</td></tr>
<tr><td>0.5</td><td>3</td><td>0.0</td><td>20</td></tr>
<tr><td>0.4</td><td>5</td><td rowspan="4">0.4</td><td>0.2</td><td>3</td></tr>
<tr><td>0.3</td><td>10</td><td>0.1</td><td>5</td></tr>
<tr><td>0.2</td><td>20</td><td><0.1</td><td>10</td></tr>
<tr><td>0.1</td><td>30</td><td>0.0</td><td>20</td></tr>
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<tr><td>0.5</td><td>1</td><td colspan="3" rowspan="6"></td></tr>
<tr><td>0.4</td><td>5</td></tr>
<tr><td>0.3</td><td>10</td></tr>
<tr><td>0.2</td><td>15</td></tr>
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0.0</td><td>30
35</td></tr>
<tr><td>Note</td><td colspan="5">1. Retinal detachment shall be deemed the event insured and insurance benefit shall be payable only if the detachment is caused by direct eye trauma (contusion, injury, orbital fracture diagnosed not later than 6 months after the date of the injury (trauma) date). Where the detachment is caused by a disease (severe myopia, hypertonic or other diseases), lifting heavy loads, sudden or unusual movements, contusion of any other part of the body, no insurance benefit shall be paid.
2. The insurance benefit paid under this section shall be deducted from the benefit payable for the same event insured under Disability clause of this wording.
3. The insurance benefit payable in accordance this clause 15.6 shall be reduced by deducting other insurance benefits paid / payable according Article 15 "Vision System".
4. When visual acuity is impaired in both eyes as a result of trauma, each eye shall be examined separately. Percentages for both eyes shall be added and multiplied by a rate of 1.25.
5. If health care institutions have no records about vision acuity before the trauma, the vision acuity shall be considered to be – 1.0, but not better than the vision acuity of the injured eye.</td></tr>
</table>

	6. If an intraocular lens is implanted after the trauma or aided lens is applied, the benefit payable shall be fixed on the basis of the vision acuity aftherimplantation or application of the lens. 7. Vision acuity shall be measured at least 3 months, but not later than 12 months, after the injury (trauma).	
16.	**Other traumatic injuries**	
16.1.	Fracture of sezamoid bone	1
16.2.	Rupture of symphysis	3
16.3.	Operation due to symphysis rupture	5
Note	1. Insurance benefit under this paragraph shall be paid only when not any other benefit under this table should be paid.	
17.	**Consequences of various traumatic injuries** **(this section shall not apply in case of traumas of hand and foot digits):**	
17.1.	Phlegmon, posttraumatic lymphostasis, posttraumatic thrombophlebitis, bedsores developed during treatment after trauma	5
17.2.	Bone graft for autotransplantation	5
17.3.	Posttraumatic osteomyelitis (except for cranium), haematogenic osteomyelitis	10
Note	1. Insurance benefit under this section shall be paid on a one-off basis, in addition to benefits payable under other sections, in cases when the consequences of traumas (except for phlegmon) are persistent at least 3 months after the trauma within 12 months after the date of accident, and the persistent consequences are confirmed by medical records.	
17.3.	Traumatic, burn-caused, anaphylactic shock (due to increased sensitivity to certain substances), fat embolism, if diagnosed during in-patient treatment	5
17.5.	Insured events for which the Insured Person was treated in hospital for more than 4 days: traumatic asphyxia, acute intoxication with chemical (toxic) substances, electrical injuries (power discharge from electricity systems, equipment or atmosphere), tetanus, snakebite, animal bites, stings (except for cases when treatment is administered as a result of infectious disease), requiring in-patient treatment for:	
17.5.1.	5 to 10 days	6
17.5.2.	11 and more days	10
Note	1. Insurance benefit under this section shall be paid only in cases if no benefit is due under any other sections/paragraphs of the Table. 2. Where the Insured Person is attacked by his/her own pet, the insurance benefit shall be reduced by 50%.	
18.	**Critical illness:**	
18.1.	**Cancer**	100
Note	1. A group of diseases whose characteristic: genetically abnormal and uncontrolled cell proliferation and cells' ability to destroy the surrounding tissue and spread to other parts of the body (metastasis). 2. Cancer diagnosis must be confirmed by histological examination and oncologist. 3. The term cancer includes leukaemia (blood cancer), sarcoma and lymphoma (except for T-cell lymphoma). The diagnosis must be confirmed by an oncologist or haematologist and a relevant blood test. 4. Insurance benefit is not paid for benign tumours (non-cancerous cells), prior-cancer illness, non-invasive tumours (cancer in situ), first stage prostate cancer, first stage of lympha-granulomatosis, chronic lymphatic leukaemia, skin cancer (except for malignant melanoma), tumours of any type for HIV (human immunodeficiency virus) infected Insured Persons.	
18.2.	**Cerebral infarction (stroke)**	100
Note	1. Sudden disturbance in the blood supply to the brain persisting longer than 3 weeks caused by arterial embolism, vein thrombosis or cerebral haemorrhage resulting in permanent neurological damage.	

	2. Insurance benefit shall be paid only in case of a permanent neurological damage which must be confirmed by a neurologist no earlier than within 12 weeks after the cerebral infarction.	
18.3.	**Myocardial Infarction**	100
Note	1. Impassable acute myocardial damage (necrosis) that occurs as a result of interrupted blood flow in the corresponding part of the heart. 2. Myocardial infarction diagnosis must be approved by the criteria listed below: 2.1. Prolonged pain in the chest; 2.2. Electrocardiographic changes endemic to myocardial infarction 2.3. Specific enzymes endemic to myocardial infarction concentration in blood. 3. Diagnosis must be confirmed by a cardiologist.	
18.4.	**Loss of sight (Blindness)**	100
Note	1. Total and irreversible loss of sight of both eyes due to illness. 2. Diagnosis must be confirmed by a physician ophthalmologist after clinical and instrument study. 3. Blindness can be of a temporary nature. In this case, insurance benefit is payable if complete loss of sight in both eyes remains 6 months after being diagnosed.	
18.5.	**Kidney failure**	100
Note	1. Chronic kidney failure which meets the below conditions: 1.1. Irreversible glomerular filtrate decrease due to functional kidney tissue nephrosclerosis. 1.2. Creatinine level more than 10mg /dl; 1.3. Conservative treatment does not help; 1.4. Treatment with dialysis or transplantation. 2. Insurance benefit is paid if Insured had kidney transplantation operation or regular dialysis for 6 months at least once a month. 3. Insurance benefit shall not be paid for a unilateral nephrectomy and acute renal failure.	
18.6.	**Multiple Sclerosis**	100
Note	1. Demyelinating disease of the central nervous system expressed by recidivating and constantly progressing symptoms of neurological dysfunction. 2. The diagnosis of multiple sclerosis must be substantiated by a neurologist after an in-patient neurological testing. 3. The said diagnosis must be substantiated by appropriate tests, motor and sensor function disorder symptoms, magnetic resonance imaging. 4. The obvious disorder of motor or sensor functions must persist for at least 6 months.	
18.7.	**Loss of Limbs/ Loss of Function of Limbs**	100
Note	1. Total permanent loss of two or more limbs or loss of their function due to illness. Loss of limb is loss over knee or elbow. 2. In some cases loss of function of limbs might be temporary. In such case – Insurer has a right to delay the decision to pay the benefit up to 6 months. Insurance benefit is paid if loss of function of limb continues for over 6 months.	
18.8.	**Transplantation of internals**	100
Note	1. Transplantation of the heart, lungs, liver, bone marrow, kidney(s), small intestine, pancreas, when insured person is the recipient. Insurance benefit is not paid for the donors.	
18.9.	***Aortic aneurysm*** (abnormal enlargement of the vessel (aorta) with the risk of rupturing and causing severe bleeding).	100
Note	1. The diagnosis must be based on objective examinations (ultrasound examination of internal organs, aortography, CT (computerized tomography), MRI (magnetic resonance imaging), or other). 2. Emergency surgery or prescribed scheduled endovascular stent grafting.	
18.10.	**Coronary artery bypass grafting**	100

Note	1. Open coronary artery bypass grafting in order to bypass narrowed or blocked two or more coronary arteries using bypassing grafts. 2. The need for surgery must be confirmed by the cardiologist or cardiac surgeon and supported with coronary artery angiographic data. 3. Insurance benefit shall not be paid in case of: • bypass grafting is performed for one narrowed or blocked coronary artery; • angioplasty of coronary arteries or stent implantation.	
18.11.	**Heart valve surgery**	100
Note	1. Heart valve surgery is used to replace or repair one or several damaged diseased valves. The term includes the following procedures: • Open valve repair or replacement surgery; • Rosso surgery; • Balloon valvuloplasty; • Transcatheter aortic valve implantation (TAVI). 2. The need for surgery must be confirmed by the cardiologist or cardiac surgeon and supported with ultrasound cardioscopy or heart catheterisation records. 3. Insurance benefit shall not be paid in case of transcatheter mitral valve repair.	
18.12.	**Benign brain and spinal cord tumours** (masses of cells with uncontrolled division and spread to the adjacent tissues (infiltration)).	100
Note	1. The diagnosis must be confirmed by an oncologist or neurosurgeon. 2. The diagnosis must be based on objective examinations (CT (computerized tomography), MRI (magnetic resonance imaging) or brain biopsy).	
18.13.	**Cerebral aneurysm** *(*abnormally dilated blood vessel in the brain that has the potential to press on the adjacent tissues or rupturing and causing severe bleeding).	100
Note	1. The diagnosis must be based on objective examinations ((computerized tomography), MRI (magnetic resonance imaging) scan, brain angiography, cerebrospinal fluid analysis or others). 2. Emergency surgery or prescribed scheduled cerebral aneurysm surgery. 3. Insurance benefit shall not be paid for asymptomatic cerebral aneurysms subject to periodic observation and examination.	
18.14.	**Loss of hearing**	100
Note	1. Permanent and irreversible deafness of both ears caused by illness. 2. Diagnosis must be determined by an otolaryngologist and requires at least 90 db hearing obstruction in the better ear established on the basis of "pure-tone" audiometric tests using threshold frequencies at 500, 1000 and 2000 Hz. 3. Deafness can be of a temporary nature. In this case, insurance benefit is payable if complete loss of hearing in both ears remains 6 months after being diagnosed.	
18.15.	**Loss of speech**	100
Note	1. Permanent and irreversible loss of speech persistent for at least 6 months. 2. Diagnosis must be confirmed by an otolaryngologist. 3. Insurance benefit shall not be paid for the loss of speech due to mental disorders or illnesses.	
18.16.	**Parkinson's disease**	100
Note	1. Parkinson's disease causing permanent loss of physical abilities. 2. Primary Parkinson's disease diagnosed to persons under 60 years old and is confirmed by at least two clinical symptoms below: • muscular rigidity; • tremor; • Hypokinesia (abnormal slowness of movement, sluggishness of physical and mental responses). 3. In spite of adequate medical treatment, Parkinson's disease should determine a total inability to perform, by oneself, at least 3 of the following 6 activities of daily living for a continuous period of at least 3 months. Activities of daily living are:	

	• Bathing: the ability to wash oneself in a bathtub, shower (including getting in/out of the bathtub or shower) or satisfactory washing using other means; • Dressing: the ability to put on and remove, button and unbutton necessary clothing, including braces, artificial limbs or other orthopaedic appliances; • Eating: the ability to consume, by oneself, food that already has been prepared and made available; • Personal hygiene: the ability to maintain adequate personal hygiene while using the toilet or to manage bladder and bowel functions otherwise; • moving around the rooms – the ability to move from one room to another on the same floor; • getting in/out of a bed – the ability to move in and out of a bed to chair or wheelchair. 4. The diagnosis must be made by a neurologist. 5. Implantation of a brain stimulator (neurostimulator) to control symptoms of the illness shall be the event insured irrespective of the ability to perform the activities of daily living. The need for implanting the neurostimulator must be confirmed by a neurologist or neurosurgeon. 6. Insurance benefit shall not be paid in the following cases: • secondary parkinsonism (including drug- or toxin-induced parkinsonism); • essential tremor; • Parkinsonism related to other neurodegenerative diseases.	
18.17.	**Alzheimer's disease**	100
Note	1. Definite diagnosis of Alzheimer's disease made for persons under 60 years old and confirmed by the presence of all the criteria below: • loss of intellectual capacity involving impairment of memory and cognitive functions (focusing, organisational, judgement and planning), which results in a significant reduction in mental and social functioning; • personality changes; • slow disease progression and permanent worsening of cognitive functions; • no disturbance of consciousness; • typical findings in neuropsychological and nervous system tests (e.g., CT ((computerized tomography), MRI (magnetic resonance imaging)). 2. The Insured Person requires permanent care due to the disease (24 hours per day). 3. The diagnosis and the needs for care must be defined and confirmed by a neurologist. 4. Insurance benefit shall not be paid in case of a diagnosis of other forms of dementia caused by brain, systemic or mental illnesses.	

<u>Additional illnesses listed below which are provided in case extensive cover is chosen.</u>

18.18.	**Primary diabetes mellitus type I** (disease characterised by disorder of insulin production and high blood sugar levels).	100
Note	1. The diagnosis must be confirmed by an endocrinologist. 2. Blood tests must have showed increased levels of glucose and/or glycated haemoglobin (HbA1c). 3. Permanent treatment of insulin injections.	
18.19.	**Systemic lupus erythematosus** (chronic autoimmune and inflammatory disease in which the body's immune system attacks (damages) healthy tissues)	100
Note	1. The diagnosis must be confirmed by a rheumatologist. 2. Blood tests (serologic test) must have showed the presence of Ro/SS -A and La/SS -B antinuclear anti-bodies.	
18.20.	**Addison's disease** (bilateral dysfunction of adrenal glands developing in adrenal cortex destruction and resulting in partial or total failure of adrenocortical function.	100
Note	1. The disease must be confirmed by an endocrinologist.	

	2. The Insured Person must be on hormonal therapy for 3 months and such treatment is to be continued. 3. Blood tests must have showed a low level of cortisol and a high level of adrenocorticotropic hormone (ACTH).	
18.21.	**Muscular dystrophy** (genetically inherited primary muscular diseases characterised by muscle weakening and wasting away (atrophy))	100
Note	1. The disease must be confirmed by a geneticist and neurologist. 2. The diagnosis is based on a morphological muscular and/or electromyographic examination and specific muscle enzyme (creatine phosphokinase) test.	
18.22.	**Bechterew's disease** (complete spinal rigidity caused by advancing ossification of joints induced by a chronic inflammatory disease)	100
Note	1. The diagnosis must be confirmed by rheumatologist. 2. The diagnosis must be based on X-rays demonstrating disease-typical spinal changes (intervertebral fusion). 3. Blood tests must have showed the presence of human leukocyte antigen (HLA) B27.	
18.23.	**Rheumatoid arthritis** (autoimmune, chronic, regularly progressing inflammation of a number of joints causing their deformity)	100
Note	1. The diagnosis must be confirmed by rheumatologist. 2. Blood tests must have showed high levels of rheumatoid factor. 3. Disease-typical changes in the joints are diagnosed on the basis of objective examinations (X-rays, CT (computerized tomography), MRI (magnetic resonance imaging)).	
18.24.	**Coma**	100
	Coma is a state of unconsciousness with no reaction to external stimuli or internal needs. The coma must persist for at least 96 hours and require intubation and mechanical ventilation to sustain life. There must also be functional neurological impairment persisting for a continuous period of at least 30 days after the onset of the coma, which in the opinion of the neurologist is of a permanent nature. Medically induced coma and coma resulting directly from alcohol or drug abuse are excluded.	
18.25.	**Major burns**	100
	There must be third degree burns with scarring that cover at least 20% of the body's surface area. A certified physician must confirm the diagnosis and the total area involved using standardized, clinically accepted, body surface area charts.	
18.26.	**End stage liver failure**	100
	Permanent and irreversible failure of liver function that has resulted in all three of the following: 1. permanent jaundice; and 2. ascites; and 3. hepatic encephalopathy. Liver failure secondary to drug or alcohol abuse is excluded.	